

Trust Board (business and risk)
Tuesday 28 July 2026 at 09.30
Small Conference Room, Learning and Wellbeing Centre, Fieldhead Hospital, Wakefield

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 <i>(received in advance in writing by e:mail to membership@swyt.nhs.uk)</i>	Chair	Verbal item	5	To receive
9.38	4. Minutes from previous Trust Board meeting held 30 June 2026	Chair	Paper	2	To approve
9.40	5. Matters arising from previous Trust Board meeting held 30 June 2026 and board action log	Chair	Paper	5	To receive
9.45	6. Service User / Staff Member / Carer Story	Chief Operating Officer	Verbal item	10	To receive
9.55	7. Chair's remarks	Chair	Verbal item	3	To receive
9.58	8. Chief Executive's report	Chief Executive	Paper	7	To receive

With **all of us** in mind.

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
10.05	9. Assurance and approved minutes from Trust Board committees and Members' Council - Quality and Safety Committee 7 July 2026 - Audit Committee 14 July 2026 - People and Remuneration Committee 14 July 2026 - Finance, Investment and Performance Committee 20 July 2026	Committee Chairs	Paper	10	To receive
10.15	10. Risk and assurance				
10.15	10.1 Board Assurance Framework (BAF)	Deputy Chief Executive/Director of Strategy, Inclusion and Change	Paper	10	To approve
10.25	10.2 Corporate / organisational risk register	Deputy Chief Executive/Director of Strategy, Inclusion and Change	Paper	15	To approve
10.40	10.3 Equality Diversity and Inclusion annual report	Deputy Chief Executive/Director of Strategy, Inclusion and Change	Paper	5	To approve
10.45	10.4 Infection Prevention and Control BAF	Chief Nurse and Director of Quality and Professions	Paper	5	To receive
10.50	10.5 Safer staffing report	Chief Nurse and	Paper	5	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
		Director of Quality and Professions			
10.55	10.6 National Staff Standards	Chief People Officer	Paper	5	To receive
11.00	10.7 NHS Leadership and Management Framework	Chief People Officer	Paper	5	To receive
11.05	10.8 Health and Safety Annual report	Director of Finance, Estates and Resources	Paper	5	To approve
11.10	10.9 Premises Assurance Model annual report	Deputy Director of Estates and Facilities	Paper	5	To approve
11.15	10.10 Patient led assessments of the care environments (PLACE) scores	Director of Finance, Estates and Resources	Paper	5	To receive
11.20	<i>Break</i>			10	
11.30	11. Performance				
11.30	11.1 Integrated Performance Report (IPR) month 3 2026/27	Director of Finance, Estates and Resources	Paper	15	To receive
11.45	11.2 Care Group Performance Report	Chief Operating Officer	Paper	10	To receive
11.55	12. Integrated Care Systems and Partnerships				

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
11.55	12.1 South Yorkshire update including South Yorkshire Integrated Care System (SYICS)	Chief Executive/ Deputy Chief Executive/Director of Strategy, Inclusion and Change	Paper	7	To receive
12.02	12.2 West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update	Chief Executive	Paper	7	To receive
12.09	12.3 Specialised Provider Collaboratives and Alliances	Director of Finance, Estates and Resources	Paper	6	To receive
12.15	13. Governance				
12.15	13.1 Assessment against NHS Constitution	Deputy Chief Executive/Director of Strategy, Inclusion and Change	Paper	5	To receive
12.20	13.2 Transformation, Innovation and Sustainability Committee Terms of Reference and Workplan	Deputy Chief Executive/Director of Strategy, Inclusion and Change	Paper	5	To approve
12.25	14. Strategies and policies				
12.25	14.1 Trust Strategy Measurement	Deputy Chief Executive/Director	Paper	10	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
		of Strategy, Inclusion and Change			
12.35	15. Trust Board work programme	Chair	Paper	5	To receive
12.40	16. Any other business	Chair	Verbal item	3	To discuss
12.43	17. Date of next meeting The next Trust Board meeting held in public will be held on 29 September 2026	Chair	Verbal item	2	To note
12.45	Close				

Minutes of the public Trust Board meeting held on 30 June 2026
Small Conference Room, Learning and Wellbeing Centre, Fieldhead Hospital

Present:	Jayne Brown (JB) Gary Ellis (GE) Mike Ford (MF) Martin Neeson (MN) Rokaiya Khan (RK) Margaret Kitching (MK) Mitch Waterman (MW)	Trust Chair Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director Appointed University of Leeds Associate Non-Executive Director
	Mark Brooks (MBr) Dawn Lawson (DL)	Chief Executive Deputy Chief Executive / Director of Strategy, Inclusion and Change
	Adrian Snarr (AS) Caroline Johnson (CJ)	Director of Finance, Estates and Resources Chief Nurse and Director of Quality and Professions
Apologies:	Natalie McMillan (NMc) Prof. Subha Thiyagesh (ST)	Deputy Chair, Senior Independent Director Chief Medical Officer
In attendance:	Christine Brereton (CB) Adele Fox (AF) Manoj Mathen (MM)	Chief People Officer Chief Operating Officer Consultant Psychiatrist and Associate Medical Director for Workforce and Operations
	Izzy Worswick (IW)	Deputy Director of Partnerships, Planning and Governance
	Andy Lister (AL) Bridgette Gill (BG) Aboobaker Bhana (AB)	Company Secretary Chief Officer, Spectrum People (Item 6) Equality and Involvement Manager/Lead for Connecting People (Item 6)
	Saima Amir (SA)	Community Connector and Chairty Advisor, Spectrum People (Item 6)
	Gemma Lockwood (GL) Debbie Beynon-Fisher (DBF)	Corporate Governance Manager Corporate Governance Officer (author)
Observing:	John Laville (JLa) Emma Cox (EC) Michael Taylor (MT) Ian Trodden (IT)	Public Governor – Kirklees (Lead Governor) (MS Teams) Staff Governor – Nursing (MS Teams) Cinapsis Care Quality Commission

TB/26/50 Welcome, introductions and apologies (agenda item 1)

Jayne Brown (JB), Chair, welcomed everyone to the meeting. Apologies were noted, and the meeting was deemed to be quorate and could proceed.

JB outlined the Board meeting protocols and etiquette, and reported the meeting was being live streamed for the purpose of inclusivity, to allow members of the public access to the meeting.

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

TB/26/51 Declarations of interest (agenda item 2)

Christine Brereton (CB) declared an interest, noting that her spouse will become Interim Finance Director at Nottinghamshire Healthcare Mental Health Trust from 1 July 2026. Jayne Brown confirmed that she had completed her conflicts of interests declaration.

It was RESOLVED to NOTE the updated declarations of interest.

TB/26/51 Questions from the public (agenda item 3)

No questions were received from the public.

TB/26/52 Minutes from previous Trust Board meeting held 28 April 2026 (agenda item 4)

The minutes of the meeting held on 28 April 2026 were accepted as an accurate record.

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 28 April 2026 as a true and accurate record.

TB/26/53 Matters arising from previous Trust Board meeting held 28 April 2026 and Board action log (agenda item 5)

No matters raised.

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

TB/26/54 Service User/Staff Member/Carer story (agenda item 6)

Dawn Lawson (DL) provided an introduction to the Connecting People programme, which is an initiative focused on strengthening community connections and ensuring that diverse voices are heard and reflected in the Trust's work. The programme aims to bring forward lived experience and strengthen connections between the Trust and the communities it serves.

Aboobaker Bhana (AB), Equality and Involvement Manager, provided an overview of the Connecting People programme and its role in supporting the Trust's statutory duties in relation to engagement and involvement. The programme has been piloted over a two-year period as an approach to delivering meaningful engagement with communities, moving beyond traditional consultation methods towards genuine partnership working. He emphasised that involvement is a legal requirement under the Health and Social Care Act, requiring the Trust to engage with service users, carers and partners.

The programme is designed to support "organic" growth of community involvement by investing in and working alongside local communities. This includes developing an infrastructure of community connectors who facilitate engagement, support participation and ensure that community voices inform service development. Approximately 138 community connectors are currently engaged, including Trust staff, and the programme is intended to build long-term capacity, with an aim to become a standard model for engagement across the organisation. Connectors play a key role in supporting Trust engagement and wider partnership working across local communities.

AB highlighted examples of impact, including targeted engagement work informing early intervention approaches and contributing to work aimed at reducing inequalities, particularly

for minority communities. The programme has also generated significant community insight, with over 1,200 pieces of feedback gathered through structured engagement activity.

Bridget Gill (BG), Chief Officer of Spectrum People, outlined its role as a community partner supporting Connecting People. She highlighted its focus on building community connections through creative, green and therapeutic activities that promote wellbeing and social inclusion. BG emphasised that trusted relationships and community-based approaches are often more effective than formal systems in reaching individuals who may not access traditional health services, including those facing language barriers or social isolation.

Saima Amir (SA), Community Connector and Charity Advisor with Spectrum People, outlined the impact of the Connecting People programme from a community perspective. She noted that the programme helps individuals build skills, confidence and networks, while enabling the Trust to engage meaningfully with communities not always reached through traditional methods. Community Connectors support early identification of health concerns, provide culturally appropriate information, signpost to NHS services and facilitate conversations on issues including mental health, diabetes, dementia, menopause and carer support. Their lived experience helps build trust, reduce social isolation and inform Trust policy and service design through structured community feedback.

The programme's contribution to increasing diversity in research participation was also noted, with connectors supporting recruitment into health research studies and widening representation.

Examples of the impact of partnership working with the Trust were shared which includes activities funded through the Carers Fund, community events and targeted engagement initiatives. These were described as creating accessible entry points for health conversations, supporting wellbeing and strengthening community trust in services.

Adele Fox (AF) raised a question regarding how the Connecting People programme engages individuals with learning disabilities, recognising that this group experiences significant health inequalities. BG advised that engagement is tailored to individual need and centred on flexible, community-based approaches rather than a single standard model. Interventions are delivered through community settings, including initiatives such as social prescribing, art therapy and play-based support, which are adapted depending on the needs, age and circumstances of the individual. Support spans a broad age range and is designed to provide safe and inclusive environments where individuals feel comfortable and able to engage. The programme also adopts a person-centred approach, working closely with individuals to understand what is most effective for them, rather than expecting individuals to fit into predetermined service structures. This approach supports improved engagement and enables individuals to access appropriate support at the right time.

It was noted that partnerships with academic institutions and community organisations strengthen the delivery of specialist interventions, including access to trained practitioners and additional support capacity.

Mark Brooks (MBr) expressed his sincere thanks to the presenters and community partners for their contributions and for sharing their experiences of the Connecting People programme. MBr commended the evident passion, commitment and impact demonstrated by those involved, recognising their shared purpose in making a meaningful difference to the lives of the communities served by the Trust. He reiterated that the Trust's core purpose is to help people reach their potential and live well in their communities, noting that the diverse populations across the Trust's footprint require strong and effective community connections to support delivery of improved outcomes. The importance of extending the Trust's reach into local communities was noted, particularly those who may not traditionally engage with services. He emphasised that the Connecting People model represents a valuable approach

to strengthening this reach and supporting the Trust's ambition to improve population health and wellbeing.

MBr further highlighted the opportunity for the Trust to build on this work through partnership working, both within the organisation and across the wider system. The programme demonstrates a potentially distinctive approach which could contribute to broader learning and development across other organisations.

JB echoed these thanks, recognising the significance of the programme and the reminder that effective community engagement requires the organisation to adapt its approach, rather than viewing communities as "hard to reach".

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

TB/26/55 Chair's remarks (agenda item 7)

JB noted that the private board meeting would include:

- Complex clinical matters report
- West and South Yorkshire System updates
- Provider Collaboratives and partnership updates
- Value for money position and financial update
- Stakeholder map
- Planning update
- Annual report and accounts
- Audit Committee Chair Designate

JB provided an update on her initial activities since taking up the post of Chair and expressed her appreciation to colleagues for their support during her induction, recognising the time and effort taken by staff across the organisation to support her transition into the role.

JB advised that she has prioritised building relationships across the system, including engagement with Chairs from other organisations within South and West Yorkshire and the Integrated Care Board (ICB), as well as local acute Trust Chairs.

JB also reported on a series of service visits undertaken across the Trust, including visits to clinical teams and services. She highlighted a visit to Cheswold Park, noting her positive impression of how well integrated the service already feels, both in terms of culture and alignment with the Trust's values. During the visit, JB sought direct feedback from staff regarding their experiences, including the impact of recent organisational changes. She reported that feedback had been consistently positive, particularly in relation to cultural integration, whilst recognising that operational challenges and pressures remain.

JB also highlighted she had attended a number of Trust events, including a learning disability awards event, which she described as inspiring and reflective of the dedication and achievements of staff and service users. Her early observations indicate a strong and positive organisational culture, while acknowledging that further work will be required to continue developing and addressing areas for improvement.

It was RESOLVED to RECEIVE the Chair's remarks.

TB/26/56 Chief Executive's report (agenda item 8)

MBr presented the Chief Executive's report which was taken as read. MBr provided an overview of key organisational, operational and national developments since the previous public Board meeting:

- The Trust retained a segmentation rating of 'one' within the NHS Oversight Framework, reflecting strong performance across quality, workforce, operational delivery and finance.

- The Trust achieved its financial targets for the previous year. However, the financial position for the current year remains significantly more challenging with a requirement to deliver a break-even position.
- The Trust has launched a Mutually Agreed Resignation Scheme (MARS) as part of wider workforce and financial planning.
- Recent Trust-wide initiatives and events included Mental Health Awareness Week, Learning Disability Week, Pride Month, Carers Week, and staff and volunteer recognition activities, which helped raise service profiles and celebrate contributions from staff, service users and communities.
- Anticipated industrial action by resident doctors had been suspended following a revised national offer, although formal confirmation was awaited.
- Lord Mann has recently published his review into tackling racism and antisemitism within the NHS along with several recommendations. The Trust continues to progress this agenda through its equality frameworks, recognising that further action is needed to address disparities in staff experience. The Trust will ensure Board oversight of implementation of recommendations via our People and Remuneration Committee.
- A judgement handed down by the Supreme Court on Tuesday 2 June 2020⁶ has resulted in immediate changes to the Deprivation of Liberty (DOLs) process was noted. The Department of Health & Social Care (DHSC) are developing guidance for the application of the new ruling. Experts in the Trust are working collaboratively with the local authorities for a consistent approach. In the 2026 King's Speech, the government outlined plans to introduce legislation to reform how the NHS is led and managed in the form of an NHS Modernisation Bill. This has implications in terms of the NHS structures and governance and the future role of Members' Council.
- MBr provided an update on system and partnership working, including developments within Integrated Care Boards (ICB) and place-based provider partnerships, noting workforce changes and restructuring across ICBs.
- There is continued pressure on inpatient services, particularly within mental health services, due to sustained high demand. MBr commended staff for their efforts in managing patient flow and maintaining service delivery during periods of high demand and extreme heat.
- There is ongoing national collaboration across mental health providers to agree priorities that will make a real difference this year, with a focus on reducing out-of-area placements, improving access for children and young people, and addressing pressures within urgent and emergency care pathways.
- MBr acknowledged a number of organisational achievements, including the Trust's annual excellence awards and long service recognition, and formally welcomed the new Chair to her first Board meeting.
- Recent senior leadership developments within NHS England and the potential implications for system leadership arrangements were also noted.

Mike Ford (MF) raised a question regarding the availability and interpretation of the Trust's performance scores under the emerging national oversight framework metrics for 2026/27. Adrian Snarr (AS) advised that early sight of the new metrics had been received and that the Trust is beginning to assess its performance against these measures. Whilst indicative scoring information is available internally, it is not yet possible to draw meaningful conclusions as scoring is relative to the performance of other organisations.

The proposed framework for 2026/27 is expected to include approximately 24–29 indicators, compared to the 11 currently measured, although final confirmation is awaited. AS noted that many of the required metrics are already captured within the Trust's existing internal reporting, including the Integrated Performance Report (IPR), but further work is required to ensure alignment between local and national definitions..

JB asked how the Trust engages with schools where it does not directly provide school nursing or public health services. AF explained that Mental Health Support Teams in schools have been implemented across the Trust's footprint and are broadly on track to meet national coverage expectations. These teams have developed close links with schools, supporting early intervention and improved access to support for children and young people.

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

TB/26/57 Assurance from Trust Board Committees, Members' Council and Joint Partnership Board (agenda item 9)

Joint Partnership Board – 27 April 2026

Mitch Waterman (MW) provided an update on recent developments within the Joint Partnership Board (JPB):

- Progress had been made in developing the partnership framework, although the formal Partnership Agreement has not yet been finalised due to ongoing changes within the NHS landscape. The agreement will be brought to a future Board meeting once finalised.
- The Joint Partnership Board had moved forward at pace over recent meetings and has established a set of shared strategic priorities between the Trust and the University of Leeds. These priorities include enhancing educational opportunities, developing research capability, and reviewing existing collaborative activity to ensure alignment with organisational objectives.
- To support delivery, two operational sub-groups are being established, focusing respectively on education and research. These groups will undertake a detailed review of current activity across the Trust, identifying opportunities for development, alignment and, where appropriate, rationalisation.
- The draft terms of reference and proposed membership for these sub-groups will be presented to a future Joint Partnership Board meeting. Initial engagement with the groups is planned in advance to maintain momentum.
- Risk identification and workforce considerations will form key components of the sub-groups' work, providing a foundation for future strategic development.
- The programme of work will include both short-term deliverables and longer-term strategic ambitions, ensuring that the partnership evolves in a sustainable and impactful manner.

MBr reflected positively on the progress made, noting that the past year had focused on establishing the foundations of the partnership. He emphasised that the next phase would be centred on maximising mutual benefit, recognising that both organisations share many common priorities. He highlighted the importance of identifying opportunities where the partnership can deliver tangible value for both the Trust and the University.

People and Remuneration Committee (PRC)

Martin Neeson (MN) provided an update following the People and Remuneration Committee meeting held on 5 May 2026:

- Workforce pressures associated with recent industrial action were noted as well as the reliance on staff to provide additional cover during this period. These pressures had been effectively managed and no adverse incidents had been reported, providing assurance to the Board on workforce resilience and safety.
- Changes have been made to the appraisal completion cycle, with a revised timeline agreed. A temporary reduction in completion rates may be expected during the transition period, with performance anticipated to stabilise following implementation.
- Detailed analysis of workforce turnover had been undertaken with no significant organisational "hot spots" identified. An exception was noted at Cheswold Park Hospital, where higher turnover was attributed to post-acquisition restructuring. Assurance was provided that turnover levels were returning to within acceptable tolerances.
- The Guardian of Safe Working report confirmed that there were no escalated concerns during the reporting period.

- Key workforce equality reports were reviewed and approved by the Committee, including the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and the Gender Pay Gap report.
- Positive feedback has been received from staff at Cheswold Park Hospital regarding their integration into the Trust, particularly in relation to the visibility and application of the Trust's values during the onboarding process.
- Christine Brereton (CB) provided a further update on work to strengthen staff networks, noting that recent engagement activity had supported the recruitment of new staff network members. This was described as an opportunity to reinvigorate staff networks and enhance engagement across the organisation.

Members' Council

Gary Ellis (GE) provided an update from the Members' Council meeting held on 6 May 2026:

- The meeting covered routine governance business, alongside a focus on future development and direction.
- The Members' Council approved the reappointment of the Lead Governor, John Laville ensuring continuity in the role during a period of organisational transition.
- Approval was given for the appointment of a new Chair of the Members' Council Quality Group.
- Governors received a presentation on the current structure of the Members' Council, including its sub-groups and committees.
- There was some group working to consider the future role and development of the Members' Council, reflecting wider changes within the NHS and the evolving governance landscape.

GE noted that the session had been constructive and forward-looking, with strong engagement from Governors in considering how the Council can continue to add value to the organisation.

JB offered her congratulations to the Lead Governor on his reappointment, recognising the importance of continuity and experience within the role.

Quality and Safety Committee (QSC)

Margaret Kitching (MK) provided an update following the Quality and Safety Committee meetings held on 19 May 2026 and 9 June 2026:

19 May 2026

- An internal audit of care planning and risk assessment was reviewed which identified variation in the quality and consistency of practice, with limited assurance provided in some areas. The Committee therefore agreed that this would remain an area of focus, with a clear action plan developed subject to ongoing review to ensure improvement is delivered.
- Work relating to women's services was acknowledged, noting that the executive had commissioned an external review. Early indications were reported as positive, highlighting a strong culture and commitment within services. It was noted that the review remained in progress, with final findings expected later in the summer.
- The Committee heard that an independent peer review of restrictive practices is underway to support further improvements to reducing restrictive practices.

9 June 2026

- The Committee considered workforce-related aspects of quality, noting positive indicators overall and requested further triangulation between workforce data, incidents and appraisal metrics to strengthen assurance.
- Areas requiring further attention were identified, including care planning and seclusion medical review compliance, where current performance was below expected standards. It

was noted that quality improvement work is underway to address these issues, with ongoing monitoring through the Committee.

- The Committee continues to receive a balance of assurance and areas for improvement, with a strong focus on learning and quality enhancement.

JB sought clarification on the timeline for completion of the external review of women's services, noting the Board's interest in the outcomes. MK confirmed that the report is expected in September, subject to final stages of review and triangulation.

Mental Health Act Committee

Rokaiya Khan (RK) provided an update following the Mental Health Act Committee meeting held on 2 June 2026:

- The Committee received assurance that robust governance arrangements remain in place across Mental Health Act (MHA) activity, with compliance in key areas continuing to be strong.
- There is continued focus on preparations for forthcoming Mental Health Act reforms which will introduce substantial changes to clinical practice, operational processes, workforce requirements and financial planning. Work to implement these changes is underway, including the development of training, guidance and governance arrangements, with ongoing oversight by the Committee.
- MHA activity remains stable, with good compliance reported in areas such as consent to treatment. However, the importance of ensuring that performance data accurately reflects patient experience was emphasised and, as a result, further work has been commissioned to better understand trends in Section 17 leave, including reasons for cancellations and any associated learning.
- Progress against Care Quality Commission (CQC) recommendations were reviewed providing assurance that action plans are being implemented effectively. Ongoing monitoring will ensure that improvements are embedded in practice.
- There is continued focus on inequalities within detention and patient experience and work is progressing beyond reporting into practical action.
- Findings from an audit of medical recommendations were reviewed which identified opportunities to strengthen the quality and consistency of documentation. It was noted that associated improvement actions are already underway.

Manoj Mathen (MM) acknowledged the scale and significance of the forthcoming MHA reforms, recognising that implementation will be complex and require sustained focus over a number of years. The comprehensive programme of work underway was also noted, recognising the importance of continued oversight of compliance, quality improvement and patient experience as reforms progress.

Commissioning Committee (CC)

Martin Neeson (MN) provided an update following the Commissioning Committee meeting held on 16 June 2026:

- System-wide pressures across forensic pathways remain significant, with increased demand, rising referral rates and constrained bed capacity contributing to higher levels of out-of-area placements. It was noted that both South Yorkshire and West Yorkshire Adult Secure Provider Collaboratives have experienced their highest levels of out-of-area placements in the previous twelve months, with associated impacts on patient flow and length of stay.
- Pressures are being further exacerbated by changes to provider pathways, including disruption given the nationally reported issues at St Andrew's. Individual patient care continues to be closely managed, with appropriate interventions in place to support patient safety and continuity of care.
- Operational pressures are also contributing to financial challenges across the system, with emerging adverse variances reported. However, the Board was reassured that strong

quality governance and oversight arrangements remain in place, with no significant safety concerns identified.

- Additional granularity in reporting was requested by the Committee, including analysis of the location of out-of-area placements. This work demonstrated that the majority of placements remain within adjacent geographical areas, providing important contextual understanding of the data.
- Positive progress was reported in relation to patient flow and discharge planning, alongside a continued focus on inequalities and patient-centred care, including analysis of length of stay, ethnicity and patient experience.
- Regional collaboration is being strengthened across West Yorkshire, South Yorkshire and Humber and North Yorkshire systems, with joint workstreams established to address key areas including access, patient pathways, learning disabilities and secure services. This work is being progressed through structured programmes with defined leadership and oversight.
- Further positive developments included the expansion of community forensic teams, which are intended to support early intervention, improve patient flow and reduce long-term system pressures. In addition, reductions in average length of stay within West Yorkshire were noted as a positive indicator of progress.

MBr stated that the Trust, as a lead provider across two systems, is in a strong position to work with partners and influence the development of future pathway models and service configurations. He highlighted the importance of adapting to changing demand patterns and optimising the balance between bed-based and community provision.

AS clarified that the interpretation of out-of-area placement data requires careful consideration, as some placements may be clinically appropriate or geographically proximate, and therefore should not be viewed solely as indicators of system failure.

Finance, Investment and Performance Committee (FIP)

Gary Ellis (GE) provided an update from the Finance, Investment and Performance Committee meeting held on 22 June 2026.

- GE set out the broader financial context, noting that regional NHS systems have been issued with breakeven control totals for the current financial year, reinforcing the scale of the financial challenge facing the organisation. At this early stage in the year, capital expenditure is ahead of plan, while cash balances remain in line with expectations and compliance with the Better Payment Practice Code continues to be achieved.
- Detailed performance metrics across workforce indicators, including vacancy rates, turnover, appraisal compliance and mandatory training, are largely on track. Targeted support is being provided to specific areas where performance is below expected thresholds, rather than applying a uniform approach across the organisation.
- A detailed review of key performance areas has been undertaken, including IAPT (Improving Access to Psychological Therapies) and it was noted that patient safety indicators, including restraint levels within care pathways, remain relatively low.
- In relation to financial performance, at month two, the Trust reported an in-month deficit broadly in line with plan, with a small favourable variance on the cumulative position. It was acknowledged that this position reflects underlying financial pressures, and that continued delivery of financial improvement actions will be critical to achieving the year-end breakeven target.
- Ongoing risks include a high-level financial risk associated with delivery of cost improvement programmes. The importance of addressing bank and agency spend within established limits was emphasised, alongside the need to sustain progress from previous years.

The Board recognised that the current financial position mirrors challenges experienced in the previous year, with continued pressure on both workforce and operational delivery.

Maintaining financial discipline will require sustained focus across all areas of the organisation, while ensuring that patient safety and quality of care remain paramount.

Audit Committee (AC)

Mike Ford (MF) gave the Board an update from the Audit Committee meeting held on 23 June 2026:

- The focus of the meeting was on year-end assurance and governance processes. The External Audit Report was reviewed, which indicated that an “unqualified audit opinion” would be issued for the Trust’s 2025/26 accounts. This reflected a positive position.
- The Head of Internal Audit Opinion confirmed an overall position of “significant assurance”, consistent with previous years. While a number of individual audits had identified areas of moderate or limited assurance, it should be noted that areas of audit had been identified on the basis that the Trust had identified there would be likely learning or improvements that could be made. These ratings had not impacted the overall positive assurance rating, demonstrating the strength of the Trust’s control environment.
- The Committee reviewed the Trust’s Annual Report and Accounts in detail and was satisfied that these were robust, compliant and appropriate for submission. The Committee recommended the Annual Report and Accounts for approval, in line with delegated authority arrangements, and signature by the Chief Executive and Chair.
- The Data Security and Protection Toolkit submission was also reviewed and a strong level of compliance and assurance in relation to information governance arrangements was acknowledged.

JB noted the consistency of positive assurance across both internal and external audit processes, recognising this as a significant achievement and a reflection of effective governance arrangements across the organisation. The importance of maintaining this position was noted, particularly in the context of ongoing organisational and system changes, and the role of the Audit Committee in providing independent scrutiny and assurance.

MF added that at the previous Board meeting the annual report of committee effectiveness had been received which aligns achievements against terms of reference which was very positive.

It was RESOLVED to RECEIVE assurance and minutes from Trust Board Committees.

TB/26/58 Performance Reports (agenda item 10)

TB/26/58a Integrated Performance Report month 2 2026/27 (agenda item 10.1)

AS provided a summary of the Integrated Performance Report (IPR) and advised that work has been undertaken to improve the visual accessibility of the report, including the introduction of summary indicators to enable the Board to quickly identify areas of strength and areas requiring attention. These summary indicators are presented both at an organisational level and across individual care groups, supporting more detailed scrutiny of performance variation.

Workforce metrics currently show strong performance however pressures remain within specific areas, including forensic services and inpatient mental health services, reflecting sustained demand. JB noted the depth and robustness of the report and confirmed that she had reviewed the detail to ensure consistency between headline indicators and supporting data. This approach provides confidence that key risks and issues are appropriately reflected within performance reporting.

JB acknowledged that, while the report is detailed, the summary indicators support effective navigation and prioritisation of key areas for focus. It was recognised that continued refinement of presentation and metrics will further enhance usability and insight.

Health Inequalities

Dawn Lawson (DL) provided a summary of the health inequalities data:

- Measures have continued to evolve over the past year through the use of improvement methodology and Board scrutiny. Revised metrics for 2026/27 have been developed and will be presented from July.
- Ethnicity and deprivation measures remain key indicators within the report. Whilst deprivation is not a protected characteristic under the Equality Act 2010, it continues to be monitored due to its significant impact on health outcomes, service access and patient experience, particularly when combined with ethnicity.
- Ongoing work is being undertaken to better understand the relationship between protected characteristics and the use of prone restraint. DL noted that monthly data can be significantly influenced by small patient numbers and may not always provide meaningful insight into wider trends.
- Assurance was provided that the Trust continues to meet its targets for recording equality data. Further detailed analysis is being undertaken to understand variations between services, although data quality can be affected by information received at the point of referral.
- It was noted that the Trust has moved from using mean length-of-stay measures to median analysis, providing a more meaningful understanding of variation and supporting pathway improvement work.
- Community mental health caseload data continues to demonstrate that people living in more deprived areas remain on caseloads for longer than those in less deprived communities. Similar patterns have been identified within physical health services, and further work is underway to understand the causes of these inequalities and identify opportunities for improvement.

JB praised the amount of detail related to health inequalities that is included in the IPR which is crucial.

Quality

Caroline Johnson (CJ) provided a summary of the quality data:

- Overall, performance across quality indicators remains stable, with key national targets largely being achieved.
- Compliance with waiting time standards continues to be strong, with the majority of risk assessments and care plans completed within the required timeframe.
- Incident reporting remains within expected levels of normal variation.
- There has been sustained progress in reducing restraint, with very low levels of prone restraint reported. The organisation continues to work towards further reduction, with a clear ambition to minimise restrictive practices wherever possible.
- There has been a slight increase in falls, including younger service users. Targeted interventions have been implemented in response, particularly within specific services where repeat incidents have been identified, with signs of improvement.
- Care planning and risk assessment performance remains below the Trust's internal target, although improved performance and trajectories are evident. Both timeliness and quality are being addressed through a comprehensive quality improvement programme, supported by audit findings and strengthened oversight arrangements.
- Supervision performance remains positive. Variations in reported compliance were attributed in part to recording issues and a change in approach rather than absence of supervision, with further work underway to strengthen data accuracy and ensure clarity between supervision and management oversight.
- Staffing levels remain stable overall, with high fill rates across inpatient services and sustained improvement in workforce indicators. Whilst some variation exists between day and night staffing levels, these are actively managed through daily oversight and escalation processes to maintain safe staffing levels.

- A reduction in reported information governance incidents was noted following targeted quality improvement activity, demonstrating the effectiveness of the Trust's approach to learning and system-wide improvement.

MK praised the significant and sustained improvement in relation to prone restraint.

MK raised a concern over incidents involving race and that it would be helpful to understand what the Trust is doing to address this.

Christine Brereton (CB) advised that race related incidents are a key priority with a specific campaign aimed at supporting staff who have been involved in incidents at work. CB advised this campaign, yet to be named, would feed through to Board via the People and Remuneration Committee.

JB requested that an update in relation to action being taken to address race related incidents is shared at a future strategy board meeting.

Action – Christine Brereton

MF queried what the impact would be of lower compliance in relation supervision. CJ responded that supervision is important to ensure the quality and standard of care provided is as expected, as well as providing support to staff.

MBr highlighted the significant improvement in access to paediatric audiology. This is a very small team that has been experiencing challenges for the last 18 months. Improvement work has been carried out which has significantly enhanced the performance of the service, in turn supporting improved access and experience for service users.

Care Groups

Adele Fox (AF) provided an update on Care Groups:

- There has been sustained improvement in a number of key service areas, with targeted quality improvement work producing positive results.
- Continued progress was reported in relation to access to Child and Adolescent Mental Health Services (CAMHS), with consistent improvement against the 18-week standard over recent months, reflecting strong clinical and operational leadership.
- Work to reduce length of stay across services remains a priority, with a target reduction of 10% being progressed. More detailed analysis by service line has been introduced to better understand variation and to ensure that improvement efforts are appropriately targeted.
- Discharge delays continue to present operational challenges, with a number of service users clinically ready for discharge but awaiting appropriate placements. These delays are most significant within learning disability and specialist care pathways, where suitable community provision is limited. The Trust is working closely with partners to address these barriers and support timely discharge.
- There is sustained pressure on inpatient capacity, with high levels of occupancy across services. Robust processes are in place to review admission decisions and explore alternatives where appropriate, ensuring that patients are supported as close to home as possible.
- Performance against LD waiting time standards remains strong. The continued delivery of awareness and engagement activity, including Learning Disability Awareness Week, was acknowledged, recognising the contribution of staff and the positive impact of this work.

MBr emphasised the challenge associated with delayed discharges, particularly within learning disability services, and highlighted the importance of continued partnership working with local authorities and system partners to secure appropriate community placements. It was recognised that length of stay metrics can be affected by factors beyond the Trust's direct control, including the availability of suitable accommodation and support in the community. The need to balance performance management with clinical appropriateness was discussed,

ensuring that service users are not discharged prematurely and that care decisions remain centred on individual need.

Finance

AS provided an update on finance:

- The Trust is currently delivering its financial plan, with the year-to-date position reported as in line with expectations. This reflects achievement against the planned financial control total, within a deficit position, and delivery of value for money schemes is expected to increase as the year progresses.
- Significant work remains to ensure the delivery of a breakeven position by year end. The current position is stable however the most challenging phase of delivery is yet to come, requiring continued focus and discipline across the organisation.
- Staffing levels have recently exceeded planned establishment, with forecasts indicating further growth if not actively managed. Targeted action is underway to maintain appropriate workforce levels aligned to service need, budget and financial plans.
- Agency usage remains very low, reflecting strong performance in reducing reliance on external staffing. However, bank staffing expenditure continues to be higher than planned, particularly in relation to the unregistered workforce, and this remains a key area of focus.
- Delivery of capital expenditure remains challenging in some areas. While progress has been made in relation to the solar programme, delays continue in relation to other capital schemes due to wider industry and safety considerations. It was emphasised that ensuring safe and compliant delivery remains a priority, despite the impact on timelines.

DL acknowledged the positive delivery against plan to date, while recognising the significant work required to sustain performance and manage financial risks over the remainder of the year. The update was noted, with continued focus on workforce costs, cost improvement delivery and capital programme management.

People

CB provided an update on the People Directorate metrics:

- Workforce performance remains strong, with all key People metrics currently performing within target.
- Despite the overall positive position, there are emerging pressures within specific service areas. In particular, continued operational demand within inpatient and forensic services is impacting workforce deployment and capacity.
- Sickness absence has reduced and is now within target levels. However, it was noted that there is a recognised seasonal element to this improvement and continued focus is required to maintain performance through periods of traditionally higher absence.
- Appraisal performance has improved despite the transition to a revised appraisal cycle. To date staff have engaged positively with the new appraisal process, resulting in strong levels of completion.
- Compliance with statutory and mandatory training remains consistently strong across the Trust and performance continues to be monitored at Care Group level, with any areas of variation subject to targeted oversight and support.
- A new workforce metric relating to vacancy rates has been introduced, designed to support improved oversight of recruitment and workforce planning. This metric will enable the organisation to track progress against recruitment plans and ensure alignment between workforce capacity and service demand.

MBr noted the importance of accurate data capture and monitoring across workforce metrics, alongside the need to maintain a proactive approach to workforce planning and staff engagement.

It was RESOLVED to RECEIVE the Integrated Performance Report.

TB/26/58b Care Group Performance Report (agenda item 10.2)

AF provided an overview of the Care Group Performance Report related to Learning Disability (LD), Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) services:

- Overall performance across these services remains strong, with continued delivery against key workforce, finance and operational metrics. LD services continue to meet national performance standards, while ASD and ADHD services demonstrate consistent performance despite increasing demand.
- Demand for ASD and ADHD services continues to increase across all pathways and localities. Although levels vary by place due to differing commissioning arrangements. This remains a sustained national pressure.
- Implementation of an innovative digital triage tool in ADHD services within some localities has enabled earlier assessment and improved throughput. Early indications show that this approach is supporting more timely access to services, despite rising referral rates.
- Activity levels remain high across all care groups, with services consistently exceeding commissioned activity levels. Incidents within these services have reduced overall, with specific increases linked to individual service users rather than wider systemic concerns.
- LD services were reported as performing strongly against waiting time standards and continue to deliver high-quality care, although workforce challenges within specialist roles remain an ongoing challenge.

AS highlighted significant variation in referral growth across localities, influenced by alternative providers and commissioning models. Trust-level data does not reflect total system demand, and a wider system view is needed. ASD and ADHD pathways remain under significant national pressure, with extended waiting times and referrals exceeding commissioned capacity.

JB queried the implications for service users awaiting assessment were discussed, focusing on the importance of effective “waiting well” approaches. AF confirmed that prioritisation processes are in place to identify those with highest need, alongside ongoing contact and support for individuals while they remain on waiting lists.

It was RESOLVED to RECEIVE the Care Group Performance Report.

TB/26/59 Risk and Assurance (agenda item 11)

TB/26/59a Patient safety oversight annual report (agenda item 11.1)

CJ presented the Patient Safety Oversight Annual report and provided assurance on patient safety activity across the organisation in line with the Patient Safety Incident Response Framework. The update included:

- No “Never Events” were recorded during the year. There was a high proportion of incidents related to violence and aggression, reflecting known risks within the services provided. This was noted as indicative of a culture of openness in reporting and learning.
- The Patient Safety Incident Response Framework (PSIRF) has been embedded enabling a more proportionate, system-focused approach to learning from incidents.
- A significant proportion of incidents related to a small number of individuals, particularly within older adult services. Targeted interventions have been implemented in response to these patterns.
- Variation in infection prevention and control within physical health services was identified early, enabling prompt analysis and targeted improvement, which led to measurable improvement and more standardised practice.
- Apparent suicides continue to occur predominantly within community settings, consistent with national trends. A small number of inpatient deaths have also been identified, prompting further in-depth review, including a specific review of women’s services, to strengthen organisational learning and prevention strategies.

- Additional internal and external reviews have been commissioned to strengthen understanding of patient safety trends, including detailed clinical review of individual cases to identify opportunities for improvement.
- Progress included reduced restrictive practice, improved medication safety through digital systems, and trauma-informed care approaches, all contributing to improved patient safety and outcomes.
- Data capture on ethnicity and other characteristics has improved, though gaps remain. Health inequalities, including reduced life expectancy for people with severe mental illness and learning disabilities, reinforce the need for continued focus on physical health care and targeted interventions.
- Priorities for 2026/27 include translating learning into measurable improvements, strengthening systems for data and insight, and further embedding co-production with service users and families.

It was RESOLVED to RECEIVE the Patient safety oversight annual report.

TB/26/59b Learning from Healthcare Deaths Report (agenda item 11.2)

CJ presented the Learning from Healthcare Deaths report and provided assurance regarding the implementation of the Trust's processes for identifying, reviewing and learning from patient deaths. The update included:

- During the reporting period, a total of 277 deaths met the criteria for inclusion within the review process. Analysis of these deaths was noted to be within expected levels of variation, with established review processes applied consistently.
- All deaths undergo an initial review to determine the appropriate level of scrutiny, with escalation to a structured judgement review, investigation process or external review where required. This ensures that learning is identified and acted upon in a timely and proportionate way.
- Forty deaths involved individuals with a learning disability and/or autism. Regional learning continues to highlight inequalities affecting these groups, including higher mortality rates and associated health risks.
- There were 24 inpatient deaths during the year, including four apparent suicides, which remain subject to further investigation. Additional causes included one death due to choking and a number of deaths associated with physical health deterioration, largely in the context of end-of-life care. The choking incident has been subject to detailed review and that evidence demonstrated appropriate clinical response and application of learning from previous incidents, providing assurance that established safety improvements are being embedded in practice.
- Governance arrangements supporting mortality review remain robust, with strong oversight, structured learning processes and ongoing engagement with families and carers.

It was RESOLVED to RECEIVE the Learning from Healthcare Deaths Report.

TB/26/59c Patient experience annual report (agenda item 11.3)

CJ presented the Patient Experience Annual Report and provided an overview:

- A high volume of feedback was received during the reporting period, reflecting strong engagement with service users, patients and carers. Satisfaction levels remained high, with approximately 97% of feedback indicating a positive experience of services.
- Complaints increased from the previous year, in line with national trends, but complaint handling improved, with more resolved within six months and many within shorter timescales.
- Increasing complexity within complaints has been noted, with individuals submitting more detailed and multifaceted concerns. This was partly attributed to greater use of digital tools, enabling more structured and comprehensive submissions.

- Positive feedback consistently related to staff attitude, compassion and the sense of being treated with care and dignity. Areas identified for improvement included access to services, waiting times, and involvement in care and decision-making.
- Themes from patient feedback remain broadly consistent with previous years, although improvements have been noted in some areas, indicating progress in organisational culture.
- While engagement levels are strong, there remain areas of inequality in representation, particularly among some ethnic groups. Further work is therefore required to ensure that feedback more accurately reflects the diversity of the population served.
- Actions are underway to strengthen feedback triangulation, improve consistency in complaint investigations, enhance dashboard oversight, and embed the Experience of Care framework to support continuous improvement.

MBr confirmed that he signs off every single complaint response, and he recognised the comments made in the report. He emphasised that complainants feel they have had a poor experience and we need to use this feedback to improve

It was RESOLVED to RECEIVE the Patient experience annual report.

TB/26/59d Quality Account (agenda item 11.4)

CJ presented the final Quality Account for 2025/26 for Trust Board approval prior to publication. She explained the report provided a comprehensive and balanced overview of performance across quality, safety and patient experience, highlighting areas of strong performance and those requiring further improvement.

CJ outlined that the Quality Account was developed through extensive internal scrutiny and broad stakeholder engagement, including partner feedback, and reflected the Trust's achievements, key challenges and improvement journey during the year.

MK noted the significant level of scrutiny and review that the document had undergone prior to presentation and the balanced nature of the report.

MF confirmed the report had been considered in detail by the Quality and Safety Committee. It was acknowledged that the Quality Account effectively demonstrates the Trust's commitment to quality improvement, transparency and accountability.

The Board approved the document for publication on the Trust's external website.

It was RESOLVED to APPROVE the Quality Account.

TB/26/59e Data security and protection toolkit (agenda item 11.5)

AS presented the final 2025/26 Data Security and Protection Toolkit (DSPT) submission, noting that delegated authority for submission had previously been agreed by Board for the Chair and Chief Executive. The Toolkit had been completed, recommended for approval by the Audit Committee to the Chair and Chief executive and formally submitted and published. The submission had been subject to detailed scrutiny and reflected a positive position for the Trust and confirmed compliance with expected standards.

AS reiterated the importance of maintaining robust oversight of information governance and cyber security risks. While the DSPT submission provides assurance on current compliance, cyber risk remains a significant organisational risk requiring appropriate Board oversight. Audit Committee noted that further work is being considered to ensure regular and proportionate Board reporting on cyber security and information governance, aligned with national expectations and good practice.

MBr noted the strength of the Trust's information governance training. The Trust has maintained an internal compliance target of 95% for IG training, despite being provided with the opportunity to reduce it.

It was RESOLVED to RECEIVE the Data security and protection toolkit.

TB/26/59f PESTLE and SWOT (agenda item 11.6)

Dawn Lawson (DL) provided an update on the Trust's strategic overview, including the refreshed SWOT (Strengths, Weaknesses, Opportunities and Threats) and PESTLE (Political, Economic, Social, Technological, Legal and Environmental) analysis.

DL reminded Trust Board colleagues that they had been engaged in the development of these updated documents at the May Trust Board strategy meeting. DL advised that, in light of the rapidly evolving NHS landscape, the Trust had taken the decision to delay the formal detailed review of its SWOT and PESTLE analysis until now, so the impact of ICB changes and emerging place provider partnerships could be understood. However, part of the annual planning process, all services completed a SWOT and PESTLE analysis. This approach enabled the analysis to be directly informed by Care Group and Directorate planning, ensuring that it reflects both operational realities and the wider external environment. Initial inputs were drawn from Care Group and Directorate plans, followed by internal executive review and validation. The draft was then tested through the Executive Management Team (EMT) and considered at the Strategy Board, ensuring robust scrutiny and alignment.

The refreshed SWOT and PESTLE provide a comprehensive view of the Trust's internal strengths and challenges, alongside key external factors including system changes, financial pressures, workforce dynamics and wider policy developments. Particular attention had been given to ensuring alignment between the SWOT and PESTLE, the Board Assurance Framework (BAF) and the Integrated Performance Report (IPR). This alignment provides assurance that the Trust has a clear and consistent understanding of its operating environment and that strategic priorities are appropriately informed by both risk and performance data.

DL highlighted the value of integrating the SWOT and PESTLE into the broader planning process, noting that this strengthens the coherence between strategy, risk and operational delivery. It was agreed that the alignment across multiple governance frameworks provides a strong level of assurance that the organisation understands both its internal capabilities and the external environment in which it operates.

It was RESOLVED to APPROVE the PESTLE and SWOT.

TB/26/59g St Andrews independent review (agenda item 11.7)

CJ presented the St Andrews Independent Review and provided an update on the Trust's response to the review and the implications for the Trust. CJ noted that the review findings had been used as an opportunity for organisational learning, with a structured reflection undertaken across key domains including patient safety, safeguarding, risk management, workforce, culture, governance and learning systems. The update included:

- The Trust has strong patient safety and safeguarding governance, supported by specialist input and regular reviews. Further work is underway to strengthen safeguarding within care planning and improve triangulation of data and learning.
- Risk assessment processes are well established, with ongoing work to improve consistency, strengthen observation practice and maintain high-quality assessments aligned to patient need.
- Workforce capacity and capability remain key areas of focus. The Trust continues to maintain strong staffing levels, with low reliance on agency staff. Recognised risks include

vacancy levels within some unregistered roles, which are being addressed through recruitment and workforce development initiatives.

- Organisational culture is positive, with open and supportive environments reported across services. However, variation in staff experience was acknowledged, and actions are in place to further strengthen psychological safety, staff support and learning following incidents.
- In respect of leadership and governance, clear reporting, escalation processes and oversight arrangements are in place. Continued emphasis is being placed on enhancing leadership visibility, strengthening assurance processes and ensuring consistent application of governance across all services.
- Learning and continuous improvement were emphasised, with a focus on ensuring learning is embedded and sustained through audit and incident learning.

AS highlighted the importance of applying learning within directly managed services and also in relation to commissioned care from external providers. Robust oversight arrangements are in place, including quality visits and ongoing monitoring, to ensure patient safety across all settings. The importance of ensuring that lessons from external reviews are translated into local practice improvements was acknowledged as this will support continuous strengthening of the Trust's governance and quality frameworks.

It was RESOLVED to RECEIVE the St Andrews independent review.

TB/26/60 Integrated Care Systems and Partnerships (agenda item 12)

TB/26/60a South Yorkshire update including South Yorkshire Integrated Care System (SYICS) (agenda item 12.1)

MBr reported that the South Yorkshire Integrated Care System is undergoing significant organisational change. Interim Chair arrangements are in place while recruitment to a substantive Chair and other key roles progresses.

Despite this transition, positive progress continues at place level. In Barnsley, the "Health on the High Street" model demonstrates innovative community-based delivery and improved access.

MBr reported that there is ongoing focus within the system on financial planning and delivery, including deployment of the Mental Health Investment Standard. Active engagement has supported the securing of some investment for Barnsley services this year.

DL provided an update on the developments within Barnsley place-based partnership arrangements and advised that wider system changes across South Yorkshire have impacted the pace of progress at place level. Positive progress has been made in establishing clear priorities and strengthening collaborative working.

Three key priorities for 2026/27 have now been agreed at Barnsley place level and further work is underway to define delivery arrangements and governance structures to support effective implementation.

DL confirmed that the Place Partnership Delivery Group has now concluded and consideration is being given to future governance arrangements, including how partnership structures will operate going forward to support delivery of shared priorities.

DL noted the continued strength of the Barnsley Community Health and Care Alliance, and advised that this model is being actively reviewed to ensure its effective alignment with new arrangements and to build on its success within future partnership structures. Discussions are ongoing regarding the relationship between new partnership arrangements and existing governance forums, including the Barnsley Health and Wellbeing Board. This work will ensure clarity of roles, avoid duplication and support effective system working.

It was RESOLVED to RECEIVE the SYB ICS update.

TB/26/60b West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update (agenda item 12.2)

MBR provided an update on developments within the West Yorkshire Health and Care Partnership and associated partnership structures:

- There continues to be a period of significant organisational change across West Yorkshire, including wider system reform and restructuring, which is impacting on leadership arrangements, organisational capacity and the pace transformation initiatives are being progressed.
- Recruitment to key posts within new structures is ongoing, with a number of appointments expected over the coming weeks.
- Collaborative structures are currently operating in a reduced or transitional form. Place Provider Partnerships continue to meet, however, decision-making authority remains with the ICB during this shadow period.
- Despite these changes, there remains a continued focus on key priority areas across West Yorkshire, including mental health, learning disability and autism services, alongside broader system priorities and delivery of the regional financial position.

MBR acknowledged the importance of maintaining strong relationships and active engagement with partners during this period of change as collaborative working remains critical to delivering system-wide priorities and ensuring continuity of services.

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/26/60c Provider Collaboratives and Alliances (agenda item 12.3)

AS provided an update on developments relating to specialist Provider Collaboratives and associated alliance arrangements and noted that there remains uncertainty regarding the future footprint of provider collaboratives and specialised commissioning, with indications that larger regional models may be the direction of travel. The Trust already operates at scale across South and West Yorkshire as a lead provider for adult secure commissioning positioning it to influence future collaborative models and pathways.

Current work across the collaboratives is focused on understanding system capacity and demand, particularly in relation to secure services. While overall bed capacity may be sufficient at a regional level, there are misalignments between capacity and clinical need, with pressures concentrated in specific pathways, including male medium secure beds.

AS reported that demand in some areas, such as learning disability secure services, is reducing. This presents opportunities to consider reconfiguration of services and redistribution of capacity to better meet current and future demand.

Further work is underway to improve provider coordination, reduce duplication, and develop a more consistent approach to patient assessment and placement, supporting timely and appropriate pathways.

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

TB/26/61 Governance matters (agenda item 13)

TB/26/61a Compliance with NHS provider licence conditions and code of governance – self certifications (agenda item 13.1)

Izzy Worswick (IW) presented the Trust's compliance with NHS Provider Licence conditions, as part of the annual governance assurance process and advised that although NHS Foundation Trusts are no longer formally required to self-certify compliance with the provider licence, the Trust has continued to undertake this assessment in the interests of good governance and to support the development of Annual Governance Statement.

IW explained that, whilst the annual review is part of our usual processes, given the changes in our operating environment, the requirements of the Provider Capability Assessment and opportunities presented by the Advanced Foundation Trust model, it was even more important to proactively and clearly understand how we comply with our licence in line with our values and improvement approach.

The assessment covered the full range of provider licence domains, reviewing compliance across nine key areas. The report reflects a retrospective review of the period from April 2025 to March 2026.

IW advised that several sections of the assessment had been updated to reflect developments over the reporting period, including:

- IC2 'personalised care and patient choice' to include the Trust's work towards alignment with the national personalised care and support framework
- WS2 'the triple aim' to reflect the Trust's performance metrics being aligned to the five national themes of the NHS System Oversight Framework and to ensure the assessment reflects how we oversee our work on health inequalities (reflecting inclusion of reducing inequalities metrics in the integrated performance report (IPR)).
- WS3 'Digital transformation' to ensure alignment with the Trusts digital strategy and digital maturity assessment.

IW confirmed that the assessment had been scrutinised through EMT and refined following feedback. IW confirmed that the organisation remains compliant with the conditions of the NHS provider licence.

It was RESOLVED to RECEIVE the Compliance with NHS provider licence conditions and code of governance – self certifications.

TB/26/61b Trust Seal (agenda item 13.2)

Andy Lister (AL) provided an update regarding the use of the Trust Seal since the previous report and advised that, in accordance with the Trust's Standing Orders and Scheme of Delegation, all applications of the Trust Seal are formally recorded and reported to the Board to provide assurance of appropriate governance and oversight.

Since the last report, the Seal had been affixed to documentation for a Trust property lease renewal. This was undertaken in line with delegated authority procedures, with the transaction appropriately authorised and recorded in the Trust's Register of Sealing.

It was RESOLVED to NOTE the update to the Trust Seal since the last report on 31 March 2026.

TB/26/62 Strategies and Policies (agenda item 14)

TB26/62a Digital Strategy bi-annual update (agenda item 14.1)

AS presented the Digital Strategy bi-annual update and reported that progress against the digital strategy remains strong, with a wide programme of activity underway aligned to the Trust's overall strategic priorities.

A key area of progress was the continued development of digital dictation and ambient voice technology. The Trust has built on its existing digital dictation platforms and is now adapting this system to incorporate ambient voice functionality. This development has the potential to enhance clinical documentation processes by integrating directly with patient record systems, subject to appropriate validation and assurance.

AS also reported progress in relation to the case load management tool, which has been developed internally and is now being implemented, and is intended to improve visibility of caseload variation across services, supporting more effective workforce planning and resource allocation.

In addition, AS advised that the Trust has applied to become an early adopter of a replacement for the Electronic Staff Record (ESR) system. While this presents opportunities for system improvement, it also introduces implementation risks that will require careful management, particularly given the system's importance to payroll and workforce processes.

AS highlighted that the use of digital tools, including emerging technologies such as AI (artificial intelligence) and Co-pilot functionality, has the potential to deliver tangible benefits. However, it was noted that measuring productivity gains remains complex and requires further development. AS raised regarding digital literacy and workforce capability, with recognition that staff confidence and skills vary across the organisation. Successful implementation of digital solutions will depend on ensuring that staff are supported to adopt new technologies effectively.

It was RESOLVED to RECEIVE the Digital Strategy bi-annual update.

TB/26/63 Trust Board work programme 2026/27 (agenda item 15)

CB advised that the Trust Board work programme should include updates relating to the delivery of the People Strategy and appropriate oversight of key developments, delivery progress and emerging priorities, particularly in the context of wider organisational and system challenges.

Action – Andy Lister

It was RESOLVED to NOTE the work programme.

TB/26/64 Any other business (agenda item 16)

No further business.

TB/26/65 Date of next meeting (agenda item 17)

The next meeting will be held on Tuesday 28 July 2026.

Signature:

Date:

TRUST BOARD 28 July 2026 – ACTION POINTS

 = completed actions

Actions from 30 June 2026

<u>Min reference</u>	<u>Action</u>	<u>Lead</u>	<u>Timescale</u>	<u>Progress</u>
<u>TB/26/58a</u>	Christine Brereton (CB) advised that race related incidents are a key priority with a specific campaign aimed at supporting staff who have been involved in incidents at work. JB requested that an update in relation to action being taken to address race related incidents is shared at a future strategy board meeting.	Christine Brereton	August 2026	Discussion of incidents in relation to violence and agreement his has been added to the agenda for the strategy board in august.
<u>TB/26/63</u>	Updates relating to the People Strategy and Workforce data, including key developments, delivery progress and emerging priorities, particularly in the context of wider organisational and system challenges, to be added to the workplan.	Andy Lister	July 2026	The Board workplan has been reviewed with the Chief People Officer and key areas of work in relation to workforce which require Board oversight have been added to the Board workplan going forward.

Actions from 28 April 2026

<u>Min reference</u>	<u>Action</u>	<u>Lead</u>	<u>Timescale</u>	<u>Progress</u>
<u>TB/26/43f</u>	Review all assurance mechanisms for raising concerns to ensure they are capturing relevant issues, with a focus on governance, improvement and patient safety and report back on findings and any gaps identified.	Izzy Worswick	July 2026	Processes for raising concerns via the FTSU route have been reviewed and updated during 2026. This includes our FTSU Strategy, policy (in line with the national direction) and operational procedures. A piece of work has commenced led by the People Directorate looking at all mechanisms for raising concerns across the Trust.

<u>TB/26/44b</u>	Review the measuring of prone restraint performance to ensure metrics support meaningful Board oversight and benchmarking.	Adele Fox/Caroline Johnson	July 2026	
<u>TB/26/27 (1)</u>	In relation to the CQC action report discussion took place regarding access to outdoor spaces. It was agreed that the Board should clearly document what is and is not possible regarding outdoor access, based on risk assessments and individualised care plans. It was agreed to provide a position statement for the Board, specifying resolved and unresolved areas, and ensure care plans demonstrate risk-based approaches to outdoor access, aiming to close this recurring issue in future CQC action reports.	Adele Fox/Caroline Johnson	July 2026	A position statement was provided to QSC, and agreed on 7 July 2026. The paper is 5b on the agenda for 28 July 2026.

Actions from 27 January 2026

<u>Min reference</u>	<u>Action</u>	<u>Lead</u>	<u>Timescale</u>	<u>Progress</u>
<u>TB/26/11.1(b)</u>	Report on The Poplars to be presented to the Quality and Safety Committee, with input from the Chief Medical Officer.	Subha Thiyagesh	July 2026	Update report provided to May QSC (as part of the Trio report). The QSC asked for further assurance in relation to vacancies and temporary staffing. This will be presented to QSC in July.
<u>TB/26/10.3</u>	To provide further clarity in future safer staffing reports to ensure it is explicit when safer staffing refers solely to nursing	Caroline Johnson	July 2026 (date of next report)	This will be included in the report to Board in July 2026.

Actions from 2 December 2025

<u>Min reference</u>	<u>Action</u>	<u>Lead</u>	<u>Timescale</u>	<u>Progress</u>
<u>TB/25/113b</u>	Board to review digital governance and capital planning alignment at a future development session	Adrian Snarr	August 2026	

Trust Board
Outside spaces on wards– restricted and supervised access
Position statement
July 2026

1. Purpose

The purpose of this paper is to provide the Trust Board with a clear Trust-wide position on access to outdoor spaces within inpatient wards. This has been presented to the Quality and Safety Committee.

This includes an overview of current practice, compliance with CQC guidance, associated risks, and proposed actions to strengthen governance and consistency across all services, including Cheswold Park Hospital.

2. Background

Following the Care Quality Commission (CQC) inspection of Forensic and Secure Services in May 2023, the Trust received a 'should do' action relating to access to outdoor spaces, specifically:

“The Trust should ensure that restrictions are individually assessed and that blanket restrictions are a proportionate response to risks posed.”

Initial work within Forensic Services demonstrated established processes for reviewing blanket restrictions, including ward-level risk assessments and governance oversight (Appendix 1). However, further discussion with the CQC identified that this issue extended beyond forensic services and required a Trust-wide review.

In November 2024, engagement with the CQC Mental Health Act (MHA) Inspector reinforced the expectation that:

- Open access to outside space should be the starting point
- Any restrictions should be justified through individual and ward-level risk assessment

In February 2025, the CQC published its *Brief Guide on Blanket Restrictions*. A Trust-wide audit against this guidance identified that:

- 26 out of 37 inpatient wards were not compliant,
- with the primary gap relating to access to outdoor space.

A series of workshops (December 2025–March 2026) explored:

- Key risks (absconding, ligature, contraband, safety)
- Environmental constraints
- Workforce implications
- Potential mitigations and solutions

These discussions confirmed that current practice is largely driven by environmental and safety risk, rather than policy intent.

3. Current Position

The table below summarises current access arrangements across inpatient wards, including level of supervision and key contributing factors.

Service line	Ward	Supervised/un-supervised	Rationale from ward/service	Estates feedback
Forensics	Aire (CPH)	Supervised	Blanket supervised throughout Forensic Care Group. The supervision of the courtyard has several benefits. It encourages engagement with staff and ensures that vulnerable service users can enjoy the courtyard.	
	Appleton (NL)	Supervised		
	Bronte (NL)	Supervised		
	Calder (CPH)	Supervised		
	Brooke (CPH)	Supervised		
	Don (CPH)	Supervised		
	Esk (CPH)	Supervised		
	Foss (CPH)	Supervised		
	Hamilton (CPH)	Supervised		
	Hepworth (NL)	Supervised		
	Johnson (NL)	Supervised		
	Priestly (NL)	Supervised		
	Ryburn (NL)	Supervised		
	Sandal (NL)	Supervised		
	Thornhill (NL)	Supervised		
	Waterton (NL)	Supervised		
Learning Disability	Horizon	Supervised	Due to the current cohort of patients, all outdoor spaces are currently supervised. Service users are often supported on level 2 observations whilst on the ward. This provides 2:1 or 1:1. Where service users are on level 3 or above with intermittent observations, they can access the courtyards/garden spaces unsupervised, and this will be	

Service line	Ward	Supervised/un-supervised	Rationale from ward/service	Estates feedback
			reflected in individual care plans. The courtyards have previously not been suitable to access. Work has been completed to make the courtyards accessible and to have a therapeutic/ sensory benefit. Anyone supported on level 3 or above will have supervised access, and this will be reflected in individual care plans.	
	Newhaven	Supervised	As Forensics above.	
Working age adult acute wards	Ashdale and Elmdale (The Dales)	Supervised	The garden space is shared with the neighbouring female ward (Elmdale). Each ward has allocated access times. There are a number of environmental aspects that present the following risks: Safeguarding related risks, absconsion risks, climb/falls risks. This area hasn't always been supervised - there have been several patient safety incidents relating to the garden area that informed the decision to have it supervised access.	

Service line	Ward	Supervised/un-supervised	Rationale from ward/service	Estates feedback
	Beamshaw	Supervised	Design of the garden is such that there are several climb points which offer and advantage to someone attempting to scale the building. Contraband items such as drugs or weapons could be concealed in the garden area if not supervised. The whole of the garden is not visible from the entrance; there are 2 areas that are concealed from sight and blind spots. There is a gap under the fence. And small area where items could be passed under. Drain covers are not secure (Floor Manhole Covers). Backs onto the main exit road for the site. Possible slips, trips & falls risks. Garden is used as a response to Melton ward via Quantec.	
	Clark	Supervised	This is due to the environmental risk that the garden poses. There are ligature points and the fence is low. Risk of absconding. Risk of injury from climbing/ fall from heights.	

Service line	Ward	Supervised/un-supervised	Rationale from ward/service	Estates feedback
			Risk of secreting weapons banned items. Identified on ligature risk assessment as having high risk ligature points. Risk of confrontation between service user /bullying.	
	Nostell	Unsupervised		
	Stanley	Usually unsupervised, currently supervised awaiting remedial works.	Needs remedial work due to risk of escaping via some building infrastructure.	
	Ward 18	Supervised	Single storey building with points which can be used to climb up and onto the roof despite the anti-climb work which is in place. Area is also aged and there are flag stones, drain covers, and planters which can be damaged easily/picked up to be used as weapons or to self-harm with. Supervision was started in 2018 following several occasions of patients climbing out of the area.	
Psychiatric intensive care units	Melton	Supervised	Mixed sex ward. Design of the garden is such that there are several climb points which offer and advantage to someone attempting to scale the building.	

Service line	Ward	Supervised/un-supervised	Rationale from ward/service	Estates feedback
			Contraband items such as drugs or weapons could be concealed in the garden area if not supervised. The whole of the garden is not visible from the entrance due to the length of the garden. Staff must be out in the garden to visually see the entire space. Drain covers are not secure (Floor Manhole Covers). Possible slips, trips falls.	
	Walton	Large areas is unsupervised. Small ECA courtyard is supervised and risk assessed access only.		
Older peoples' services	Beechdale	2 areas unsupervised 1 area supervised	The garden that is supervised is due to the uneven flooring and a falls risk this is more prominent in bad weather, also there is no observation for staff to see patients in the garden due to the location of the garden , we also have a large tree in the centre of the garden which has been identified as a ligature point. The garden became supervised approximately 4 years ago due to a number of incidents and therefore we	

Service line	Ward	Supervised/un-supervised	Rationale from ward/service	Estates feedback
			were able to obtain the money to have a garden made in the centre of the ward that so the patients could have access.	
	Crofton	Large courtyard – supervised Small courtyard – unsupervised	The large courtyard which is observable from main lounge area is a supervised access only. This large courtyard also has a corner that could be deemed unsafe due to having observation issues. This courtyard is also a falls risk. Courtyard is supervised access because of its risks and also location and limited observation from ward area. Patients could be harmed by falling should they attempt to climb fence. Patients could self-harm, attempt suicide should they abscond from the garden. Patients are risk assessed, if risk of falls, then FRAT undertaken, individual care planning to manage falls risk, input and assessment from OT/Physio. The Smaller courtyard which is adjacent to main ward area. This is Observable from the ward office and off the main	

Service line	Ward	Supervised/un-supervised	Rationale from ward/service	Estates feedback
			corridor. It is an internal area, surrounded by building walls on all sides.	
	Poplars	Unsupervised		
	Ward 19	Unsupervised	Both male and female side have an unsupervised courtyard. If supervision is required, this is part of their individual risk assessment.	
	Willow	Unsupervised		
Rehabilitation	Lyndhurst	Unsupervised	The courtyard is only supervised if a service user is not willing to engage in their section 17 leave plan and there is an absconding risk, or there is any safeguarding concerns with a service user.	
	Enfield Down	Unsupervised		

4. Summary

Access to outdoor space across the Trust is variable and largely influenced by environmental design, patient safety considerations, and security risks. Supervised access remains the predominant model, particularly within forensic, PICU, and acute settings, while unsupervised access is more commonly observed in rehabilitation and some older people's services, where risks can be managed at an individual level. Across services, environmental constraints such as limited visibility, ligature risks, and absconding potential are the primary drivers of restrictions.

While the table above provides a comprehensive Trust-wide review of current practice, it also highlights that not all areas of non-compliance can be addressed in the same way. In some settings, environmental constraints mean that supervised access remains the safest and most appropriate approach. In other areas, there is clear opportunity to reduce restrictions through strengthened individual risk assessment and changes in practice.

A proportionate, risk-based approach will therefore be taken on a ward-by-ward basis to determine where improvements can be made and where restrictions remain necessary, supported by appropriate governance and oversight. This is recorded in Blanket restrictions registers where necessary.

A standardised framework to support assessment of outdoor spaces is in place (Appendix 2), which provides a structured approach to identifying risks and determining appropriate levels of access.

5. Position Statement

The Trust recognises that access to outdoor space is an essential component of therapeutic care and recovery.

The Trust's position is as follows:

- Open and unsupervised access to outdoor space should be the default position, wherever it is safe to do so
- Where this is not achievable, restrictions must:
 - a. Be based on robust individual and environmental risk assessment
 - b. Be clearly justified and documented
 - c. Represent the least restrictive option available
- Blanket restrictions will only be applied where:
 - a. Risks cannot be safely managed through individualised approaches
 - b. They are proportionate to the current patient cohort
 - c. They are time-limited, regularly reviewed, and subject to governance oversight

The Trust is committed to reducing reliance on blanket restrictions through improved risk assessment, strengthened governance, and environmental improvements where feasible.

6. Recommendations

The Trust Board are asked to **RECEIVE** this report as assurance that access to outdoor spaces is appropriately managed, balancing least restrictive practice principles with the management of environmental and clinical risks.

Appendix 1

Forensic Care Group Process: Blanket Restriction Risk Assessment:(should do action).

The forensic care group have a range of processes in place to support the review and monitoring of Blanket Restriction Risk Assessment to ensure that restrictions are proportionate to need and are the least restrictive approach is considered at all times. All wards have in place a risk assessment which describes common restrictions on wards and controls in place to reduce harm. The risk assessment is reviewed on a monthly basis. All community meeting agendas contain an item with a focus on ward risk assessments. The governance framework within the security committee has an agenda item to review and monitor blanket risk assessments in place across wards to ensure management oversight is maintained and any restrictions are proportionate. This process allows for challenge.

All ward-based risk assessments are also subject to organisational governance monitoring and are submitted centrally on an annual basis for review.



Individualised Risk assessments:

There are a range of day-to-day individual risks for all service users e.g. access to the internet where certain sites associated with individual risk would not be suitable. These individual risks are overseen by the primary nurses and clinical team on a day-to-day basis. An individual approach is taken so that the implementation of a blanket approach impacting the whole ward.

Risks are assessed and included in a service users HCR20 & FIRM and may be further supported by an individual care plan to support their needs.

Appendix 2 - Global Access Risk Assessment for Outdoor Inpatient Areas:

Individualised risk assessment and management must continue to guide practice when providing access to any outdoor space (supervised or unsupervised) including risks of absconsion, risk of falls and any other identified risks

<u>Courtyard/ Outdoor Space risk assessment Ward: <WARD NAME></u>	<u>Date of assessment:</u>
Describe the outdoor space you are assessing (including access and observation from ward areas)	
What is the design and height of the outer perimeters? Do they create additional risks specific to the patient group e.g. fall risk in Older Persons? Is there scope for a review of the current design to mitigate identified risks?	
Security systems in place (e.g. CCTV and climb alarms) including procedure for their use/ observation	

What are the hazards?	Who might be harmed and how?	What are you already doing?	Are current controls sufficient to allow unsupervised access?	Do you need anything else to control this risk?	Action by?	Action when?
Service users may attempt/abscond from the garden. <i>Historical incidents of abscond via this route on this ward and other areas of the Trust</i> <i>Risk of fall from height is included in the ligature risk assessment</i> <i>SU's could use outward swinging door as a platform to climb upwards onto roof with aid of drainpipe cover if bent downwards.</i>	Patient could be harmed by falling should they attempt to climb furniture, drainpipe. Patient could self-harm, attempt suicide should they abscond from the courtyard. Depending on risk profile, patient could be a risk to others should they abscond from courtyard. Patients could inadvertently or deliberately injure staff intervening to prevent absconding via the roof or as a result of fall.	Patients are risk assessed. Where significant risk of absconsion is identified, the courtyard will be supervised use only. Where it is not possible to supervise (e.g. due to resource and/or risk being too high) the courtyard will be locked and a temporary blanket restriction applied (recorded via Datix). Individual care plans/risk assessments to support this intervention. Use of observation levels to manage risk in accordance with Obs & Engagement policy. Staff to check positioning of furniture as part of hourly environmental check – to reposition away from walls if needed.	No			

What are the hazards?	Who might be harmed and how?	What are you already doing?	Are current controls sufficient to allow unsupervised access?	Do you need anything else to control this risk?	Action by?	Action when?
		RRPI guidance for safe physical containment of patients in line with Policy				
Ligature points within the outdoor area <i>Areas/items identified as a ligature risk would require some ingenuity to use by virtue of design and high visibility. Included in ligature risk assessment.</i>	Patients at risk from ligature.	Patients are risk assessed and supervised as indicated. Care plans/risk assessments to support interventions which are reviewed on a regular basis. Use of observation levels to manage risk in accordance with Obs & Engagement policy. Annual ligature assessment audit.	Yes	No		

What are the hazards?	Who might be harmed and how?	What are you already doing?	Are current controls sufficient to allow unsupervised access?	Do you need anything else to control this risk?	Action by?	Action when?
Secretion of controlled or banned items in garden area. Courtyard area cannot be <i>approached from outside therefore reducing the potential for contraband to be thrown over the fence.</i> Patients could however secrete item for others to find/use.	Individual patient by use of substance.	Patients are risk assessed and courtyard supervised as indicated. Use of Trust search policy as required (in regard to searching courtyard, searching service users on return from leave off ward, search of property brought into ward)	Yes	No		
Slip, Trips and Falls risk	Individual patient by falling	Patients are risk assessed, if risk of falls, then FRAT undertaken, individual care planning to manage falls risk, input and assessment from OT/Physio. Provision of nurse call band to individual service users with identified falls risk. Use of observation levels to manage risk in accordance	Yes	No		

What are the hazards?	Who might be harmed and how?	What are you already doing?	Are current controls sufficient to allow unsupervised access?	Do you need anything else to control this risk?	Action by?	Action when?
		with Obs & Engagement policy Reporting of environmental risks to estates for action in a timely manner.				
Violence/Aggression in an unsupervised garden/outdoor area	Patients/escorting staff	Individualised care plans. Courtyard supervision for additional safety as required Pinpoint system Lock off courtyard access until identified risk reduced (recorded as temporary blanket restriction via Datix)	Yes.	No		
Breach of privacy Some bedrooms adjacent to garden areas	Individual breach of privacy	Individual risk assessment and supporting care plan where risk identified. Bedrooms adjacent to courtyard have curtains to promote privacy. Individual risk assessment and supporting care plan where risk identified in terms of intrusion on privacy of	Yes	No		

What are the hazards?	Who might be harmed and how?	What are you already doing?	Are current controls sufficient to allow unsupervised access?	Do you need anything else to control this risk?	Action by?	Action when?
		others (knocking on or looking in bedrooms for instance) eavesdropping, noise and other disturbance.				
What are the risks of not providing unsupervised access?						

Based on the risk assessment and control measures/actions, can the gardens be safely unsupervised?				
Summary:				
	Authorised by:			
Ward Manager/Lead Clinician:			Date:	Signed:
General Manager:			Date:	Signed:
Matron & Quality Lead:			Date:	Signed:
Health & Safety Lead:			Date:	Signed:
Security Lead:			Date:	Signed:

Updates:

**Trust Board
28 July 2026
Agenda item 8**

Private/Public paper:	Public		
Title:	Chief Executive’s Report		
Lead Director:	Mark Brooks - Chief Executive		
Mission/values:	As an all-encompassing report this reports aligns fully with the Trust mission and all of its values		
Purpose:	To provide the strategic context for the Trust Board conversation.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	All risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The report includes highlights of what is happening in both our systems and places. The Trust regularly reviews that its own objectives are aligned to those of our systems and places as well as taking account of national guidance and requirements.		
Any background papers / previously considered by:	This cover paper provides context to several of the papers in the public and private parts of the Trust Board meeting and also external papers and links.		
Executive summary:	Temperatures have been increasingly hot during the latter part of June and into July. This has placed significant pressure on many of our services and in particular our inpatient wards where service users and patients are resident. Along with many buildings in the UK our facilities were not designed or constructed for this regular type of heat. We are grateful to our colleagues and service users for managing in these hot conditions. As a Trust we are reviewing what further practical steps we can take to mitigate the impact of hotter summers.		

The Trust Board papers this month include further detail on the recently launched NHS leadership and management framework and the new NHS staff standards. Trusts are asked to begin embedding the framework within development, appraisal, recruitment and talent processes, and to support leaders and managers to use the self-assessment as part of their normal appraisal and development conversations during 2026/27. We are recommending that oversight will be provided by the People and Remuneration Committee on behalf of the Trust Board.

Following the suspension of planned industrial action in June, resident doctors have accepted the latest offer from the government. This offer includes pay reform, additional training and improvements to working conditions. We will continue to focus and report on the 10-point plan to improve the working lives of resident doctors. More recently the BMA has advised that medical consultants have voted in favour of industrial action over pay and working conditions.

NHS England on behalf of the National Quality Board has recently published a Quality Strategy for NHS funded care in England. This strategy aims to support the delivery of the 10-year plan for health. Ambitions include greater transparency, a stronger patient and staff voice, and a renewed commitment to tackling inequalities. As with all national strategies and guidance received, this document will be assessed, and we will ensure alignment with our own Trust quality strategy. Oversight will be via by the Quality & Safety Committee.

NHS England has also recently published new guidance, the Mental Health Personalised Care Framework (MHPF), to support improved care for people of all ages requiring secondary mental health care. The Framework focuses on the foundations of good care and aims to improve the quality of care for all people accessing secondary mental health care. It also responds to recent learnings from failings of care and when things go wrong. The guidance sets out the expectations on services related to the assessment, planning and management of safety and risk, including where there is a risk of harm to others or history of violence.

It centres on four key principles:

1. Everyone has a personalised care and support plan
2. Everyone has a person within the services responsible for their plan
3. Plans are reviewed regularly and when things change
4. Outcomes are measured and responded to

The guidance will be reviewed in depth by the Trust executive and leadership team and further reports will be brought back to Trust Board and Board Committees as appropriate.

Whilst we have recently been experiencing a heatwave the Trust has received the winter planning guidance for 2026/27. In line with previous years this guidance will be assessed and incorporated within our own plans.

Donna Ockenden has published her independent review into maternity and neonatal services at Nottingham University Hospitals NHS Trust. This report describes years of serious and repeated failures in care, including poor leadership and culture, a lack of accountability, unacceptable racism and discrimination and women and families being disbelieved or dismissed. It also

describes extremely serious failings in post death care. Whilst these services are not provided by our Trust the issues identified could apply to other services and led by our Chief Nurse, we are reviewing this report to identify any areas of learning or improvement for us. A separate request has been made for Trust Boards to receive assurance regarding their mortuaries. Whilst the Trust does not have such facilities it is planned for provide a report to the Quality & Safety Committee regarding how dignity is provided after death.

NHS England has written to trusts asking boards and executives to assure themselves that cyber security risks are being managed effectively, with clear, sustained programmes for improvement. Our Audit Committee receives updates on the Trust's approach to cyber security and will receive a response to this most recent request at its October meeting.

NHS England has also written to trusts setting out new minimum standards for planned patient care for people referred to an elective pathway. This document is being reviewed internally to identify how any of the standards could be beneficial and applied to the services we provide.

The LeDeR report for 2024 'Learning from Lives and Deaths – people with a learning disability and autistic people (LeDeR)' has very recently been published. The headlines do show some improvement over recent years. For example, the median age of death has risen to 62.8 years in 2024 from 61.8 years in 2018 and avoidable deaths fell from 46.3% in 2021 to 39% in 2024. Whilst the latter is positive and statistically significant it remains much higher than the general population. We can therefore recognise that many of the interventions including the focus on annual health checks and action plans are having a positive impact, whilst still recognising there is much to do to improve the lives of people with a learning disability and autistic people. As a Trust we will continue to provide this focus both internally in the services we provide and externally with commissioners and partners to ensure the voices of people with a learning disability and autistic people are heard and their needs met.

We continue to work with partners on the introduction of place provider partnership (PPP) meetings in each of Barnsley, Calderdale, Kirklees and Wakefield. All West Yorkshire PPPs are operating in shadow form with statutory decision-making and accountability remaining with ICB Place Committees under existing ICB delegations. Focus to date has been on development of governance arrangements and of neighbourhood health models.

The Chief Executive of NHS England, Sir Jim Mackey has written to all trusts regarding the rights of all users of NHS services to have their information kept secure. This is on the back of recent reports in the media of staff accessing patient information in unauthorised circumstances. Requirements of Trust Boards are outlined in this letter and include a renewed focus on educating staff as well as ensuring there is a 'tough approach' to those who breach patient trust in this manner. The Trust via our Senior Information Risk Owner and subject matter experts are evaluating our current policies and arrangements and it is recommended a report is taken to the Audit Committee for review and discussion on behalf of the Trust Board.

The reorganisation of Integrated Care Boards (ICB) continues. Having concluded staff consultation and agreed new operating models both South and West Yorkshire are recruiting into roles that exist within the new operating

model and structure. Both the operating model and recruitment into roles have major significance and direct impact on the Trust and we continue to work with ICB partners during this period of major change.

NHS Talking Therapies (TT) remains a priority for the government and the NHS. In response to a recent ministerial steer on the current delivery position, systems have been written to setting out a number of priority actions for NHS Talking Therapies delivery. Not all systems are achieving the performance expected and those seen as under-performing are being subjected to meeting with NHS England to understand the current position and establish an improvement plan. It should be noted the Trust's Talking Therapy services are largely meeting expected performance. However there have been conscious decisions by commissioners not to fully invest for the level of growth expected nationally.

This month's Trust Board meeting has a focus on business and risk, and papers include both our Board Assurance Framework (BAF) and Organisational Risk Register (ORR). Risks are inherent in the services we provide and the environment in which we operate. Our approach to risk management includes scrutiny and review at each of our Trust Board committees. Consideration has been given to any changes in performance or the operating environment over the past quarter and this has included the ongoing financial challenge, sustained high demand in many services and the structural changes taking place in both NHS England and Integrated Care Boards.

In terms of performance the Trust continues to meet many national, local and internal targets and much credit is given to our colleagues who strive to meet the needs of our service users every day. As previously reported demand for inpatient beds is relentless, and this has resulted in these services being places in OPEL 4 during July. Under the leadership of chief operating officer, Adele Fox we have engaged with system partners to escalate the issue of delayed discharge, but this remains a challenge given the regular requirement for specialist placements that are often in short supply.

Whilst our financial position is in line with plan this is a deficit position and a step change in run rate is required in the remaining three quarters of the year to achieve our planned break-even position. The executive team are currently drawing up contingency measures to potentially action should they be required. There has been notable interest in the Mutually Agreed Resignation Scheme (MARS) for which applications come to a close at the end of July. These applications will be considered during August.

Following a recent period of ill health Fiona Edwards has decided to leave her role as regional director for NHS England for personal reasons. Sam Allen, CEO of the North East & North Cumbria Integrated Care Board (ICB), will be covering the role of interim regional director as well as retaining her ICB role. Plans are being put in place to manage any conflicts of interest.

The Trust's long-serving deputy director of estates & facilities, Nick Phillips retired from his role during July. Nick has played a key role in the success of the organisation with us largely having very good quality estate and we wish him every happiness in his retirement. Kevin Gelder has been successful in being appointed to this role.

	The July Trust Board is the final one being attended by Mike Ford as his term of office ends. Mike has led the Audit Committee with great skill and expertise over the past six years as well as being a committed and valued non-executive director. I would like to thank Mike for all that he has done for the Trust and wish him every happiness for the future. Whilst an appointment has been made to replace Mike this has not yet been announced as the usual pre-employment checks are being completed In line with previous reports, I am providing a sample of positive achievements by our colleagues who continue to provide outstanding care in what can often be challenging circumstances. • Our catering managers Daniel French and Jake Fawcett won the Yorkshire/North East regional heat of the NHS Chef of the Year 2026, held at The Sheffield College on Wednesday 8 July and will now participate in the national final at Edgbaston, Birmingham from 5-8 October. • Our Paths service lead Dr Estelle Verdi has recently published a paper exploring how creative health approaches may support minoritised women's mental health following baby loss. • The Trust has been shortlisted for the Inclusive Organisation of the Year Award at the Asian Professionals National Alliance NHS Awards 2026. These prestigious awards celebrate the outstanding contributions of South Asian professionals and allies within the NHS, recognising excellence, leadership, and commitment to equality, diversity and inclusion.
Recommendation:	Trust Board members are asked to: • NOTE the Chief Executive's report.



The Brief

2 July 2026

Our monthly briefing
for colleagues,
including feedback
from Trust Board
and executive
management team
(EMT) meetings



Our purpose and values



South West Yorkshire
Partnership Teaching
NHS Foundation Trust

It is important we focus on our values.

Our purpose is to help people **reach their potential and live well in their community**.

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

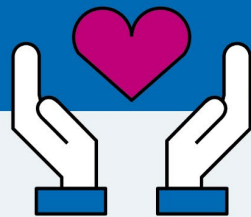
- We put **people first and in the centre** and know that **families and carers matter**
- We're **respectful, honest, open and transparent**
- We constantly **improve and aim to be outstanding** so that we're **relevant today and ready for tomorrow**



Our learning disabilities teams celebrated LD Week 2026 by hosting various events with partner organisations across our localities to promote services and offer taster sessions in a fun environment. Read more on [the intranet](#).

Our priorities for 2026-2027

We will be the **best we can be** and will focus on keeping our **services safe**.



Best quality

Improve our clinical pathways, reducing waiting times, and improving access and flow.

Best quality

Accelerate digitally enabled care, improving quality of care, patient outcomes and staff experience.

Best value

Make the most of our resources, increasing efficiency, and living within our means.

Best place to work and learn

Ensure our workforce is fit for the future, and supports all our colleagues so that they feel they belong, are proud to work here, and want to stay.

Best partner

Lead implementation of integrated neighbourhood care and development of Place Provider Partnerships and Provider Alliances.

Live our values

Reduce inequalities and better describe our impact on those we serve, being clear that we deliver on our purpose.

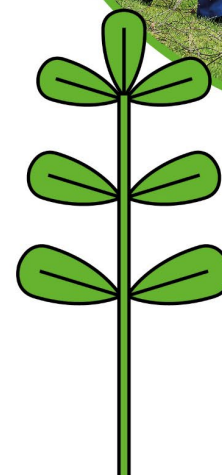
Underpinning all of our priorities is a continued focus on **quality and safety**, and **compassionate trauma-informed care**.

If you require a copy of this information in any other format or language please contact your line manager or your healthcare worker at the Trust.

NHS

**South West Yorkshire
Partnership Teaching**

NHS Foundation Trust



#allofusimprove
and be outstanding

With **all of us** in mind.

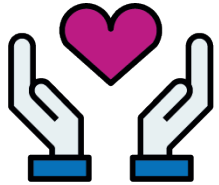


Updates on our priorities



South West Yorkshire
Partnership Teaching
NHS Foundation Trust

Our priorities set out how we will achieve our aim of being the best we can be, while ensuring we focus on keeping our services safe.



Best quality

- **Improving our clinical pathways so they are more effective and efficient and provide a good patient experience**
 - we continue to focus on improving access and waiting times, strengthening clinical pathways and consistency of care, enhancing crisis and inpatient pathways, and delivering productivity and efficiency improvements.
- **Improving access to care** – we continue to focus on improving access, reducing waiting times and strengthening pathway consistency. Current focus is CAMHS waiting times (including 104-week and 18-week waits), with improvement work and oversight, neurodevelopmental pathways, an emerging priority, and high-demand pathways.



Best partner

- **Place provider partnerships** are being developed in all of our areas, focused on practical collaboration and establishing governance structures. The next phase is the development of neighbourhood health plans.



Best value

- We continue to focus on making the most of our resources, increasing efficiency and living within our means. More information on this work is included later in the Brief.



Best place to work and learn

- An update on the NHS staff survey results, including actions taken is included in the Brief.



‘Leading Well’ – our #allofus leading well conversations



South West Yorkshire
Partnership Teaching
NHS Foundation Trust

We are anticipating a CQC Well Led inspection this year – allofus are thinking about how we prepare

- A well-led CQC inspection comprises of assessments of frontline services which then leads into a well-led review across the organisation. The well led review is essentially a frontline service to board review made up of 8 domains that explore how we lead and manage our organisation.
- It is an opportunity for feedback, learning and improvement, and for us to show our best. We lead well everyday, we just have to think about how we describe this and provide evidence.
- It is a time for us to reflect on what we are good at, feel confident in what we do, and help identify where we can improve.

To help us prepare are holding ‘Leading Well’ conversations across the organisation. This means answering 4 key questions:

1. **We are well led because...**
2. **We can evidence we are ‘leading well’ because...**
3. **We would be even better if...**
4. **So, what we are doing to be the ‘Best we can be’ is...**

The conversations are really important to have as part of business as usual, we can hear the views of colleagues and think about how we respond. It will also help us with annual planning next year. Early testing of this approach has received very positive feedback from the teams that have tested this.

We have developed resources to support the conversations, please visit the [intranet](#). If you have any ideas about how we can improve our approach please share your ideas at leading well email.

We know that because everyone is busy it can be difficult to find time to reflect on our strengths and, also to learn from others. So we asking colleagues to share their thinking and conversations so that we can see the views and learning from our conversations. You can share this by emailing leadingwell@swyt.nhs.uk. We will also share monthly leading well themes to support thinking and learning across the Trust.





Best partner



South West Yorkshire
Partnership Teaching
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.

A new creative psychotherapy pathway has been introduced at HM YOI Wetherby, marking a step forward in trauma-informed mental health support for young people in custody. Led by the secure CAMHS team, the initiative is the first of its kind at the site and began earlier this year with the appointment of a specialist creative psychotherapist. It forms part of a wider multidisciplinary approach to care. Read more about this on the [Trust website](#).

To mark Carers Week 2026, the Trust hosted a celebration event on 10 June. Held in the cabin in Fieldhead's caring gardens, the session brought together staff carers, unpaid carers, and carer champions to create a warm and supportive space aligned with this year's national theme: Building carer friendly communities. [Find out more](#).

In June our research and development department hosted a two-day work experience event for students from New College Pontefract to help them understand the importance of research and its impact on careers.

Last year, the government introduced the use of quarterly segmentation ratings for providers. Each Trust is given a rating of one to four, with one being the best. In the results for quarter four 2025/26, we have retained our rating of one and we are ranked third in the country out of 61 comparable organisations.

We attended the launch event for the Kirklees Involvement Network (KIN) Cancer Champions at Huddersfield Mission. The project is a collaboration between the Trust and partners to raise awareness of early signs of cancer and increase uptake of cancer screens using video podcasts, co-produced to support people with learning disabilities.



On Thursday 4 June, colleagues from Wakefield Recovery and Wellbeing College were special guests at a district-wide event celebrating the power of creativity in health in Wakefield. The college shared how they use free creative courses and workshops to transform lives, their involvement in the Hope Collective poetry anthology, and their plans for the future. [Read more on our website](#).

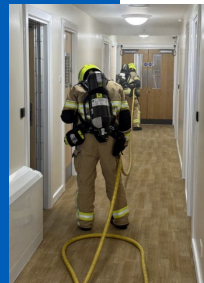


Managing risk

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

Key areas of risk identified in the risk register are:

- Increased demand, acuity and complexity
- Staffing, recruitment, and access to temporary staffing where it is needed
- Staff wellbeing
- Patient safety
- Out of area bed placements
- Young people waiting for treatment and access to inpatient beds
- Confidence in our services resulting from waiting times
- IT infrastructure and cyber crime
- Health inequalities
- Service provision and resource of local authorities
- Creating a positive culture for speaking up
- Sexual safety
- Finance
- Changes to the role of NHS England and ICBs
- Integration of Cheswold Park Hospital
- Medical Devices
- Fire



There are changes to the **Deprivation of Liberty Safeguards** (DoLs) process with immediate effect, arising from a judgement handed down by the Supreme Court on Tuesday 2 June 2026. Any potential DoLs should be raised to mhamcmanagement@swyt.nhs.uk before an application is made. More information is available on the [Mental Capacity Act](#) intranet pages.

On Thursday 25 June, Newton Lodge conducted a multi-agency exercise named '**Exercise Hatfield**'. The purpose of the exercise was to conduct a fire drill along with testing the newly revised and implemented fire procedures for the medium secure unit. The exercise proved to be successful, with additional learning and feedback captured from a hot de-brief with all of those involved. It is important that wards, departments and buildings comply with fire safety guidance and policies to ensure we have a safe working environment. As a reminder staff should ensure they attend and complete their mandatory training, and ward and building managers ensure that regular fire drills are undertaken. with consultation and planning with the Trust's fire advisors.



Best quality

Our performance in May



South West Yorkshire
Partnership Teaching
NHS Foundation Trust

- **55.7%** of people completing Talking Therapies treatment and moving into recovery
- **100%** of Talking Therapies referrals beginning treatment within 18 weeks. **99.6%** within 6 weeks.
- **87.2%** of MH service users followed up within 72 hours of discharge from inpatient care
- **85.8%** assessed within 14 days
- **92%** inpatient risk assessment completed within 24 hours before or after admission
- **93.8%** on community active caseload at month end with a risk assessment which has been reviewed within the last year
- **100%** of people died in a place of their choosing
- **87.9%** in CAMHS services waiting less than 18 weeks for treatment

The physiotherapy mental health team in Barnsley celebrated Mental Health Awareness Week with activities to promote wellbeing, connection and recovery.



We have seen an improvement in the **care plan and risk assessments** this month, which is positive. To continue to keep our patients safe this requires a sustained position.

Friends and Family: 93% of people in our mental health services rated us good or very good. 96% in our physical health community services.

Our **customer services** team dealt with 33 new formal complaints in May, a 10% increase from last month. None of the complaints received had staff values or behaviours as the primary reason for the complaint.

Discover the latest **All of us improve quality improvement training sessions**. The introduction to quality improvement session provides an overview and the information on the six-step methodology. For a more in-depth understanding, the 'quality improvement essentials' training explores every stage of the six-step process over two sessions. Find out more on the [intranet](#).

Our aim to be a truly anti-racist organisation is key to our ongoing journey with the Patient and Carer Race Equality Framework (PCREF). **Watch our video** from our leadership team, explaining how we're committed to embedding PCREF into our ways of working, to ensure equal access, experience, and outcomes for all.





Best quality

Our performance in May



South West Yorkshire
Partnership Teaching
NHS Foundation Trust

- **82** inappropriate out of area bed days
- **2** children / young people under 18 in adult inpatient ward
- **4.8%** of service users clinically ready to discharge. There were 23 people still delayed at the end of the month.
- **96.7%** with care plan that includes service user input/views
- **95.7%** of our service users have their ethnicity equality data recorded, **56.8%** their disability status, **56.7%** their sexual orientation, and **99.6%** deprivation (postcode)
- We had **5** information governance breaches

The **Nursing and Midwifery Council (NMC)** is currently consulting on proposed changes to nursing and midwifery education standards, focusing on practice learning, programme hours, and community placements, with responses open until 23 July 2026. More information can be found on the [intranet](#).

Make sure your medical devices are asset tagged and serviced.

It's your responsibility to make sure all medical equipment used is serviced, asset tagged and in date. If equipment is out of date, come along to one of the drop in days listed and updated regularly on the [medical devices intranet page](#). If you can't make these dates, we can arrange a service day for specific areas or you can [log a job with the helpdesk](#) to pick these items up.

We marked [Dietetic Week 2026](#), celebrating the achievements of our colleagues and the impact they have every day. The daily themes focused on different topics, sharing stories to promote their fantastic work.



Find out more about our new Word 360 **interpreter** contractor service. Sessions will be held on Friday 25 September from 9.30am-12pm in the Langsett room at Kendray Hospital and 1.30-4pm in the small conference room at Fieldhead. Email [Gary Garvey](#) to book your place.

The NMC has launched [new anti-racism principles](#) to help tackle health inequalities suffered by racially minoritised people.



Best quality

Reasonable adjustment digital flag



South West Yorkshire
Partnership Teaching
NHS Foundation Trust

Under the Equality Act 2010, we have a legal duty to make "reasonable adjustments" for disabled patients to ensure they receive the same quality of care as everyone else.

The digital flag is a national initiative designed to make these requirements visible at the point of care, ensuring no patient must repeat their needs every time they visit a different service. This became a legal requirement in December 2025 and aligns with our legal requirement to conform to the Accessible Information Standard (AIS).

We all have a role to play in making our services more accessible.

Find out more on the [intranet](#) or email

InvolvingPeople@swyt.com

Reasonable adjustments start with barriers — not labels

- You don't need a diagnosis to offer support
- You don't need proof or paperwork to remove barriers

Focus on what helps, not what's "wrong"

- Adjust the environment, not the person
- Support should respond to barriers, not medical labels

Let's be realistic

- Not everyone can access a diagnosis (long waits, costs, or no formal label at all)

What matters most?

- Creating inclusive environments where people can thrive

What do I need to do:

- Identify barriers and act early
- Check out the About me Visualisation on SystmOne
- Ask individuals about their needs and put adjustments in place.

Examples include:

- Flexible appointments or longer slots
- Large print
- Interpreters
- Quiet or low-sensory spaces
- Assistive technology or alternative formats



Best place to work and learn

Our performance in May



South West Yorkshire
Partnership Teaching
NHS Foundation Trust

- **4.8%** sickness rate for the month.
- The rolling 12 months sickness rate is **4.9%**
- **93.5%** of staff have a completed annual appraisal

Please ensure that appraisals are carried out in line with the updated requirements. Following recent changes to the appraisal process, the system has transitioned from a rolling 12 month cycle to a fixed appraisal window effective from 1 April 2026. Details are on the [intranet](#).

We celebrated our estates and facilities colleagues as part of National Healthcare Estates & Facilities Day. To say thank you, we held coffee and cake mornings in our dining rooms and held a special raffle, drawn by deputy director Nick Phillips. [Find out more.](#)



Congratulations to our newly appointed steering groups across our four **staff networks**. After a two-month recruitment and voting period, we're delighted to welcome 11 new members to the steering groups.

Your Health Hero Employee Assistance Programme (EAP) gives you access to counselling, legal information, money and debt support and health and wellbeing. Find out more on the [intranet](#).



The Trust is running a **Mutually Agreed Resignation Scheme** (MARS) as part of its workforce efficiency programme for 2026/2027. The window for applications will be open from 1 June – 31 July 2026. Applications will be considered during August. Please note that the Trust has no plans to run any voluntary redundancy schemes. [Read more on the intranet.](#)

Our **volunteer service** had a fantastic time celebrating Volunteers' Week (1 – 7 June) with a range of our services, recognising our volunteers for their contributions in helping our Trust to live our values every day.



All new recruitment for band 3 peer support worker positions must use the [updated standardised job description](#). Any service-specific details must be reflected within the accompanying job advert. Anyone currently in the recruitment phase will stay on the previous job description. If you have any questions, please contact recruitment@swyt.nhs.uk

Are your contact details up to date on ESR? Please ensure your diversity profile data is correct and up to date, as we use this information to make sure we meet the needs of our people.



Best place to work and learn

NHS staff survey results at the click of a button



South West Yorkshire
Partnership Teaching
NHS Foundation Trust

Colleagues can now access the latest staff survey results on our dashboard. You can find it on the [NHS Staff Survey intranet page](#). The dashboard provides visibility of results at care group, service line and team level. Simply log in as you would on your usual computer or laptop to explore your area's results.



This year, we are taking a more focused and collective approach to driving meaningful improvement. As an organisation, we have agreed to prioritise two people promise themes:

- **We are compassionate and inclusive**
- **We are safe and healthy**

Teams are also encouraged to identify a third priority aligned to the people promise theme that matters most to them, based on their local results.



A range of resources to support your action planning is available on the intranet page. We encourage all teams to take time to **review your results and agree clear, meaningful actions**.

These steps will contribute to our shared “**You said, we’re doing**” commitment, helping ensure that every voice is heard and that staff can see the impact of their feedback.



Best value

Our finances in May



South West Yorkshire
Partnership Teaching
NHS Foundation Trust

Performance Indicator		Year to Date	2026/27 Forecast
	NHS Oversight Framework	1	1
1	Surplus / (Deficit)	(£1.2m)	£0
2	Agency Spend	£0.3m	£2m
3	Bank Spend	£3.8m	£20.4m
4	Financial sustainability and efficiencies	£2m	£17.7m
5	Cash	£59.1m	£67.m
6	Capital Spend	£1.3m	£14.7m
7	Better Payment Practice Code	98%	

The Trust financial position in May 2026 has seen the deficit run rate increase with a £0.8m overspend. The year-to-date deficit is £1.2m, remaining marginally ahead of plan but action will be required to ensure the breakeven target can be delivered.

Agency spend has continued to be maintained at a low level. Spend in May 2026 is £143k and within plan but forecast to increase due to pending staff retirements.

Although Trust actions are forecast to achieve a £5m reduction in bank spend, the current rate and forecast is that the nationally set maximum spend limit will be exceeded.

The value for money programme is in line with plan due to maintained run rate reduction of spend on temporary staffing and out of area placements.

The current cash position continues to be positive.

Capital spend is ahead of plan in May 2026 due to the timing of updated lease contracts.

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



Best value

Our value for money drive



South West Yorkshire
Partnership Teaching
NHS Foundation Trust

Value for money continues to be a major focus across the whole NHS. We need to continue working hard to ensure we deliver value for money, improve productivity, and live within our means.

Treat Well
For Less?

Each year the Trust spends £4.6m on **medication** for those people who use our services. Effective prescribing (balancing cost and clinical effectiveness) can save the Trust £170,000 every year – that's the equivalent of four full-time nurses or pharmacy technicians. Take a look on the [intranet](#) for resources, tips and guidance on how you can help to reduce medication costs.

Register your interest in loaning a Trust e-bike

Looking for a way to boost your wellbeing, save money and reduce your carbon footprint? Why not take advantage of our free e-bike loan offer for staff and enjoy cycling this summer. Find out more and email e.bike@swyt.nhs.uk to book.



[Read our guidance](#) for sending post correctly. The poster will provide useful steps to use and consider when you are posting, to help reduce costs, waste and environmental impact.



If you're curious about how to reduce your carbon footprint, join an online talk led by our sustainability change manager Tony Wright on 22 July. The session will explore simple, practical actions we can all take - both at work and at home - to reduce our environmental impact. [Find out more on the intranet.](#)

What you can do to help

In the past year we have saved money resulting directly from the suggestions many of you have made through our value for money programme. We need your help to identify further initiatives that will save us money or help to improve our efficiency. Please continue to send through your suggestions and ideas. Every little bit helps. You can send your ideas through the value for money section on the [intranet](#).



Take home messages



South West Yorkshire
Partnership Teaching
NHS Foundation Trust

Safety comes first.
Do all you can to
make our services
and places as safe
as possible.

Share your views,
ideas, good practise
and learning as a
part of our 'leading
well' conversations.

Find out more about
our new Word360
interpreter service by
attending one of our
learning sessions.

Help us to make our
services more
accessible by
following the
guidance regarding
reasonable
adjustments.

The window for
appraisals is open
until September for
all staff. Make sure
yours is booked in.

Support our value for
money work by
helping to reduce
any unnecessary
spend and sending
through your ideas.

Take a look at the
NHS Staff Survey
dashboard and use
the resources to help
develop your action
plans.

Your wellbeing is
important to us. Take
a look at our
employee assistant
programme to see
how this can help.

If you would like
something including in
a future edition of the
Brief speak to your line
manager or contact
comms.

With **all of us** in mind.

Trust Board 28 July 2026
Agenda item 9 – Assurance from Trust Board Committees

Quality and Safety Committee

Date	7 July 2026
Presented by	Margaret Kitching, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	<u>Alert:</u> • The Poplars Staffing Risks: Staffing levels remain under close monitoring. Vacancy rates and bank shift utilisation continue to reduce, with the majority of bank shifts filled by substantive Trust staff, supporting continuity and quality of care. The unit's isolated location presents an ongoing risk should the OPS process be prolonged; however, robust business continuity plans are in place to mitigate any impact and maintain safe service delivery. • The Trust has remained in OPEL 4 for several weeks, with regular escalation meetings established, although ICB representation at meetings has at times been limited. At the time of the Committee there were early signs of improvement, with fewer patients awaiting admission. The COO is maintaining close oversight to manage system pressures and mitigate risk, Admissions to non-designated beds are being restricted. <u>Advise:</u> • A review of community apparent suicides has been commissioned via the mortality group led by two psychiatrists and the suicide prevention lead. The review is expected to complete by the end of July. • Enhanced monitoring quality review has been commissioned for Elmdale Ward and a rapid improvement group is being established. • EDI Dashboard – we would like to see more analysis and a presentation at a future Committee. • Pressure Ulcer Incidents noted through SPC to have increased, however there has been an increase in caseloads, reporting increased through introduction of Purpose. A new wound care template has been developed. Part of a wider piece of work re definitions of pressure ulcers across the region (prevalence v incidence). • RRP – 2nd highest level of seclusion on working age adult wards in the country, external review of restrictive practice team and training underway to be reported imminently. An improvement plan is in development and will be overseen by QSC. <u>Assure:</u> • Team story focussed on an innovative programme of work aimed at reducing DNA rates for migrants attending for immunisations. Early indications are demonstrating positive impacts and importantly positive patient experience. • R&D Strategy – well received by QSC who agreed to recommend to the Board pending minor changes requested. • Safer Staffing Report – vacancy rates reducing in mental health services, the focus needs to strengthen in forensic services now.
Approved Minutes of previous meeting for receiving	Minutes of 9 June 2026

Audit Committee

Date	14 July 2026
Presented by	Mike Ford, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	<u>Alert:</u> - As part of the regular update on committee related risks there was a brief update on the management capacity risk to be merged with the risk of the Trust not achieving its strategic objectives. Committee requested that a more formal report be submitted in future. - The Committee received the regular report on Internal Audit delivery against the agreed annual plan. There were two topics of note - A report with <i>moderate assurance</i> was received on Risk Management – the recommendations mainly relate to the embedding of risk management processes at care group and operational level. Actions to address the findings of the report and other improvements to risk management processes were covered in the revised Risk Management Procedure which was approved by the Audit Committee at this meeting. - There has been a proposed change to the approved annual internal audit plan with the planned Freedom of Information and Subject Access Request audit to be replaced by a review of controls relating to inappropriate access to patient records, following recent high-profile incidents nationally and increased scrutiny from NHS England. The Committee questioned whether this was appropriate and also had a discussion about internal audit capacity more generally - but the Committee noted that the risk regarding medical devices is not covered on the IPR and asked for this to be reviewed. <u>Advise:</u> - A number of annual updates were received from the Estates team - The latest position of compliance with the NHSE Core Standards for Emergency Preparedness, Resilience and Response (EPRR). The Trust is making progress in meeting the requirements but remains non-compliant but as previously reported there have been no implications from non-compliance. - The annual Premises Assurance Model (PAM) submission was reviewed. The Trust achieved a high overall level of compliance; however, changes to the national assessment methodology now effectively measure organisations against 100% compliance, with any lower score categorised as non-compliant. - The 2025 PLACE Assessment results were also received, with separate reports provided for Trust sites and Cheswold Park Hospital to improve visibility of performance. Overall scores remained consistently high, although several domain scores had reduced slightly, largely reflecting the impact of the Cheswold Park Hospital results. Committee members stressed the importance of these measures as indicators of patient experience and the estates environment which reinforced the need for continued focus and investment. - The Health & Safety Services Annual Report reflecting ongoing work in areas such as lone worker device compliance, fire safety arrangements and local governance. - The annual report on completion of a Declaration of Interest by identified senior decision-making managers was received. 80% of those staff still with the Trust have updated their declarations since April 2026. All outstanding returns are being followed up. - The Committee also received updates on - The Trust's submission to the National Cost Collection process

	• The latest update on the COVID 19 public inquiry and the preparations for and compliance with any requirements of the inquiry • Preparation of the annual accounts for the Trust's charities <u>Assure:</u> • The ORR risks assigned to the Committee were reviewed in detail. Detailed discussions took place on ◦ The Cyber security risk with a separate meeting arranged to look at strengthening Board level oversight of this risk ◦ The Committee agreed that the reduction in the freedom to speak up risk was premature • Further to the above, the Committee reviewed the regular report on the triangulation of risks between the BAF, ORR and IPR. This report provided positive assurance re the way that risks are reflected in the IPR. • In addition, positive assurance received from regular reporting of ◦ Counter Fraud activity by 360 Assurance including the outturn of the annual counter fraud plan ◦ Procurement activity ◦ Treasury management • Deloitte provided a verbal update on the completion of the Trust's 2025/26 external audit work reporting that following presentation of the ISA 260 report at the previous Audit Committee meeting, there had been no subsequent changes to the accounts. The audited accounts were signed on the following Thursday and submitted to NHS England on the Friday in accordance with required deadlines. • Audit Committee received the regular update on progress in delivering the Trust's systems development plan. Strong progress against individual deliverables continues to be reported. NOTE in future this report will be presented to the new Transformation Committee. • An update was provided on the progress in implementing the recommendations from the limited internal audit on Risk Planning and Care Assessments
Approved Minutes of previous meeting for receiving	Minutes of 12 June 2026

People and Remuneration Committee

Date	14 July 2026
Presented by	Nat McMillan, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	<u>Alert</u> • The committee were made aware that the local collective written agreement regarding the implementation date for NHS term and conditions for staff at Cheswold Park Hospital remains unsigned. It was noted that the risk was low but it was a condition of the offer. At this stage, it is hoped that it will be signed off at the July partnership meeting or next steps will need to be considered. • The committee discussed the current position of bank spend which is off track. It was agreed that the PRC meeting in September (2026) will review the position and if it remains off track expect a contingency (or plan b) to be presented and discussed. The chair of PRC will discuss with the chair of FIP to ensure alignment between the oversight of both committees and FIP's role regarding the Value for Money programme. <u>Assure</u> • The committee have confirmed regular oversight of the Workforce Efficiency/Reduction plan and Sickness Absence Reduction plan for 2026/27 to monitor delivery. The board previously approved.

	• The committee invited representatives of the staff networks to attend to share their experiences in person and specifically around the relaunch. The committee were assured that they had experienced a robust and fair process with new support in place from the People directorate. • The committee received the PRC performance report and noted the strong performance across the metrics. Further assurance was taken from the sustained levels of performance and the identification of hotspot areas such as forensics and estates with additional focus. • The committee received the report on Employee Relation cases across the trust with no concerns and assurance they are being appropriately managed. • The committee received the 10 Point Plan which was presented by the resident doctor representative. The committee were assured on progress with 3 actions amber, 5 actions green and 2 actions blue (complete). Further assurance has been requested on the RAG rating used to provide clarity on the amber rating. Nonetheless overall progress is good including the provision of hot food at Kendray Hospital and the reporting of no payroll errors. • The committee received the Medial Staffing Compliance report which provided assurance that there have been no concerns or incidents correlating to individuals with job plans of over 10 PAs. The committee has previously been assured that there are no issues with legal compliance. The focus of the report is being developed to focus on productivity, quality of care and the wellbeing of medical staff. • The committee received a report and assurance that the Trust was compliant with the changes in the Employment Rights Act and noted there may be future implications for the use of zero hours contracts. <u>Advise</u> • The committee were presented with the launch of the staff standards and note that the full board will receive this on 28th July 2026 (the next board meeting). • The committee received an update on the MARS scheme which has been previously approved by board. It is open to applications until 31st July 2026 and the PRC will plan for an extraordinary meeting to ensure oversight of the process and decisions. • Risk 1157 has been assigned to PRC following the closure of the Equality, Inclusion and Involvement Committee. Ongoing monitoring of this risk and evaluation of the updated work programme will continue to ensure that there are no gaps with this change to committee structures. • Risk 1432: the target risk score is proposed to change from 6 to 8 which PRC supported and recommend the change to board.
Approved Minutes of previous meeting for receiving	Minutes of 5 May 2026

Finance, Investment and Performance Committee

Date	20 July 2026
Presented by	Gary Ellis, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	<u>Alert:</u> • At the end of month 3 the Trust had an in month deficit of £0.5m and a cumulative deficit of £1.8m. The in month deficit was worse than plan however, cumulatively we are still ahead of plan by £8k. • Given the marginal amount we are ahead of plan and the one off benefits that have contributed to this position in the first quarter further action is required to achieve the breakeven financial target.

	• Pressure remains around workforce and pay variances within this bank usage has been the main line of volatility. In addition, the provider collaboratives reported an in month adverse variance to plan of £158k. • The Trust value for money programme is ahead of plan at the end of the first quarter with the largest contributor the reduction in corporate costs. The trajectory includes the identification and delivery of new schemes later in the year. These need to be recurrent in nature to ensure that the Trust medium term financial plan of break even is maintained. • The savings from the Value For Money Programme that are categorised with a high level of risk is now £5.4m in respect of workforce savings required. • Although this is early in the financial year the current baseline deficit forecast is significant and requires immediate actions resulting in a change to the Trust run rate. <u>Advise:</u> • In respect of the NHS Oversight Framework (NOF) we have undertaken an assessment of the metrics and identified a forecast score for 22 of the 25 metrics which suggests for quarter 1 the Trust is likely to have a segmentation score of 1 or 2. • The committee received and noted the Waiting List Report and the Trust priority to reduce waiting times and support people whilst they wait in hotspot areas as part of its strategic aim to improve care. • It was noted that Barnsley GP's (about a third) are no longer accepting shared requests for ADHD medication. This is resulting in SWYPFT services not accepting transitions to our services without a shared care agreement. This is resulting in a blockage of in patient flow for the ADHD pathway and waiting lists are increasing. Ongoing discussions with commissioners are taking place. • The update on Capital expenditure was received and noted the intention to issue a stage 3 contract before the end of the month alongside a cost plan to confirm affordability ahead of receipt of a Guaranteed Maximum Price from the contractor for work on the OPS. It is likely that the revised cost plan will exceed the value of the original business case and so Board approval will need to be sought before signature. • The financial context from NHS England is that all systems are adverse to plan at month 2 with a deficit of £109.3m which is adverse to plan by £20.8m excluding Deficit Support Funding. • The committee received an update on NHSE Delivering the NEY 2026/27 Financial Plan Delivery Approach with a clear emphasis on earning autonomy for Boards over time. <u>Assure:</u> • A review of committee related risks was undertaken with no changes at this point in time. Further review will be undertaken in August. • The committee received the first annual update report in respect of progress using our strategic measurement framework. The report demonstrated where we were leading well and noting the areas that we have identified where we could be "even better if" and therefore our proposed areas for improvement. • The IPR for May was received and the overall strong performance of the Trust was noted as we continue to perform well against most national metrics. It was also noted that in respect of Quality and Safety the report demonstrated 76% of the metrics are being fully achieved. • The committee received a deep dive report on the Forensic Care Group. It was noted that through a detailed analysis where performance is below threshold focussed support is available for the areas that need

	to improve. It was highlighted that restraint within the forensic pathway is relatively low evidencing good de-escalation and meaningful day activities and good therapeutic interventions. • Cash balances are ahead of plan and best practice continues to be reviewed. • Performance in respect of the better payment practice code demonstrates compliance with the target. • The committee received a deep dive on ADHD- ASD-LD services. It was noted that ADHD/ASD services continue to deliver strong performance across their workforce, quality and financial metrics. While demand remains very high with significant waiting lists all commissioned activities are being met. • Learning Disability services show improvement whilst simultaneously facing specialist workforce and discharge challenges.
Approved Minutes of previous meeting for receiving	Minutes of 22 June 2026

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

**Minutes of Quality & Safety Committee
9 June 2026
12.30 -15.00
MS Teams**

Present:	Margaret Kitching (MK) Nat McMillan (NM) Mike Ford (MF) Caroline Johnson (CJ) Prof Subha Thiyagesh (SThi) Adele Fox (AF)	Non-Executive Director (Chair of the Committee) Non-Executive Director Non-Executive Director Chief Nurse / Director of Quality and Professions (Lead Director) Chief Medical Officer Chief Operating Officer
Apologies:	Amy Hartley (AH) Yvonne French (YF)	Deputy Director of Nursing, Quality & Professions Assistant Director of Legal Services
In attendance:	Sarah Harrison (SLH) James Waplington (JW) Laura Garfoot (LG)	PA to Chief Nurse / Director of Quality & Professions General Manager for Item 6 General Manager for item 6v
Observing		

QSC/26/47 Welcome, introduction and apologies (agenda item 1)

Margaret Kitching (MK) welcomed attendees, noted apologies as above. The meeting was quorate and proceeded.

QSC/26/48 Declarations of interest (agenda item 2)

The Committee received one declaration of interest from Nat McMillan (NM) in relation to an item scheduled for the private section concerning complex clinical incidents.

NM advised that, having only become aware the previous day, she has a personal connection to the family of one of the patients involved. To ensure transparency and maintain robust governance, this interest was formally declared. It was confirmed that she would withdraw from the meeting for the duration of that item.

The Committee noted that the declaration would be formally recorded, with written confirmation to the Chair, ensuring appropriate documentation and management of the conflict of interest.

The Quality & Safety Committee NOTED the declaration.

QSC/26/49 Minutes from previous Quality and Safety Committee meeting held 14 April 2026 and 19th May (agenda item 3)

The minutes of 14 April 2026 and 19th May 2026 were approved as an accurate record, not formally recorded.

It was RESOLVED to APPROVE the minutes of the Quality & Safety Committee meeting held on 14 April 2026 and 19th May as a true and accurate record.

QSC/26/50 Matters arising from previous Quality & Safety Committee meetings and action log (agenda item 4)

Apparent Suicide Report

The Committee received the updated Apparent Suicide Report as part of the matters arising, noting that following the identification of an error when presented in April the data has been refreshed and was included within the meeting papers for assurance and governance purposes.

The Committee noted the refreshed Apparent Suicide Report, which reported 35 apparent suicides for the period 2024/25. The Committee acknowledged the report as a key area of governance oversight and noted that no further action was agreed beyond ensuring the accuracy of the data in future reports.

Blanket Restrictions and Locked Doors Report

The Committee received the blanket restrictions report as an action arising from Caroline Johnson's (CJ) walkaround on Horizon Ward which was reported in the March Trio report. During the walkaround CJ had identified locked doors that constituted a blanket restriction. The doors had been originally locked due to estates work being undertaken and to maintain patient safety during the duration of the works but had not then been reopened. A Trust-wide review confirmed that the overall policy and reporting framework were fit for purpose, but Horizon was an outlier because no local blanket restrictions register was in place and restrictions had not been recorded or monitored consistently.

CJ confirmed that immediate corrective action had been taken under Emma Cox's leadership, (Assistant Director of Nursing) including implementation of a Horizon blanket restrictions register, recording all restrictions via Datix, and ensuring incidents remain open until restrictions are lifted. The Committee noted that oversight has been strengthened through a Datix-derived dashboard reported through Care Group governance, Patient Safety Oversight Group and Trust-level forums. Documentation is also being standardised to improve consistency across services.

Members welcomed the strengthened governance arrangements but sought assurance that monitoring was robust. NM queried whether reliance on self-reporting by wards was sufficient and asked whether independent checks would be undertaken. It was confirmed that spot checks are embedded within quality monitoring and ward review processes, providing additional assurance. The Committee noted that Horizon appeared to be an anomaly, but agreed that routine dashboard oversight, Datix reporting and documentation standardisation should continue to be embedded.

The Committee reviewed the action log, noting progress against existing actions, updates provided within the papers and items requiring carry forward. Completed actions were closed where members were assured that the requested updates had been made or embedded.

QSC/26/30 Minutes from the Previous Quality & Safety Committee held 14.4.2026

The action relating to *Learning from Deaths* was confirmed as complete, with the requested amendments incorporated into the previous minutes. Members were satisfied with the revisions and agreed closure.

QSC/26/35 Internal Audit Report

The Internal Audit action on care planning and risk assessment was confirmed as complete, with updates now embedded within the report as a standing monthly update. Members agreed this provided appropriate assurance and closed the action.

QSC/26/36 Clinical Strategy Update

In relation to the Clinical Strategy Steering Group, CJ was of the understanding that meeting dates had been circulated but confirmation of Nat McMillan receiving the invitation is to be confirmed.

Action: Sarah Harrison to chase confirmation of NM's invitation/attendance.

QSC/Staff / Team Story

The Committee noted that the update relating to the Apparent Suicide Report had been completed and included within the matters arising section. Members agreed this action could be closed.

QSC/26/9 Quality & Regulatory Oversight Paper

The CQC Assessment Framework Consultation update had been prepared but was not included in the report. Members agreed it should be deferred and brought back to the July meeting.

Action: Caroline Johnson

QSC/26/13 Completion of Actions from Internal Audits

Covered within internal audit report. No further challenge and accepted as complete.

QSC/26/14 Pressure Ulcer Update Report

It was noted that this item had been deferred until the July meeting.

QSC/26/16 Deprivation of Access Report

Subha Thiyagesh (SThi) provided a detailed update on the Deprivation of Access / Access to Care inequalities work, confirming that initial scoping, literature review and community feedback analysis had been completed. The scope had broadened beyond detained patients to the wider population, with the next phase focused on impact through clinical engagement and pilots in selected services. Members supported the approach and noted alignment with Trust priorities on access and inequalities. STHi to present a formal project brief to the July Committee; existing action closed and replaced with a new six-month progress monitoring action.

Action: Subha Thiyagesh

QSC/25/233 Committee Annual Report

The Committee considered the action relating to the Committee Annual Report and work programme. It was reported that governance arrangements were being strengthened through the refreshed Clinical Governance Group, which would support alignment of both work programmes. Update to be given in September.

QSC/25/206 Quality Strategy Update.

The action concerning Quality Strategy Update remained open. Members noted the delay associated with the forthcoming national strategy and expressed concern about potential slippage. It was agreed that, should the national update be delayed further, the Trust would need to refresh its own strategy to avoid it becoming out of date. No specific new action was assigned at this stage, but the Committee flagged this as a risk requiring ongoing monitoring.

QSC/25/181 Safer Staffing Report – 6 monthly

The Safer Staffing Report action was deferred, with members noting that further work had been requested from the Executive Management Team and the report will be presented in July.

QSC/25/163 R&D Strategy

The Committee also noted that the Research and Development Strategy update would be brought to the July meeting ahead of Board consideration.

QSC/26/51 Review of Committee related risks, update following Board discussion (agenda item 5)

The Committee received the risk report, noting a broadly stable profile following recent disaggregation, clearer alignment to risk appetite and strengthened governance arrangements. Members noted new and refined risks, including Clinical Risk Assessment (2086), Restrictive Practice (2087), the reclassification of Delayed Discharge (1839) and Medical Devices (1757), transfer of Speaking Up risk (1887) oversight to Audit Committee, and completion of diagnostic work on Culture risk (1820), with an action plan to follow.

The reduction in the health inequalities risk score (1689) from 9 to 6 prompted significant challenge. Mike Ford (MF) expressed concern that health inequalities remain a material community and service-user risk and that the rationale provided, particularly reference to staff speaking up, did not adequately justify the reduction and appeared more aligned to the Freedom to Speak Up risk. NM supported this, noting that the closure of the Equality, Inclusion and Involvement Committee (EIIC) and transition of oversight arrangements created uncertainty and made the reduction feel premature. Members agreed that the risk definition, ownership and scope needed clearer articulation, particularly the distinction between inequalities in access and wider determinants.

Action: Caroline Johnson

It was RESOLVED to RECEIVE the update.

QSC/26/52 Staff/Team Story (agenda item 6)

James Waplington (JW) and Laura Garfoot (LG) attended to present the inpatient flow improvement work and the national programme to reduce mental health demand within emergency departments.

The Committee heard that significant system pressures across inpatient and community services had led to a comprehensive improvement programme focused on patient flow, discharge efficiency and partnership working. Actions included strengthened daily and weekly oversight, seven-day senior leadership input, daily ward huddles, multi-agency barriers-to-discharge discussions, escalation with ICB and local authority partners, and targeted work with high-intensity service users and emergency department pathways.

Members noted measurable improvements, including increased discharge rates, improved bed availability, reduced waits for admission, reduced length of stay in working-age adult wards and fewer patients clinically ready for discharge. SThi commended the progress and queried whether similar length-of-stay improvements had been achieved in older people's services. LG advised that progress had been more limited due to external factors such as specialist placements and care packages, although time spent clinically ready for discharge had reduced.

CJ welcomed the improvements and emphasised the need to continue transforming community provision to sustain progress. Adele Fox (AF) noted that further work remained,

particularly around Section 136 suite demand, admission appropriateness and seasonal mental health pressures. The Committee concluded that the work had delivered clear improvement through strong leadership, operational grip and partnership working, while recognising that system constraints and development of community alternatives require continued focus.

The members of the Committee thanked both JW and LG for their attendance at the meeting and for the great presentation and information provided.

QSC/26/53 Executive Trio Update inc. update of topical & legal risks, escalations, quality impact assessment (QIA) (agenda item 7)

The Trio report was noted as deferred due to the short timeframe between committees caused by the committee moving in May.

QSC/26/54 Quality & Regulatory Oversight Paper (agenda item 8)

The Committee received the Quality and Regulatory Oversight report, noting a stable overall position, positive and transparent regulatory engagement and continued strengthening of internal quality assurance arrangements. Members noted that CQC action plans for forensic services and Cheswold Park had closed, with one remaining acute/PICU action relating to seclusion medical review compliance.

SThi described the work undertaken to improve seclusion review compliance, including pathway review, clearer escalation, visible ward tracking, enhanced electronic documentation and strengthened training for junior doctors and consultants. Assurance was provided that reviews are taking place, although timeliness remains affected by competing clinical priorities.

CJ confirmed that a real-time dashboard for seclusion and long-term segregation is being developed to strengthen oversight.

Members noted an increase in CQC enquiries, linked to greater use of Learn from Patient Safety Events (LFPSE) data, and were assured that all enquiries had been comprehensively responded to and closed. Themes were consistent with known risks, including patient safety, risk management, environmental issues, safeguarding and staffing. A Mental Health Act visit to Ashdale Ward identified eight actions relating to patient rights, care planning, risk assessment and engagement, with an action plan progressing through governance.

The Committee discussed recurring concerns around care planning, risk assessment and documentation, noting these issues had been identified through internal audit, CQC inspections and Mental Health Act visits. CJ acknowledged the sector-wide challenge and emphasised the need to simplify processes, improve staff confidence in risk formulation and reduce duplication. AF noted that current policy and system requirements can drive perceived non-compliance and that staff are often required to record information multiple times.

Members agreed that internal audit, quality monitoring and Board reporting should more clearly articulate risks, barriers and improvement trajectory.

It was RESOLVED to RECEIVE the Update

QSC/26/55 Quality Assurance System Update (agenda item 9)

The Committee received the Quality Assurance System report, outlining current progress in quality monitoring, governance, and service-level assurance across the Trust. It was reported

that there has been continued strengthening of governance arrangements, with evidence of improved quality and safety oversight, though variability remains across services.

Members noted that Cheswold Park remains in intensive monitoring (until inspected by CQC), with reported improvements and a positive recent Quality Monitoring Visit (QMV). However, concerns were raised in relation to Barnsley East Enhanced Team, where issues identified through a quality walkaround included issues with Care Programme Approach (CPA) status, ongoing concerns regarding risk assessment, and weaknesses in clinical documentation. It was confirmed that a rapid quality review had been undertaken, and a targeted improvement plan is being implemented in partnership with the service team. Members noted positively that the service itself had proactively requested support.

The Committee was advised that seven quality walkarounds had been completed during the reporting period, identifying consistent themes including strengthened governance and positive cultures, alongside ongoing workforce and capacity challenges. While service user experience was generally positive, variability was identified in meaningful patient involvement and activity.

A detailed discussion focused on coverage and consistency of quality walkarounds. MF noted that, despite improvements in reporting, there remained a number of services without recent walkaround dates and questioned how assurance is maintained for those areas. He raised concern that some services may not have been visited for extended periods and queried the expected frequency of review.

In response, CJ acknowledged the limitation of the current model, noting that executive-led quality walkarounds alone cannot cover the full breadth of services. She emphasised the importance of a triangulated assurance approach, incorporating quantitative performance data alongside strengthened audit and quality monitoring processes to identify risk areas requiring escalation.

Members were reminded that the Board had previously approved a peer review model to complement executive walkarounds. Under this approach, higher-risk (“red”) services would receive Executive and Non-Executive visits, while lower-risk services would be subject to annual peer review visits between teams. This model was intended to ensure that all services receive at least one form of assurance activity annually.

However, members noted that implementation of the peer review model has been limited. AF highlighted significant workforce and capacity challenges, advising that services are currently being asked to undertake additional review activity whilst simultaneously managing workforce reductions and operational pressures. She emphasised that this has restricted the ability to progress peer reviews as intended.

Members acknowledged these constraints but reinforced the importance of maintaining robust quality assurance arrangements, particularly in the context of workforce pressures. CJ emphasised that reduced capacity increases the importance of effective quality oversight and that a balance must be found to ensure that quality risks are not overlooked.

The Committee discussed the need for improved visibility and tracking of assurance activity. It was suggested that the quality walkaround reporting should include clearer identification of peer reviews, informal visits, and executive assurance activity to highlight any gaps in coverage.

MK emphasised that the quality assurance model had already been formally agreed at Board level and that any proposed changes, driven by capacity constraints, would need to be clearly articulated and brought back for discussion and approval. Members supported the need to

work through practical solutions while maintaining alignment with agreed governance arrangements.

Actions:

- Further develop and implement the peer review model to ensure all services receive at least annual assurance coverage. **Action: Caroline Johnson**
- Review and enhance reporting to include visibility of all assurance activity (peer reviews, executive visits, and informal reviews) to identify gaps in coverage.
Action : Caroline Johnson
- AF to progress discussions with operational teams via OMG to identify a practical and sustainable approach to delivering peer reviews within current workforce constraints.
Action: Adele Fox

It was RESOLVED to RECEIVE and NOTE the update.

QSC/26/56 CQC Action Plan Update (agenda item 10)

CJ confirmed that the CQC Action Plan had been covered through the preceding regulatory and quality assurance discussions. Members agreed that future reporting should provide a clear narrative distinguishing completed actions from ongoing quality improvement, particularly in relation to seclusion reviews, to avoid presenting substantively completed work as an unresolved compliance deficit.

It was RESOLVED to RECEIVE and NOTE the CQC Action Plan Update.

QSC/26/57 Community Mental Health Survey (agenda item 11)

The Committee received the Community Mental Health Survey results, noting strong feedback on staff compassion, respect, support and communication, particularly around medication. Wider pressures were reflected in areas requiring improvement, including access, crisis response, involvement in care planning and decision-making, carer engagement, continuity and the need for service users to repeat their story.

Members noted that five areas were in the top 20% nationally, most results were mid-range, and two areas were in the lowest range: repeating their story and knowing who to contact in crisis. MF expressed concern about the overall negative direction of travel, with more indicators declining than improving or remaining stable. CJ acknowledged that small sample sizes can create fluctuation, but agreed the findings required a stronger response.

It was confirmed that an action plan exists following the 2024 survey but is not yet sufficiently developed to provide assurance. CJ advised that a task and finish group is strengthening the plan in light of the latest results. Members agreed the revised plan should directly address care planning involvement, carer engagement, crisis access and continuity of care and would like for this to come back when available.

Action: Caroline Johnson

It was RESOLVED to RECEIVE the Community Mental Health Survey.

QSC/26/58 Quality Account 25/26 (agenda item 12)

The Committee received the draft Quality Account as the final opportunity for review prior to Board approval. Members noted that only minor amendments had been made since the previous version, including stakeholder feedback and revisions to the executive statement, with some responses still awaited.

Members agreed that, given the extent of prior scrutiny, further detailed line-by-line review in the meeting was not proportionate. Final comments would be submitted offline by the end of the week and incorporated ahead of Board submission.

The Committee also discussed the appropriate signatory following Marie's departure and agreed that she should remain named for the Quality Account because she was the accountable executive during the reporting period; this differed from the Annual Report, which requires signature by the current post-holder at submission.

It was RESOLVED to RECEIVE and NOTE the Quality Account 25/26.

QSC/26/59 Safer Statting Report- 6 monthly (agenda item 13)

It was noted that this item was deferred pending EMT approval.

QSC/26/60 Quarterly Patient Safety Oversight Report and Annual Report (agenda item 14)

The Committee received the Quarterly Patient Safety Oversight Report and annual overview, noting that PSIRF is embedded across the organisation, with proportionate system-based responses, refreshed governance arrangements and a stronger focus on learning and improvement. The Committee was assured that no never events had been reported and that most incidents resulted in no or low harm.

Key themes included self-harm and suicide prevention, violence and aggression, physical health monitoring, care planning and risk formulation, discharge processes, pressure ulcers and medication safety. Members noted emerging improvements in reduced repeat self-harm linked to co-produced safety plans, falls management, NEWS2 monitoring and EPMA implementation, while recognising that pressure ulcers, medication errors and community suicide prevention require continued focus.

MK welcomed the clearer format but noted that some high-level visual assurance indicators, such as no never events and the proportion of no/low harm incidents, had been lost. She also asked that reports more clearly link improvement activity to intended patient outcomes and measures of success. Members supported the continued focus on learning but agreed the report should demonstrate impact more explicitly.

CJ will ask for the reinstatement of the clear high-level summary metrics and strengthen the link between improvement actions, intended patient outcomes and measures of success in future reports. This will be added to the version of the report going to Board in June.

Action: Caroline Johnson

It was RESOLVED to RECEIVE and APPROVE the Quarterly Patient Safety Oversight Report.

QSC/26/61 Learning from Healthcare Deaths (agenda item 15)

The Committee received the annual Learning from Healthcare Deaths report, noting 2,125 deaths during the reporting period, consistent with the previous year, with 277 in scope for further review. Members were assured that overall data remained stable, no emerging trends or concerns had been identified, and proportionate scrutiny and escalation processes were in place.

Members noted that most deaths occur in community mental health services, reflecting the Trust's service model. Inpatient deaths were mainly linked to physical health deterioration or end-of-life care, with no evidence that care contributed to the physical health related deaths, however, learning was identified around transfers of care, end-of-life planning, documentation, risk assessment and care planning. Suicide prevention remains a key focus, with thematic review and wider independent review work informing learning.

MF identified that the cover sheet duplicated the previous paper rather than reflecting the correct report. This was acknowledged as an administrative error. Members requested that the narrative be strengthened, particularly around suicide and inpatient mortality, before Board submission.

Action: Caroline Johnson

It was resolved to RECEIVE and NOTE the Learning from Healthcare Deaths Update.

QSC/26/62 Internal Audit Reports (agenda item 16)

No reports for consideration this month.

QSC/26/63 Completion of Actions for Internal Audits (agenda item 17)

The Committee received an update on completion of internal audit actions, noting positive progress overall. No safer staffing actions were due in the reporting period and current actions remained on track. Members noted that risk assessment and care planning actions continue to be progressed, with monthly updates now included in future reports to maintain visibility and assurance.

The Committee then considered the Restrictive Practice Programme, a priority following internal audit findings on culture, consistency of practice and alignment with Trust values. CJ advised that early discussions with AF had identified shared concerns about restrictive practice, including seclusion, and that an independent external review had been commissioned to provide objective assessment of current practice, culture and training. Early feedback was consistent with concerns already identified and supported the improvement programme underway.

The programme includes review of training content, delivery, governance and reporting, with a proposed shift from solely classroom-based training to clinically embedded practice support. CJ acknowledged resistance from some existing trainers, with some potentially choosing to leave rather than move to the revised model, but confirmed there was confidence that the approach would better support real-time modelling of best practice and sustainable cultural change.

SThi provided additional assurance, noting positive engagement with the external reviewers and openness from staff to improve. She reflected that her own experience of Trust training showed a clear emphasis on de-escalation and restraint avoidance, but agreed that further alignment between training and ward-based practice is required. MF queried whether the findings reflected a wider organisational issue around the balance between classroom and experiential learning, and sought assurance that training reflects Trust values. Members agreed this should remain a focus and that wider application of practice-based learning should be explored.

Members also requested that reporting appendices be standardised for clarity and ease of review. The Committee was assured that there is strong leadership alignment and a structured approach to addressing the audit findings, with emphasis on sustainable behavioural and cultural change.

Action: Caroline Johnson

It was resolved to RECEIVE and NOTE the internal audit update

QSC/26/64 Falls Annual Report (agenda item 18)

The Committee received the Falls Annual Report, noting a slight increase in falls but strong overall performance, with an inpatient falls rate of 3.4 per 1,000 bed days, 86% resulting in no harm and no red incidents. Members were assured that falls management remains effective, while recognising ongoing risks in older adult inpatient services due to frailty, complexity and patient mix.

Members noted that frequent fallers account for a significant proportion of incidents and that increasing falls in younger adult inpatient services may be linked to agitation and behavioural factors rather than frailty. Improvement work includes thematic review of frequent fallers, enhanced personalised care planning, strengthened discharge planning and continued learning from high-frequency incidents.

MF queried the comparator used for the reported UK average, noting that interpretation may differ depending on whether the benchmark reflects mental health, community or acute providers. AF and STHi highlighted the impact of system pressures, delayed discharge and patient cohort, particularly in older people's services where some patients may be better supported in alternative environments. Members welcomed the report as strong and informative but agreed the comparator should be clarified.

It was resolved to RECEIVE and NOTE Falls Annual Report.

QSC/26/65 Pressure Ulcer Annual Report inc Monthly Update (agenda item 19)

It was noted that that this report has been deferred as agreed due to short turnaround time between committees due to the move of the May date.

QSC/26/66 Resus Annual Report

It was noted that that this report has been deferred as agreed due to short turnaround time between committees due to the move of the May date.

QSC/26/67 Patient Experience / Customer Services Annual Report (agenda item 21)

The Committee received the Patient Experience and Customer Services Annual Report, noting 11,880 pieces of feedback, high overall satisfaction at 97%, and improved complaint handling. CJ reflected that complaint responses had improved significantly in quality and tone, requiring less revision before sign-off, which was welcomed as evidence of improved responsiveness and culture.

Members noted that feedback is disproportionately received from working-age adults and female service users, with further work required to capture the experiences of older people, male service users and individuals from diverse ethnic backgrounds. The Committee also noted work to improve triangulation of complaints, surveys and Friends and Family Test data, supported by improved dashboards and real-time feedback mechanisms such as patient portals, QR codes and apps. It was agreed to continue the work to improve engagement with under-represented groups, strengthen triangulation of patient experience data and develop real-time feedback mechanisms.

Members queried the retrospective reporting period and noted that the positive feedback did not fully align with the more negative Community Mental Health Survey trends. It was clarified that the survey is a point-in-time snapshot, while the annual report reflects continuous

feedback across a broader period. Members agreed that differences between data sources should be better analysed and presented to support clearer organisational insight, particularly around access, waiting times and service user involvement in care and decision-making.

It was resolved to RECEIVE and NOTE the Patient Experience / Customer Services Annual Report

QSC/26/68 Deep Dive in the PSIRF (agenda item 22)

It was noted that that this report has been deferred as agreed due to short turnaround time between committees due to the move of the May date.

QSC/26/69 St Andrews Report and any action for the Trust (agenda item 23)

The Committee received a report summarising findings from the St Andrews CQC report and mapping these against Trust arrangements. Members noted assurance in relation to safeguarding systems, Patient Safety Oversight Group governance and executive oversight, while recognising the need to strengthen safeguarding within care planning, improve data triangulation and continue work on risk assessment, care planning and therapeutic observations.

The Committee noted that staffing levels and workforce stability remain broadly positive, with good fill rates and relatively low agency use, although vacancies persist. In relation to ward culture and psychological safety, members were advised that cultures are generally open and supportive but variable across services. It was noted that there will be further development of a more systematic approach to monitoring culture, including a cultural dashboard and enhanced staff support following incidents and deaths.

Members discussed leadership visibility and ward-level oversight, noting existing arrangements including executive walkarounds, daily huddles and escalation routes. NM emphasised the importance of visible leadership at all levels, particularly matrons. CJ provided assurance that matrons are active and visible, while acknowledging the risk of them being drawn into operational pressures. AF added that matron redeployment to frontline services, while challenging, provides real-time service insight.

Members noted that the St Andrews themes are consistent with other national and local reviews and reinforce the need for vigilance around closed cultures and early identification of risk, particularly in services less frequently subject to external scrutiny. MF highlighted the importance of ensuring less frequently visited services remain visible within the assurance framework, including community services. SThi reinforced the importance of sustaining an open, supportive culture following incidents. AF confirmed work is underway to triangulate findings with other reports, including Edenfield and Southport, to support a coherent organisational response.

It was resolved to RECEIVE and NOTE the St Andrews report.

QSC/26/70 Reports from Formal sub-committees (agenda item 24)

The Committee received reports from formal sub-committees, including CGG, QUIT, Safer Staffing and NMET, presented through the Assurance, Advice and Alert framework. Members noted that sub-committee reporting provides structured oversight but reflected on the need for clarity and consistency of escalation through the AAA process.

- CGG
- QUIT (no further update since the last meeting)
- Safer Staffing

➤ NMET

In relation to CGG, members noted that items had been appropriately categorised, including external alerts, and were assured that key risks were being identified and escalated. Safer Staffing prompted more detailed discussion, with MF highlighting appraisal completion, fill rates and temporary workforce reliance, and MK noting that triangulation of workforce data, incidents and sickness may provide a clearer ward-level risk profile.

AF advised that work is underway to analyse incident severity alongside staffing levels and workforce pressures, with a workforce recruitment plan in place, particularly for healthcare support workers. Members also noted that a new system had affected appraisal reporting, with improvement expected as issues are resolved. The Committee agreed that, while work is progressing, the current data does not yet provide sufficient service-level assurance to determine whether the Safer Staffing position should be escalated as an alert. It was noted that the safer staffing report will be provided to the next meeting as per earlier discussions.

The Committee RECEIVED and NOTED the Reports from Formal sub-committees Update.

QSC/26/71 Issues and items to be brought to the attention of Trust Board/Committees (agenda item 25)

Alert

- Safer Staffing requires further triangulated analysis of workforce metrics, incidents, vacancies, sickness and appraisal data before sufficient assurance can be provided.
- Risk assessment, care planning and documentation quality remain repeated findings from internal and external reviews. The Committee received an update on the actions being taken to address this and will continue to receive monthly updates on progress of improvement action and their impact.
- Seclusion medical review compliance remains below expected standards, though improving, and requires continued monitoring. The improvement group remains in place to deliver the required improvements.

Advise

- Community Mental Health Survey findings require a strengthened action plan focused on involvement in care, carer engagement, crisis access and continuity.
- Health inequalities risk requires clearer scope, ownership and rationale for the reduced score to support effective oversight.
- Restrictive practice, risk assessment, care planning and patient experience data triangulation remain areas of continued improvement and oversight.

Assure

- Patient flow improvement work has demonstrated measurable progress in discharge rates, bed availability, length of stay and waits for admission.
- Blanket restrictions governance has been further strengthened, with Horizon addressed as an isolated issue and oversight improved through Datix and dashboard reporting.
- Falls, Patient Experience, Patient Safety and Learning from Deaths reports provided assurance on low harm, high satisfaction, no never events, stable mortality trends and robust review processes.
- St Andrews assurance work confirmed strong safeguarding, governance and leadership visibility, with continued alignment to national learning

QSC/26/72 Risk Register Review (agenda item 26)

CJ asked whether any discussion during the meeting changed the position on public risks; the Committee confirmed that no changes were required.

QSC/26/73 Work Programme (agenda item 27)

The Committee reviewed the work programme and confirmed that no changes were required.

QSC/26/74 Date and time of next meeting (agenda item 28)

7 July 2026- Face to face with teams link available.

**Audit Committee Minutes
Wednesday 23 June 2026
Via Microsoft Teams**

Present:	Mike Ford (MF) Natalie McMillan (NM) Martin Neeson (MN)	Non-Executive Director (Chair of the Committee) Non-Executive Director Non-Executive Director
Apologies		
In attendance:	Mark Brooks AS) Adrian Snarr (AS) Rob Adamson (RA) Nicola Wright (NW) Caroline Jamieson (CJa) Elaine Dower (ED) Lianne Burtoft (LB) Andy Lister (AL) Izzy Worswick (IW) Jane Wilson (JW)	Chief Executive (observing) Director of Finance, Estates and Resources Deputy Director of Finance Partner, Deloitte Senior Manager, Deloitte Client Manager, 360 Assurance Client Manager, 360 Assurance Head of Corporate Governance Deputy Director of Partnerships, Planning and Governance Personal Assistant (minute taker)

AC/26/33 Welcome, introduction, and apologies (agenda item 1)

The Chair of the Committee, Mike Ford (MF), welcomed everyone to the meeting. There were no apologies noted. MF confirmed that the meeting would be recorded for administration purposes to support minute-taking. Once the minutes had been completed, the recording would not be retained.

AC/26/34 Declaration of interests (agenda item 2)

There were no further declarations beyond those made in the annual return to the Trust Board or subsequently.

AC/26/35 Actions delegated to Audit Committee from Trust Board (agenda item 3)

MF confirmed that there were no new actions delegated from the Trust Board. He advised that the purpose of the meeting was for the Audit Committee to review and recommend the Annual Report and Accounts under delegated authority, in line with the requirement to submit by 30 June 2026 in accordance with the Board timetable.

Izzy Worswick (IW) clarified that the Committee would formally recommend the Annual Report and Accounts for approval, with final sign-off delegated to Mark Brooks, Chief Executive, and Jayne Brown, Trust Chair, following agreement at the previous Board meeting.

AC/26/36 Report to the Audit Committee on the audit for the year ended 31 March 2026 – ISA260 Audit of Account 2025/26 report to those charged with governance (agenda item 4)

Nicola Wright (NW) Deloitte, introduced the report, confirming that the audit had progressed well with strong support from the finance team and was on track for completion by the end of the week. A minor issue relating to pension data had been resolved following intervention from Adrian Snarr (AS). NW then invited Caroline Jamieson (CJ) Deloitte to highlight the key audit risks and findings.

Accruals and judgement discussions

CJ highlighted the significant risk relating to management override, including journal testing and estimates, and confirmed that journal testing had not identified any issues. In relation to accruals, CJ noted a number of judgmental items, including some carried forward from previous years, one of which had been adjusted during the audit. She confirmed that these had been reported due to their judgmental nature, with a recommendation to strengthen supporting documentation and management papers.

AS acknowledged differences in view between management and Deloitte, particularly regarding the application of accounting standards and the identification of an obligating event. He confirmed that one accrual had been removed where the evidence did not support it, while others remained as management judgements despite being reported as audit differences. AS noted the intention to engage earlier with auditors on such judgements in future years.

MF noted the importance of robust processes, particularly where items had already been invoiced but remained within accruals. RA confirmed that this would be addressed with the team.

MN commented that the report did not read well in relation to management judgements and emphasised the need for clear rationale to support decisions, aligned with audit guidance.

Super user access

CJ confirmed that concerns remained regarding super user access within the finance team. Testing had identified gaps in the control process, including incomplete SBS listings and changes made without documented approval. A control recommendation had therefore been included within the report.

AS acknowledged that the issue had been raised in previous years and that the current findings indicated weaknesses in the control environment, particularly where changes were not evidenced. He confirmed that the management response would be strengthened and that the Trust would revisit its approach, including reviewing practice across peer organisations.

CJ also provided an update on the remuneration report, confirming that final pension information had now been received and incorporated. She advised that final checks were underway following agreed amendments, and no further significant issues were noted.

Overall, Deloitte confirmed that they were comfortable with the unadjusted errors reported, which remained within materiality, and that constructive discussions with management had enabled resolution of key issues during the audit process.

MF to liaise with other Audit Committee Chairs to support benchmarking of super user access arrangements and associated controls.

ACTION: Mike Ford

AC/25/37 Internal Audit Update including internal audit annual report 2025/26 including the head of internal audit opinion (HOIA) (agenda item 5)

Lianne Burtoft (LB) 360 Assurance presented the Head of Internal Audit Opinion and Annual Report, drawing attention to the key elements of the report.

LB confirmed that the overall opinion provided was Significant Assurance, noting that this reflected the outcomes of one limited assurance report and five moderate assurance reports issued during the year, alongside the Trust's recognition of areas of known issue. She highlighted the internal audit plan outturn, noting that most reviews had been

completed, with two audits still in progress which would be incorporated into the 2026/27 opinion.

LB also drew attention to the action implementation rate, confirming that performance was positive, with all actions closed by year end. In addition, she outlined the third-party assurance work, which also demonstrated positive assurance outcomes.

Finally, LB referenced the annual report narrative and KPI performance, noting that this reflected performance reported throughout the year and contained no unexpected findings for the Committee.

The committee confirmed that they had no questions on the report.

MF welcomed the report and noted the continued achievement of a Significant Assurance opinion, highlighting that this had been consistently maintained over a number of years. He emphasised that this should not be underestimated, particularly given the focus on higher-risk audit areas and the increasing number of moderate assurance reports, and acknowledged the strength of both the internal audit work undertaken and the Trust's responsiveness to audit recommendations.

MF thanked LB and colleagues from 360 Assurance for their work over the year, and also acknowledged the contribution of RA and the wider Trust team in supporting the audit process and maintaining a strong control environment.

AC/26/38 Letter of Representation (agenda item 6)

CJ introduced the representation letter and confirmed that it was a standard representation letter, with no additional or bespoke representations required for the Trust. She advised that the only element subject to change was the table of unadjusted errors, which reflects the items reported during the audit process.

MF noted that the letter appeared routine in nature and invited comments from members. MN and NM confirmed that they had no questions or comments on the representation letter.

The Committee APPROVED the representation letter and its standard content.

AC/26/39 Annual Accounts and Trust Consolidation (TAC schedules including the draft audit opinion (attached) and the Director of Finance & Chief Executive certificates on TACs (agenda item 7)

MF introduced the annual accounts and Trust consolidation papers, noting that these had been circulated in advance as the detailed schedules underpinning the financial statements. He confirmed that he had reviewed the documentation and had provided comments to RA, which had been addressed where appropriate.

AS confirmed that the key issues arising from the accounts had already been covered within the Deloitte audit report discussion and did not highlight any additional matters.

Mike Ford invited comments from members.

MN raised a query regarding references within the document to 31 March 2024, noting that this appeared inconsistent with the current reporting period and caused some concern when reviewing the papers. RA clarified that these references formed part of the audit opinion template, which would be replaced with the updated Deloitte opinion

once the audit was finalised. He explained that this section is updated at a late stage in the process.

MN acknowledged the explanation but noted that, until clarified, the wording reduced confidence in the document. He confirmed that, aside from these preamble sections, he was content with the main body of the accounts.

AS acknowledged the point raised and agreed that it would be helpful in future to make this clearer within the document to avoid confusion.

Izzy Worswick (IW) provided clarification regarding the formal position for the minutes, confirming that the Committee was recommending the accounts for approval, in line with the agreed governance process.

The Committee NOTED the update and agreed to RECOMMEND the Annual Accounts and Trust consolidation for approval.

AC/26/40 Consideration of the draft Annual Report 2025/26 including the Statement of Accounting Officer's Responsibility and Annual Governance Statement (agenda item 8)

Izzy Worswick (IW) introduced the draft Annual Report, confirming that the key outstanding issues had been finalised during the week ahead of the meeting. She advised that the main areas of focus had been the remuneration report, including final pension disclosures, and the treatment of prior year exit payments, all of which had now been resolved and incorporated within the version presented to the Committee.

IW noted that the draft report had previously been reviewed by the Board in May and, ahead of submission to the Audit Committee, had undergone detailed review by three Non-Executive Directors. She confirmed that Margaret Kitchen and Rokaiya Khan had reviewed the report prior to the Committee, alongside Mike Ford and that MF had also undertaken a further review following completion of the audit process.

AS confirmed that the Annual Report and Annual Accounts reconcile, and that these checks had been independently verified by Deloitte.

MF invited comments from members.

NM confirmed that she had no further questions, noting that the report had already been subject to prior review.

MN confirmed that he was content with both the report and the process followed, including the level of scrutiny undertaken prior to consideration by the Committee.

The Committee NOTED the update and agreed to RECOMMEND the Annual Report for approval.

AC/26/41 Data Security and Protection Toolkit (agenda item 9)

AS introduced the Data Security and Protection Toolkit report, noting that whilst not directly part of the annual accounts sign-off process, it shared the same submission deadline and had been delegated to the Audit Committee for review and recommendation.

AS confirmed that both the Trust self-assessment and the independent review by 360 Assurance were included within the papers. He reported that the Trust had again received positive assurance, with two green indicators from 360 Assurance, reflecting low risk and high confidence in the Trust's arrangements. He highlighted that this

continued a strong track record in this area, with only a small number of lower-risk recommendations identified.

AS advised that the Trust had met all required standards to enable the Committee to recommend the Toolkit for approval.

MF welcomed the report but noted that the terminology used within the assurance rating could be misleading, particularly the reference to “low assurance risk,” which may appear negative when, in fact, it reflects a positive position. He confirmed that the narrative within the report provided the necessary reassurance regarding the strength of controls.

MF drew attention to a recommendation relating to regular Board discussions on information governance and cyber security, noting that this aligned with previous Audit Committee discussions regarding Board oversight in this area. He confirmed that this would be taken forward by Audit Committee members to review Board engagement against best practice and report back.

NM confirmed that she had no questions and found the report clear.

MN also confirmed that the report was clear but highlighted the areas assessed as partially achieved, noting that he would welcome further detail on these outside of the Committee to better understand the position and assurance level.

AS acknowledged these points.

The Committee noted the positive assurance position and AGREED to RECOMMEND the Data Security and Protection Toolkit for approval.

Chair’s final remarks

MF confirmed that he would provide a verbal update to the Board and noted that the Annual Report would be considered in private session due to publication requirements. He thanked members for their participation and noted that the meeting had been helpful in progressing the sign-off process. He expressed his appreciation to all colleagues involved in preparing the papers, recognising the significant work undertaken to ensure the quality and completeness of the documentation.

MF closed the meeting

**Minutes of People and Remuneration Committee Meeting held on
5 May 2026
Microsoft Teams Meeting**

Present:	Nat McMillan (NM) (Chair) Martin Neeson (MN) Christine Brereton (CB)	Non-Executive Director Non-Executive Director Interim Chief People Officer
Apologies:	Mark Brooks (MB) Marie Burnham (MBu)	Chief Executive Officer Chair of the Trust
In attendance:	Damien Macdonald-Bloomfield (DMB) Ellie Valentine (EV) Suzanne Heron Rebecca Talman (RT)	Associate Director of Education, Learning and OD (ELOD) Deputy Chief People Officer Training & Education – CPH Ward Manager - CPH

PRC/26/309 Welcome, introduction and apologies (agenda item 1)

A/A

PRC/26/310 Declarations of interest (agenda item 2)

No declarations of interest to note.

It was **RESOLVED** to **NOTE** there were no further declarations of interest.

PRC/26/311 Minutes from previous meetings of People and Remuneration (agenda item 3)

It was **RESOLVED** to **APPROVE** the minutes of the People and Remuneration Committee meeting held on the 17 March 2026 as a true and accurate record.

PRC/26/312 Matters arising from previous People and Remuneration Committee meeting held on 17 March 2026 and action log (agenda item 4)

Deep Dive Turnover

CB introduced the paper responding to a query raised at the previous meeting regarding staff turnover, particularly whether any issues were being masked at care group, service, or occupational group level.

CB explained that further analysis had been undertaken following the previous discussion. She advised that although overall turnover remained within tolerance, additional scrutiny had been applied to ensure that no specific problem areas were being overlooked. She confirmed that the deeper analysis did not identify any areas of concern by occupational group or care group. An ongoing issue at Cheswold Park was acknowledged, however it was explained that this was expected to resolve over time.

It was noted that turnover data was also being strengthened through the revised Integrated Performance Report (IPR) format, which provided greater detail. CB confirmed that turnover would also be discussed at the Executive Management Team (EMT) later in the week.

MN commented that the paper was helpful and provided appropriate reassurance. He noted the higher medical and dental turnover rates but acknowledged that this was explained within the paper and appeared consistent with national norms.

NM confirmed that medical staff rotation, particularly among resident doctors, contributed to higher turnover rates and agreed with MN's observation. NM reflected on a discussion at Trust Board, noting that concerns can arise both when turnover is high and when it becomes unusually low. It was highlighted that Trust Board members had raised this issue and that the more detailed IPR data would enable the Committee to monitor turnover trends more closely in future.

The Committee were assured that current turnover levels did not give rise to concern and members agreed that enhanced IPR reporting would support ongoing oversight. It was agreed that ongoing monitoring of turnover would continue through revised IPR reporting and EMT discussion.

Verbal Update – Staff Survey Comments (Sexual Safety)

DMB provided a verbal update on staff survey feedback, including comments relating to sexual safety. It was reported that approximately 530 comments had been received and were being shared with Executive colleagues and their direct reports. In line with national guidance, comments were only being shared thematically in order to protect anonymity.

Key overall themes identified from the comments related to staffing, continued support, time pressures and fatigue.

In relation to sexual safety specifically, DMB confirmed that no direct comments were received raising concerns about sexual safety. A small number of comments (around three) related to gender balance in staffing, particularly on wards managing challenging patients. He advised that gender references had been removed to preserve anonymity. It was confirmed that these points would be taken forward in discussions with the Chief Operating Officer and the care groups as part of the staff survey.

Members welcomed the absence of direct sexual safety concerns and recognised this as a positive finding. NM acknowledged that while there can be questions about whether staff feel confident to speak up, the anonymous nature of the survey provided an appropriate level of assurance. CB noted that sexual safety would continue to be monitored through refreshed IPR reporting and through the Trust's People themes, which are submitted to PRC. CB also highlighted that "Safe and Healthy" would be one of the three overarching People themes, with a strong focus on staff safety, including sexual safety. Discussion referenced the potential alignment with the "All of Us" ethos to reinforce expectations around respectful behaviour. The Committee was assured by the absence of sexual safety concerns in staff survey comments and took assurance from ongoing reporting routes and planned thematic focus and agreed to close this action.

Action 301 – Violence and Aggression/Safe & Healthy Theme

CB highlighted two related elements within this action, developing Non-Executive Director understanding of violence and aggression and reporting processes (including RIDDOR) and clarifying how violence and aggression aligns with organisational priorities under the *Safe and Healthy* theme.

NM expressed concern about the lack of specific dates within the progress update, noting that as Committee Chair she took reassurance from having clear timelines. She confirmed that violence and aggression would be addressed as part of the *Safe and Healthy* people theme but asked whether further work should be undertaken sooner, including through Board development sessions. CB confirmed that no date had been added to that actions as she wanted to take guidance from committee members about what they were seeking.

NM explained that she had been contacted by other Non-Executive Directors seeking clarity on where violence and aggression is formally reported and through which committees it is reviewed. NM noted that while such reporting routes exist (including Audit Committee), the distribution of information across multiple committees created a risk that themes might not be fully triangulated. CB agreed and highlighted that she had also raised this at EMT.

CB responded by reassuring the Committee that such incidents were not considered acceptable and reiterated that the *Safe and Healthy* theme aimed to bring together workstreams on violence and aggression, racism, sexual safety, police involvement and reporting processes, to provide a more systematic and joined-up approach. CB explained that multiple reporting routes currently existed, which may cause confusion for staff. Although emphasising that data is a well understood process for staff. Work was underway to simplify reporting through a more accessible, consolidated approach and a process-mapping exercise was planned to improve staff experience and data triangulation. CB acknowledged that while individual data sources might not indicate a significant issue in isolation, triangulation suggested a broader concern that warranted focused attention. CB confirmed that significant work had already taken place through EDI discussions and that this action was progressing. CB also agreed to discuss with Adele Fox, and wider EMT about linking this.

NM concluded that violence and aggression could be addressed through safe and healthy but also board may need to give further consideration to how to build this into a development day.

It was RESOLVED to RECEIVE the UPDATE and NOTE the changes to the action log.

PRC/26/313 Actions from the Trust Board (agenda item 5)

NM provided an update on matters arising from the recent Trust Board meeting, noting that CB had not been present at Board and that a brief verbal update had therefore been shared with her in advance. NM advised that Trust Board had considered risks aligned to the People & Remuneration Committee. While there were no concerns about the approval of risks, Board members had raised points regarding the timing and formality of assurance, including the importance of ensuring that risks aligned to the Committee were formally approved at PRC level.

It was also noted that, following the disbanding of the Equality, Inclusion and Involvement Committee (EIIC), a number of risks would transition to the People & Remuneration Committee. Members were advised that this was reflected within the accompanying risk paper. NM highlighted a specific Board discussion concerning a risk relating to succession planning and workforce planning (referenced as risk 1432). Trust Board had queried how assurance was being provided in relation to succession planning and talent management at both executive and board level, noting that some of this work had previously been considered in private session. Members acknowledged this point and noted that it would be picked up further when considering the risk paper later on the agenda.

NM reported that Trust Board had received the Freedom to Speak Up annual report, and that one of the issues arising had been the need to better triangulate Freedom to Speak Up data with staff network intelligence. It was noted that the report evidenced improvement in speaking up among Black, Asian and Minority Ethnic (BAME) staff. However, a deteriorating trend was identified for LGBTQ+ staff and disabled staff.

NM advised that this was not unexpected given the focus of national workforce equality schemes, but emphasised that there was a risk of unintentionally overlooking other protected groups. Members acknowledged the importance of triangulating insights from multiple sources, including staff networks. NM confirmed she was assured that the issues raised were being addressed through existing routes, including the Equality, Diversity and Inclusion (EDI) Action Plan. Members took assurance that relevant risks were appropriately aligned to the Committee, succession planning would be considered as part of the risk review and Freedom to Speak Up issues were being addressed through established governance and EDI mechanisms.

It was RESOLVED to NOTE the actions from the Trust Board.

PRC/26/314 Staff Story – CPH Staff Experience (agenda item 6)

CB introduced the staff story and welcomed XX to the meeting. Members were advised that both had volunteered to share their experiences of working at Cheswold Park following its transition into South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) in October 2024.

XX described the transition as an emotional “roller coaster”, noting significant anxiety during the early stages when there was uncertainty about the future of Cheswold Park and individual job security. She explained that she had worked at Cheswold Park for over 18 years and had initially believed the service might close, which had a significant personal impact.

XX described the challenge of rapidly learning new systems while also supporting other staff through the transition. She explained that there had been a prolonged period of waiting to receive confirmation of job security and contract offers, which had increased anxiety for staff, particularly where redundancies occurred. She reflected positively on the support received from managers and colleagues, opportunities to develop new skills, integration into a larger Trust-wide team and feeling more able to showcase capabilities within SWYPFT.

XX identified one key area for improvement, suggesting the value of a central, confidential support hub (potentially via Teams) during major organisational change to provide emotional reassurance and one-to-one support for staff.

XX shared a generally positive and optimistic perspective on the transition, particularly from a clinical standpoint. She explained that she had been excited by the move to the NHS and the strengthening of standards and governance. XX highlighted the adaptability and resilience of Cheswold Park staff, pride in teams managing multiple system and process changes and positive experiences working with SWYPFT colleagues who were described as passionate and supportive. X acknowledged challenges experienced by ward teams, including significant system changes (rosters, ESR, training platforms and medicines systems), supporting staff with limited digital confidence, morale challenges linked to Agenda for Change.

XX commented that her own Agenda for Change process had been straightforward, but that she had supported other staff (particularly senior support workers and nursing staff) who were experiencing ongoing uncertainty and frustration, including concerns about pay parity with bank staff. XX confirmed that from 1 October 2024 she personally felt part of SWYPFT and described positive engagement with Trust-wide activity, including peer review and governance processes. She also noted some ongoing patient perception issues, with patients sometimes referring to “the Trust” as separate from ward staff.

XX acknowledged communication was reasonable but highlighted the emotional impact of prolonged uncertainty. RT reiterated her own process had been smooth but emphasised the knock-on impact for staff she managed.

Members acknowledged feedback regarding HR accessibility. CB provided assurance that a People Directorate Service Offer would be launched shortly, clearly setting out who to contact

for specific HR, recruitment and people queries. XX confirmed she would cascade this information to colleagues.

NM acknowledged the feedback regarding pastoral support and communication methods during organisational change and emphasised the importance of learning from staff experiences.

NM thanked XX for their openness and reassured them that their feedback would be formally taken forward. She confirmed that the Committee would seek assurance on HR accessibility improvements and lessons learned from the transition experience would inform future large-scale organisational change. Also that their contribution would be noted at Trust Board level.

**It was RESOLVED to NOTE the update on the staff story (agenda item 6)
EV joined the meeting.**

PRC/26/315 Chief People Officer Remarks/Update (agenda item 7)

The committee were asked to take the paper as read.

CB confirmed that the Trust was nearing completion of the Cheswold Park transition, with the majority of posts through job evaluation. CB acknowledged ongoing challenges relating to a small number of roles (including senior support workers) and trade union discussions but expressed confidence that these would be resolved. CB reflected on the human impact of prolonged job evaluation processes, acknowledging the anxiety experienced by staff during periods of national and local negotiation.

CB updated the Committee on the refresh of the Trust's appraisal process, aligned to the Trust Strategy and annual priorities. A return to a cascade-based appraisal approach had been introduced. Executive team appraisals were underway. Senior managers (Band A and above) to be appraised by June and remaining staff to be appraised by September. CB confirmed that the approach had been launched at Extended EMT and that mitigations were in place to manage reporting risks during the transition. CB noted that a specific risk relating to appraisals had been added to the risk register.

CB provided a brief update on job evaluation and nursing profile work, advising that this would remain a standing update and confirmed that EV would provide a more detailed deep-dive on job evaluation and nursing profiles at the July Committee meeting.

NM commented positively on the report, noting that it provided a helpful overview of national context and internal activity. NM specifically welcomed the update on mileage rates, noting the long-standing nature of the issue and the likely positive impact for community staff. NM also acknowledged the uncertainty associated with ongoing industrial action and noted the unpredictability of national negotiations.

Members were assured regarding the progress towards completion of Cheswold Park job evaluations, the structured rollout of the refreshed appraisal process and the continued monitoring of national workforce and industrial relations issues

It was RESOLVED to NOTE the update on the Chief People Officers Remarks / Update and comments made.

PRC/26/316 Consideration of items from the Organisational Risk Register allocated to the People and Remuneration Committee (Previously Strategic Workforce Risks) (agenda item 8.1)

CB introduced the Organisational Risk Register, noting that the timing of the meeting meant the risks had already been considered and approved by Trust Board the previous week. The

purpose of the item was therefore to ensure that the People & Remuneration Committee (PRC) formally noted and approved the relevant risks within its remit. NM explained that there had been no substantive concerns at Trust Board regarding the risks themselves. Discussion had focused on ensuring appropriate formality and alignment, including confirmation that risks aligned to PRC were approved and noted at Committee level.

A minor presentational improvement for future papers was requested, asking that the summary page clearly list the risk numbers being reviewed, to support ease of reference when chairing discussions.

The following risks were referenced and noted by the Committee:

- **Risk 1614** - The Committee approved the revised wording, noting this had already been agreed by Trust Board.
- **Risk 1689** – Members noted the rewording and that this risk had transferred to PRC following the disbanding of the Equality, Inclusion and Involvement Committee (EIIC).
- **Risk 1157** – The Committee noted that this risk had also transferred from EIIC. The risk score remained unchanged, with further reviews planned in May.
- **Risk 10008** – Members noted that controls had been reviewed and that there was no change to the risk score.
- **Risk 1820 (Culture)** – The Committee approved the revised wording, as previously agreed by Trust Board.
- **Risk 1729 (Staff Wellbeing)** – Members formally approved this risk as already agreed by Trust Board.
- **Risk 1432 (Succession Planning / Workforce Planning)** – NM reiterated that this was the risk she had highlighted earlier in the meeting and confirmed that she was content with the wording change, provided that the detail within the controls clearly referenced succession planning and talent management at executive and Board level. It was noted that assurance on this would also be supported through a paper to be considered in private session.

Members raised no objections to the risks or wording changes. MN confirmed he had no additional comments. The Committee acknowledged that Board approval had already been given, and that PRC's role was to formally note and approve within its governance remit. The Committee formally approved and noted the risks within its remit, consistent with Trust Board approval.

Members were assured that risks transferring from EIIC were appropriately placed within PRC governance, succession planning considerations were captured within risk controls and no changes to risk scores were required at this stage.

It was RESOLVED to RECEIVE the consideration of items from the Organisational Risk Register allocated to the People and Remuneration Committee (Previously Strategic Workforce Risks)

PRC/26/317 Integrated Workforce Performance Report (agenda item 9.1)

The committee were asked to take the paper as read.

EV advised that the report differed in format from previous iterations, reflecting ongoing work to redesign the people performance reporting framework and this was part of a wider review of the People Directorate management information offer, aimed at strengthening the line of sight between Care Group performance review, Executive Management Team (EMT) oversight, and Committee-level assurance. Members were advised that the report was in transition, with proposals set out in Appendix 1 to show how future reporting would be structured across IPR, Care Group reports and Committee reporting. EV confirmed that further refinements were dependent on final confirmation of Trust priorities, emerging national requirements, including anticipated Workforce standards within the NHS National Oversight Framework (NOF), ensuring robust and consistent underlying data sets.

Further detailed analysis had been included following previous Committee requests. EV confirmed that turnover remained within tolerance and that deeper analysis had not identified latent or emerging risks at occupational group or care group level. It was confirmed that turnover data would also be discussed in more detail at EMT later in the week (it was acknowledged by the committee that it had been discussed as a matter arising).

EV reported that sickness absence had returned within tolerance. She acknowledged national and regional trends of increased sickness over winter months, particularly linked to seasonal illness and slightly longer short-term absences. It was highlighted that interventions in known hotspot areas, particularly Forensics and Estates and Facilities, were beginning to show sustained improvement.

Appraisal performance remained slightly below tolerance and this reflected the transition to the new appraisal framework and revised appraisal windows. It was confirmed that reporting would be reset to align with the new cascade approach.

MN commented positively on the sickness absence data by Care Group, noting that this demonstrated the impact of targeted interventions previously discussed by the Committee. He highlighted this as a positive example of learning and improvement. MN also queried the presentation of senior leadership diversity data, commenting that while figures appeared reasonable, it was not clear what benchmark or “good” looked like. EV acknowledged the point and explained that this data should be considered alongside the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and Gender Pay Gap reporting, which together provided longer-term trend assurance.

NM welcomed the direction of travel of the report and supported the move toward clearer alignment with Trust priorities. She suggested that future versions include clearer narrative assurance statements (for example, explicitly stating whether performance demonstrated sustained improvement) to support non-executive oversight.

Members were assured that turnover did not present an emerging risk. Sickness absence interventions were showing positive impact and the IPR reporting was being strengthened to improve clarity (an action identified at the previous meeting and now addressed), triangulation and Committee assurance.

It was RESOLVED to RECEIVE the Integrated Workforce Performance Report.

PRC/26/318 Temporary Staffing Update (Agenda item 9.2)

The committee were asked to take the paper as read.

EV highlighted the key messages from the report, noting that the Trust had achieved its agency spend target for the previous year, and performance had been better than forecast, a position also reported to Trust Board. Notwithstanding this, there remained ongoing challenges around rate cap breaches, primarily within medical staffing and Band 2–3 roles agency. Bank usage continued to present challenges, driven largely by registered nursing demand. EV confirmed that recruitment activity updates had been included again this month in response to Committee feedback and were intended to provide additional assurance alongside the financial data.

MN commented that, while the report was comprehensive, elements of the presentation (notably red performance indicators) drew the eye and prompted concern. He specifically queried the bank and locum position, seeking clarity on what the red indicators were signalling and whether this should be a cause for concern.

EV explained that the unregistered workforce remained a known challenge. Planned reductions in temporary staffing relied on filling substantive vacancies, but workforce supply constraints made this difficult. Entry requirements for unregistered roles (Band 3) limited the available candidate pool, prompting work on alternative entry routes. Work was underway to explore

apprenticeship pathways and earlier entry-level roles, within financial constraints. EV advised that a recruitment plan would be presented to the Temporary Staffing Group in early June, comprising an interim plan using existing recruitment approaches and a longer-term plan outlining alternative workforce solutions.

MN noted that if the position remained unchanged over successive meetings, further detail and formal updates would be required to support assurance.

CB added further context, explaining that bank spend was reported externally as a blunt financial metric. In practice, a significant proportion of bank shifts were worked by substantive staff, which was positive from a quality and safety perspective and avoided premium agency costs. It should also be noted that these bank shifts covered vacancies and were paid at flat rate, so it remained value for money. This distinction was not visible in national reporting, but internal analysis was being developed to provide a more balanced picture. National finance discussions had similarly recognised the limitations of the current metric.

NM reflected that from a quality perspective, the use of known substantive staff via bank was preferable to unfamiliar agency workers. From a financial perspective, the absence of premium rates provided some reassurance. However, this context needed to be clearer within Committee reporting to support Non-Executive assurance.

NM also commented on medical recruitment information included in the report, noting that future assurance would be strengthened by demonstrating whether successful recruitment translated into reductions in locum usage. Members were assured that agency spend was being effectively controlled. Workforce supply challenges were recognised and actively being addressed and further work was underway to improve the narrative and assurance behind bank usage data.

It was RESOLVED to RECEIVE the update on Temporary Staffing Update and the comments made.

PRC/26/319 Update on Employee Relation Cases (Agenda item 9.3)

The committee were asked to take the paper as read.

EV summarised the key points from the report, drawing particular attention to high-risk employee relations cases, which were highlighted in the opening section of the paper and the progress of employment tribunal matters, including one case that had been closed since the previous report and one new claim submitted. Some of the high-risk cases had protracted timescales, which was acknowledged as undesirable, but explained that this was largely attributable to factors outside the Trust's direct control, including external third-party processes and the health and wellbeing of individuals involved, which had impacted the pace of proceedings.

EV confirmed that where cases carried heightened reputational or financial risk, these were escalated through private Board discussions.

Members were assured that high-risk cases were being actively monitored, that the Trust was taking an appropriately robust and proportionate approach to litigation and that clear escalation routes were in place for cases presenting higher risk.

It was RESOLVED to RECEIVE the update on Employee Relation Cases and the comments made.

PRC/26/320 Workforce Internal Audit Updates (agenda item 9.4)

It was reported that there were no outstanding internal audit actions relating to areas within the remit of the People & Remuneration Committee. An outstanding internal audit report relating

to EDI statutory reporting was acknowledged. Members were advised that the audit related to Quarter 4 and the final draft report had not yet been received. As a result, it could not yet be brought formally to Committee. It was confirmed that a meeting with Internal Audit was scheduled later the same day to discuss the internal audit programme for the current financial year, which was expected to include audits relating to Sickness absence, Temporary staffing and other workforce-related areas.

NM noted that she and MN, in their roles on the Audit Committee, were aware of the outstanding EDI statutory reporting audit and emphasised the importance of triangulation between Audit Committee and PRC oversight.

NM reflected on a recent discussion at Audit Committee regarding the timing and purpose of internal audits, suggesting that audits can provide useful peer review and assurance during periods of significant change, not solely after completion of major work programmes. It was noted that while the audit programme for the current year was already agreed, it would be beneficial to consider future audit coverage of areas such as medical job planning and recruitment, particularly given the volume of work and Committee scrutiny in these areas. The Executive confirmed agreement with this approach, noting the balance between auditing ongoing transformation work and assessing value for money and effectiveness once programmes were more established.

Members were assured that no workforce internal audit actions were currently outstanding, appropriate audit coverage was being planned for key workforce risks and alignment between Audit Committee and PRC oversight was being maintained.

It was RESOLVED to RECEIVE the update on Workforce Internal Audit Updates and the comments made.

PRC/26/321 Guardian of Safe Working (agenda item 9.5)

US advised that the Trust continued to receive a low number of exception reports, which he confirmed was not unusual for a Mental Health Trust. Five exception reports were received in quarter two, two related to industrial action, where doctors stepped down from higher training roles into middle-tier posts. Three exception reports were submitted by Foundation Year doctors due to unforeseen sickness on the wards. Payments were made in some cases, and time off in lieu was taken in others. No fines were levied and no safety concerns were raised.

Similarly, in quarter three no fines were issued and no safety concerns were escalated.

US reported that the Trust was operating with very few resident doctor gaps, with only three gaps recorded since August 2025. Gaps within the on-call rota during the period were primarily attributable to industrial action and sickness and occupational health-related issues. All rota gaps had been covered internally, supported by effective work from the rota co-ordinator. In cases where consultants had stepped down to cover duties, there were no associated safety concerns.

US confirmed that work was underway to move towards a more centralised rota system. He advised that three areas were not yet included those being Barnsley, Community Services and Forensic Services. The intention was for these areas to be incorporated into the centralised rota by August 2026. It was noted that one recurring issue raised by resident doctors related to annual leave, particularly for new starters who were unclear about whom to contact. Usman advised that centralisation of rota arrangements was expected to address this concern.

US advised that following new national guidance and revised terms and conditions introduced in February, exception reporting had moved to a more confidential process and that the changes appeared to be operating smoothly. Nationally, increases in exception reporting were being observed, though this had not yet been reflected locally. Additional new requirements, such as detriment surveys, were being implemented and embedded into routine practice.

CB sought assurance regarding interim arrangements for resident doctors to take annual leave while rota centralisation was being developed. US advised that interim arrangements were in place and generally working, although he acknowledged that cultural change would take time. He confirmed that issues had been manageable and were being actively addressed.

MN referred to the executive report recommendation noting the “ongoing challenges” associated with the Guardian role and invited Usman to expand on this. US explained that the challenges related primarily to the implementation of new national guidance, increased confidentiality requirements and additional processes (including detriment surveys). US confirmed that he was being supported by Medical Education colleagues and expected pressures to ease as the new processes became embedded.

NM summarised that there had been no fines and no safety concerns. Central rota development and leave oversight were key areas for continued Committee oversight and that she had been appointed Non-Executive Director sponsor for the Resident Doctors 10-Point Plan and confirmed this would strengthen governance linkage with PRC.

NM also confirmed her intention to meet with Usman outside the Committee for further discussion and assurance relating to the Guardian role. Members were assured that resident doctor safety concerns were being appropriately managed. Exception reporting arrangements were effective and rota coverage and annual leave issues were being addressed through interim and longer-term solutions.

It was RESOLVED to RECEIVE the Guardian of Safe Working and the comments made.

PRC/26/322 Annual WRES Data Report (agenda item 9.6)

The committee were asked to take the paper as read.

DMB advised members that the report followed the established WRES format and reflected continued progress against the Trust’s Equality, Diversity and Inclusion (EDI) Action Plan.

Key points highlighted included evidence of progress in representation and access to development, particularly in relation to recruitment outcomes. Continued challenges around structural inequalities, particularly at more senior levels. WRES data should be considered alongside other assurance sources, including staff survey feedback and the EDI Action Plan. It was noted that the Trust continued to work within the national WRES framework, with actions aligned to improving both workforce experience and outcomes.

MN reflected on previous leadership development undertaken within the Trust, particularly sessions focused on race, equity and unconscious bias. He queried whether more could be done at Board and senior leadership level to better understand the lived experience of staff from ethnic minority backgrounds. He commented that senior leadership teams can be increasingly removed from day-to-day inequalities and that further reflection and challenge at the top of the organisation could be helpful. MN also queried whether the Trust could do more to visibly support staff networks, sharing experience from another organisation where the Chief Executive and Chief People Officer met regularly with network chairs to strengthen influence and accountability.

In response, CB acknowledged the points raised and advised that Compassionate and Inclusive had deliberately been selected as one of the Trust’s three People priorities for the year. There was clear evidence, including from staff survey outcomes, that the experience of staff from ethnic minority backgrounds, disabled staff and other protected groups was poorer than that of other staff. Strengthening staff networks remained a priority, although recruitment into formal network leadership roles had been challenging. There had been some recent progress, including increased interest in leadership roles within the LGBTQ+ network. Work was ongoing through the EDI operational group, insight work and engagement activity to

strengthen staff voice. The potential value of reciprocal mentoring and further Board development activity focused on equality and inclusion was acknowledged as part of longer-term improvement.

The Committee noted that the current EDI Action Plan remained relevant and was not being replaced but would continue to be refined based on WRES learning and triangulated insight. Members were assured that appropriate actions were in place through the EDI Action Plan. WRES findings were being triangulated with other workforce intelligence. Equality, inclusion and staff experience remained a clear leadership priority.

It was RESOLVED to RECEIVE the Annual WRES Data Report and the comments made.

PRC/26/323 Annual WDES Data Report (agenda item 9.7)

Due to a late amendment, the paper was not submitted with the agenda pack but it was available. CB offered apologies and it was agreed by the committee for the report to be presented verbally.

DMB advised members that the WDES report followed the standard national framework and was broadly consistent with assurance previously provided through other workforce and EDI reporting. Disability disclosure remained a key focus. While there had been an increase in disclosure, this continued to be an area requiring further improvement. The Trust remained a Disability Confident Employer, with positive outcomes for disabled applicants at recruitment stage. There were no significant year-on-year changes across several indicators, and performance was broadly in line with previous years and national benchmarking. The report identified ongoing gaps in senior representation and career progression for staff with declared disabilities, which would be a continued focus of activity.

It was noted that there were currently no declared disabled members at Board level, reflecting a limitation in available disclosure rather than a confirmed absence. The submission deadline for WDES data was 31 May, with an action plan deadline later in the year.

An issue was highlighted in relation to dismissals for ill-health capability, which was reported as zero. It was clarified that there had been three relevant cases, but these had been managed and recorded through absence processes rather than formal ill-health capability routes. This late clarification was a contributing factor to the report being temporarily withdrawn from the agenda pack pending alignment of data.

NM confirmed that the issues raised did not present new concerns and were consistent with themes already reflected within the Trust's EDI Action Plan. Members discussed the importance of improving disclosure rates, noting that staff may not always recognise what constitutes a disability, particularly in relation to long-term health conditions. It was acknowledged that leadership-led initiatives to encourage disclosure could help improve data quality and staff confidence.

MN highlighted a practical issue experienced by Board members when attempting to update personal equality and disability information. He advised that his profile defaulted to "prefer not to disclose" and that he had experienced difficulty amending this, despite wishing to update his details. It was clarified that disclosure captured during recruitment does not automatically transfer into the Electronic Staff Record (ESR) and staff are required to re-declare information post-appointment. Targeted initiatives (e.g. themed staff engagement and awareness campaigns) were planned to support improved disclosure. Examples were referenced of planned focused engagement activity, including encouraging updates to personal records during awareness periods.

Members were assured that WDES findings were consistent with other workforce intelligence, actions were already in place through the EDI Action Plan and data quality and disclosure remained an active area of focus.

It was RESOLVED to RECEIVE the update on Annual WDES Data Report and the comments made.

PRC/26/324 Gender Pay Gap Reports (agenda item 9.8)

The committee were asked to take the paper as read.

Members were advised that the report set out the Trust's Gender Pay Gap position using the required snapshot data. It was noted that the report was being shared with the People & Remuneration Committee in advance of the statutory publication deadline, providing early governance oversight and assurance.

Key points highlighted were that there had been an improvement in both the mean and median hourly gender pay gap, demonstrating a positive direction of travel. The improvement reflected continued progress over time, rather than a single-year change. The data aligned with other workforce intelligence previously considered by the Committee, including senior leadership representation by gender. The Trust's position compared favourably with regional and national benchmarks, including Yorkshire and national comparator organisations.

NM welcomed the report and the opportunity for early review, commenting positively on the sustained improvement in both mean and median hourly rates. NM also noted that the data triangulated well with other assurance received by the Committee, including information on senior leadership profiles and workforce representation. Members did not raise concerns or request further clarification and were content with the explanation provided. Members were assured that progress continued to be made in narrowing the Gender Pay Gap. Improvements were consistent with broader workforce trends and leadership representation and the Trust was on track to meet statutory publication requirements.

It was RESOLVED to RECEIVE the update on Gender Pay Gap and the comments made.

PRC/26/325 People Strategy Delivery Updates (agenda item 10.1)

The committee were asked to take the paper as read.

CB updated that the Board received an update on the People Strategy following its formal launch with Extended EMT (the Senior Leadership Group) in February. Ongoing communication activity has included organisation-wide engagement and dissemination of a "People Strategy on a Page."

The update focused on progress in embedding the strategy through the alignment of annual priorities, ensuring delivery is structured and measurable.

The following three priority areas have been established to underpin delivery Workforce Supply, Safe and Healthy and Compassionate and Inclusive. It was noted that detailed actions under each priority have now been further developed beyond the position at the time of the report. Examples of key initiatives include, development of apprenticeship pathways, ongoing recruitment plans for clinical support workers, focus on reducing avoidable harm and improving staff experience and the requirement for a sickness absence reduction plan in line with national expectations. It was acknowledged that organisational focus on staff wellbeing has been limited in recent years, partly due to constrained occupational health capacity. A renewed emphasis is being placed on enhancing the wellbeing offer as part of the Safe and Healthy priority.

Planned developments include expansion and clearer communication of wellbeing services, introduction of accessible "wellbeing on a page" resources and strengthening occupational

health provision. Changes have been made to improve accessibility, shifting from an occupational health-led referral model to direct employee access. Early indicators show increased uptake, with approximately 70 staff accessing the service in recent months. Services accessed include support for mental health, financial advice, and legal guidance.

The Committee welcomed the structured approach to delivering the People Strategy through annual priorities. It was highlighted that regular updates on delivery are valuable for maintaining oversight. A gap in visibility and awareness of wellbeing initiatives was identified, reinforcing the importance of the renewed focus in this area. Assurance was provided that wellbeing enhancement is a key priority moving forward and aligns with staff feedback.

The Committee noted the report and the progress made in embedding the People Strategy, with particular emphasis on the strengthened approach to staff wellbeing and clear alignment with organisational priorities.

It was RESOLVED to RECEIVE the update on People Strategy Delivery and the comments made.

PRC/26/326 Items to bring to the attention of the Trust Board

Alert

The BMA have advised further strike action being taken by resident doctors.

The new appraisal process is being rolled out and the committee was alerted to the expectation that as the new approach is implemented and cascaded there will be a drop in the overall completion rates. This will be a temporary dip. (The Board has been made aware of and supported the change to an appraisal completion window between April and September to ensure the cascade of objectives, moving away from the 12 month rolling period previously in place.

Advise

The committee had the opportunity to hear first hand from colleagues working at Cheswold Park Hospital and their experience of transferring to the trust. It was particularly positive to hear their feedback about the prevalence of our values throughout their experience.

The committee received an update on the EDI action plan and the chair (NM) attended the recent staff network appreciation day to hear about the ongoing work to support these and ensure there are options for the board to hear about their role, impact and experience. The committee discussed the opportunity to ensure board sponsorship on this agenda alongside the other priority identified through the staff survey on keeping staff safe and healthy.

Assure

The committee received a deep dive into turnover and gained assurance that the overall figure being reported was not masking any hotpots or areas of concern other than one exception, which is Cheswold Park Hospital. The assurance was received based on the peer benchmarking through Model Hospital and regional comparators. Further assurance was provided on proactive steps to mitigate future immigration changes later this year and steps to mitigate.

2. The committee received assurance that sickness levels were back within tolerance levels as evidenced on the workforce IPR presented.

The committee received the quarterly Guardian of Safe Working report for both Quarter 2 and Quarter 3 and gained assurance through the reporting that there were no fines or concerns raised.

The committee received the Workforce Race Equality Scheme (WRES), the Workforce Disability Equality Scheme (WDES) and the Gender Pay Report. Assurance was taken through the existing EDI Action Plan, which this committee has previously received and continues to monitor for progress

It was RESOLVED to NOTE the update on Items to bring to the attention of the Trust Board and the comments made.

PRC/26/327 Agree redactions for minutes going to public board (agenda item 11.5)

It was RESOLVED to NOTE the redactions for minutes going to public board and the comments made.

PRC/26/328 Date and Time of Next Meeting (agenda item 13)

14 July 2026

It was RESOLVED to NOTE the date and time of the next meeting.

Minutes of the Finance, Investment & Performance Committee

Held on 22 June 2026

(Virtual meeting, via Microsoft Teams)

	Jayne Brown (JB)	Chair of the Trust
Attendees	Gary Ellis (GE)	Non-Executive Director (Chair)
	Rokaiya Khan (RK)	Non-Executive Director
	Adrian Snarr (AS)	Director of Finance, Estates & Resources
	Rob Adamson (RA)	Deputy Director of Finance
	Adele Fox (AF)	Chief Operating Officer
	Christine Brereton (CB)	Chief People Director
	Izzy Worswick	Assistant Director- Corporate Governance (Item 9.1)
	Mel Wood (MW)	Head of performance and business intelligence
Apologies:		

FIP/26/10 Welcome, introduction, and apologies (agenda item 1)

The Chair of the Committee, Gary Ellis (GE), welcomed everyone to the meeting and extended a particular welcome to Jayne Brown, who was attending for the first time. There were no apologies received. The meeting was recorded for administrative purposes and will be deleted once the minutes have been finalised.

FIP/26/11 Declarations of interest (agenda item 2)

There were no declarations of interest reported in the meeting

FIP/26/12 Minutes from previous Committee meetings held on 21 April 2026 (agenda item 3)

There were no issues raised and the minutes of the previous meeting on the 21 April 2026 were accepted as a true and accurate record.

FIP/26/13 Finance Matters arising from previous meeting held on 21 April 2026 (agenda item 4)

AS provided an update on the action log, noting that a number of actions remain ongoing due to the nature of the work and external dependencies. Where appropriate, actions are being progressed with clear timelines, and items will be brought back to Committee once further clarity is available.

Jayne Brown (JB) highlighted the importance of ensuring clear milestones and regular review to support timely closure of actions.

AS confirmed that key areas of focus include the continued enhancement of IPR reporting in line with national requirements, further development of Value for Money (VFM) reporting, and ongoing review of capital planning and spend profiling. It was noted that action FIP/25/38, relating to benchmarking under the National Oversight Framework, is no longer valid and can be closed.

In relation to action FIP/25/62, AS advised that the action should be amended to reflect the current national work underway on the deconstruction of block contracts. He confirmed that templates are now in place, with completion expected to commence shortly. A further report will be brought back to the Committee, likely in August or September, once the outputs and implications are clearer.

ACTION: Adrian Snarr

The Committee supported the proposed approach, recognising that this represented a significant step forward in strengthening assurance around contract and cost pressures. JB emphasised the

importance of triangulating activity, income and budget to ensure a clear understanding of the financial impact, particularly in the context of future commissioning arrangements.

AS acknowledged this point and highlighted the ongoing national debate regarding whether deconstruction should be based on cost or price, confirming that further analysis would be required. RA advised that patient-level costing (PLICS) and reference cost benchmarking would support this work. He also noted that the return of Victoria Brain, Costing Lead, had improved capacity, although overall resourcing remained a risk.

The Committee noted the update, including the current risks and scores, which had last been reviewed in May. Members acknowledged the dynamic nature of the risk profile and agreed that this would continue to be kept under close review throughout the year.

FIP/26/14 Items delegated to Finance, Investment and Performance Committee from Trust Board agenda item 5)

GE confirmed there were no items directly delegated from the Trust Board to the committee for this meeting.

FIP/26/15 Performance (agenda item 6)

6.1 Finance, Investment and Performance Risk Register

AS presented the Finance, Investment and Performance Risk Register and advised that the risks had been recently reviewed and remained broadly unchanged. The most significant financial risk continued to relate to unfunded pay award pressures, with an estimated c.£2.7m gap included within the financial plan and contributing to the Trust's overall efficiency requirement. AS also highlighted the ongoing challenge of delivering recurrent cost improvements, noting that effective workforce management would be critical to delivery, with further detail to be considered through the workforce plan.

In relation to Risk 1585, AS highlighted the continued mismatch between available capital and delivery, including previous underspend linked to slippage on key schemes. He advised that strengthened planning and profiling would be required. AS also drew attention to emerging risks arising from system and structural changes, particularly place-based provider collaboratives, where significant due diligence and contract review were expected to impact internal capacity.

Rokaiya Khan (RK) sought assurance on the actions being taken to mitigate further capital slippage. AS confirmed that securing a guaranteed maximum price for the Older Peoples Services scheme remained a key dependency, although potential delay continued to present a risk and would be closely monitored.

The Committee was assured that the risks and current ratings remained appropriate at this stage, while recognising the need for continued review.

6.2 IPR people directorate performance dashboard

Christine Brereton (CB), People Director, presented the April People Directorate performance dashboard and advised that the report reflected the revised approach following the IPR review. A smaller number of headline indicators were now reported to the Committee, with more detailed analysis undertaken through PRC and care groups. CB highlighted two new nationally required indicators: vacancy rate and sexual safety incidents. Early performance against vacancy targets was reported as positive.

CB advised that overall performance remained strong, particularly in relation to statutory and mandatory training. Sickness absence had reduced to below the Trust's 5% target for the first time in a sustained period; however, she cautioned that this was typically the strongest quarter and that maintaining performance would be important, particularly in the context of the national requirement to reduce absence further to 4.1% over time. Appraisal compliance was reported as just below target,

with the transition to a revised appraisal window aligned to annual planning expected to impact performance in the short term.

GE reflected on the challenges associated with sickness absence, particularly in the context of workforce pressures and an ageing workforce, noting that averages can mask variation and impact across different areas. AF highlighted observed patterns of increased absence during school holiday periods and emphasised the importance of considering flexibility to better support staff.

CB confirmed that a sickness absence reduction plan was being developed, with a focus on strengthening policy application, improving case management and addressing the underlying causes of absence. This included factors linked to working conditions, management approach and ensuring that appropriate reasonable adjustments were in place

6.3 National Oversight Framework 25/26 Q4 update

Melanie Wood (MW) presented the Quarter 4 NHS Oversight Framework position and advised that the Trust had achieved a sustained Segment 1 rating from Quarter 2 onwards, with an improved overall ranking of third out of 61 providers. Strong performance was highlighted, including maintaining zero waits over 52 weeks for community services. MW noted that, whilst deterioration had been reported across a number of metrics, relative performance had improved in some areas compared to peers, reflecting wider system pressures. A number of indicators, including staff survey measures, had also been refreshed in Quarter 4, contributing to movement in performance.

The Committee welcomed the positive overall position. GE noted that the Committee's focus was typically on performance by exception but acknowledged the significant progress made and the importance of maintaining focus on sustaining performance going forward. AS highlighted that benchmarking remained increasingly challenging due to changes in peer performance, noting that some previously high-performing organisations had moved segments, and emphasised the need to broaden comparator groups in future.

JB commended the achievement and highlighted that this represented a very strong outcome for the year, which should be recognised. She asked that thanks and appreciation be shared with teams for their contribution. JB also emphasised the importance of continuing to focus on areas where performance had deteriorated to support sustained improvement.

6.4 NHS Oversight Framework 26/27 update

MW presented an update on the NHS Oversight Framework for 2026/27 and advised that the full framework and draft technical guidance had recently been released, although further clarification was still awaited. She reported a significant increase in the number of metrics compared to the previous year, with approximately 27 scoring metrics and a small number of contextual measures likely to apply to the Trust, subject to confirmation. Key changes included revised scoring methodologies, the introduction of fixed thresholds for some metrics, and a stronger link between segmentation, organisational capability and oversight response. MW advised that initial modelling suggested a broadly positive position for the Trust; however, this remained uncertain pending confirmation of the final metric set and methodology.

The Committee discussed the report and acknowledged the complexity and evolving nature of the framework. AF raised concerns regarding specific metrics, including length of stay, noting the extent to which these were influenced by system factors outside the Trust's direct control. JB supported this point and emphasised the importance of clearly articulating system-level constraints through appropriate forums, requesting that briefing information be provided where required. JB also sought assurance on the mechanisms for deep-diving into individual metrics and maintaining appropriate oversight. MW confirmed that a dedicated Trust-wide group was being established to support detailed review and improvement activity.

AS highlighted the pace of change and the limited opportunity to fully socialise the framework internally to date. He noted the need to provide Board members with appropriate briefing and

assurance, potentially through private Board or supplementary sessions. GE acknowledged the complexity of the framework and the challenge of presenting this clearly to Board, emphasising the need for clear summarisation and ongoing assurance. JB further noted that, whilst the framework was complex, understanding of the methodology could be supported through targeted briefings, and stressed the value of benchmarking insight alongside performance data.

MW advised that further refinement and updates would be provided as national guidance was finalised, with Q1 segmentation expected later in the year.

6.5 Forensic Care deep dive

Adele Fox (AF) presented the Forensic Care Group deep dive and advised that this built on earlier Board discussion, providing a more triangulated analysis across workforce, quality and performance indicators. She reported continued variation in performance and workforce metrics across wards, with a more targeted, ward-level approach now being taken to understand the underlying drivers, rather than applying a single system-wide response. This had enabled specific areas of concern to be identified, including variation in sickness absence, appraisal compliance, training and the impact of workforce pressures within individual wards.

AF advised that establishment review work was ongoing, supported by the Mental Health Optimal Staffing Tool (MHOST), with a second phase of data collection underway to provide a more robust evidence base before any decisions were taken. Whilst turnover across forensic services remained relatively stable overall, challenges continued in specific staff groups, particularly healthcare assistants. AF also highlighted ongoing work to stabilise medical staffing at Cheswold Park, noting that progress was being made but that this remained a key dependency before further expansion of capacity could be considered.

In relation to quality and safety, AF advised that patient safety indicators remained broadly positive, with low levels of restraint and no use of prone restraint, supported by strong therapeutic engagement and meaningful activity. However, it was acknowledged that incidents, when they occurred, could be significant due to the nature of the service. AF also referenced wider cultural work underway within forensics, noting emerging themes which would be explored further through a separate deep dive.

The Committee welcomed the level of detail and triangulation presented. RK noted the value of the more nuanced, ward-level approach and sought assurance that differing root causes across wards were being appropriately addressed. AF confirmed that this was the case. RK also highlighted the importance of understanding wider workforce and cultural themes.

GE referenced the wider commissioning context, including demand pressures and the potential for increased capacity at Cheswold Park, noting that this remained dependent on resolving medical workforce constraints. AS provided an update on national discussions regarding secure provision and capacity, including ongoing system-level activity, engagement with other providers, increasing demand across the region and variation in demand across pathways.

GE concluded that the report was comprehensive and acknowledged that, whilst forensic services presented ongoing challenges, this was an area in which the Trust led and therefore required continued focus. He emphasised the importance of maintaining oversight of performance and continuing to drive improvement.

FIP/26/16 Finance (agenda item 7)

7.1 Month 2 finance report

RA presented the Month 2 finance report and advised that the Trust had reported a year-to-date deficit of £1.2m, marginally ahead of plan, with a monthly deficit of £791k in May. Whilst the position remained broadly in line with the financial plan, RA noted that it reflected the expected deficit run rate at the start of the year and highlighted the need for improved performance over the coming months to achieve the planned breakeven position. He provided assurance that work was underway to better understand the underlying run rate and strengthen forecasting and delivery assumptions.

RA highlighted workforce as the most significant area of financial pressure, with expenditure above plan in the early part of the year and an increasing trajectory identified through the baseline forecast. He advised that a detailed bottom-up forecasting approach was being used to understand the position, although further refinement was required, particularly in relation to turnover assumptions. Non-pay expenditure was currently underspending against plan, which was supporting the reported position; however, some elements related to timing differences and were expected to materialise later in the year.

AS reinforced the focus on run rate as a key measure of financial performance, noting that whilst the Trust had historically delivered its financial targets, there was an increasing need to demonstrate that underlying performance aligned with plan. He emphasised that understanding and addressing the drivers of workforce expenditure would be critical to improving the financial trajectory.

GE reflected on the extent to which the current position reflected underlying trends from the previous year, noting that improvements in prior performance had been supported by one-off factors which were no longer available to offset pressures.

JB sought assurance on the assumptions underpinning workforce forecasts, including the balance between recurrent and non-recurrent drivers and the treatment of turnover. She emphasised the importance of clearly articulating this in future reporting, particularly for Board.

AS and RA confirmed that further work was underway to strengthen the clarity and robustness of the modelling and its presentation.

AF highlighted the need to balance financial control with operational and safety considerations, noting that reduced availability of agency staffing could present risks in some areas, particularly where reliance on temporary workforce solutions had historically been required.

RA confirmed that, whilst agency spend remained low, bank usage continued to require close oversight. Planned reductions remained in place; however, usage was above target levels. He added that workforce planning and operational management arrangements would continue to be closely monitored.

RA advised that the Trust continued to perform well against key financial metrics, including agency expenditure and liquidity, with a strong cash position maintained. He also noted ongoing work through the VFM programme, with delivery broadly in line with plan, although risks remained in the latter part of the year and would require continued focus.

7.2 Financial forecast

RA presented the Month 2 financial forecast and scenario modelling and advised that the baseline forecast, based on detailed bottom-up submissions, currently indicated a deficit of c.£15.7m–£16m. He noted that this reflected an early-year position with a degree of prudence applied and that, despite identified mitigations and delivery actions, the current modelling did not yet demonstrate a return to breakeven.

RA highlighted that delivery of the VFM programme remained broadly in line with plan at this stage; however, a risk of c.£5m had been identified in relation to delivery in the second half of the year. Further mitigations would be required to close the gap and achieve the financial target.

AS advised that there remained a number of moving parts within the forecast, including ongoing system discussions and further refinement of assumptions. He emphasised that the position reflected a typical prudent forecast at this stage of the financial year and confirmed that the focus would be on working through the forecast at a more granular level. AS indicated that the position was expected to improve over time, although confidence would depend on seeing consistent improvement over the coming months. The Month 3 position was expected to provide a clearer view of the underlying trajectory.

GE acknowledged the scale of the challenge and emphasised the importance of maintaining a clear understanding of the drivers of the position. JB sought assurance on the robustness of the modelling and the range of potential outcomes. She also emphasised the importance of determining when the position should be treated as a firm baseline for action, noting the risk of delay in implementing mitigating actions. RA and AS confirmed that the modelling would continue to be refined and strengthened, with further updates to be brought to the Committee.

7.3 Financial context – NHS England (month 1)

RA presented the updated system financial reporting approach and advised that organisations now submit data directly to NHS England, with a standardised pack provided in return. He shared the Month 1 position, highlighting that most systems were currently off plan in relation to year-to-date delivery and efficiency targets, reflecting a broader system-level financial challenge.

AS provided further context, advising that the North East and Yorkshire region, historically a strong-performing area, was now showing signs of increased financial pressure, with potential for greater national scrutiny as a result. He noted that this could lead to more detailed oversight at organisational level, including a stronger focus on run rate performance and variance analysis, rather than reliance solely on the forecast position.

AS highlighted workforce as a key area of focus, noting that workforce trajectories across the region were not aligning with plans and were likely to be subject to increased scrutiny. RA advised that it remained unclear how NHS England would utilise the data provided; however, there was an expectation that areas such as temporary staffing and workforce performance would form part of future lines of enquiry.

The Committee discussed the potential implications of a more structured and responsive oversight approach. GE reflected that, whilst the Trust had a strong track record of financial delivery, including managing agency and establishment spend, this may not prevent challenge if performance deviated from plan at any point. AS agreed, noting that the regional approach was likely to be more proactive, with an increased focus on identifying and challenging variances at an earlier stage.

7.4 West and South Yorkshire Collaboratives Financial updates

RA presented the financial position for the Provider Collaboratives and advised that performance remained volatile, particularly within adult secure services, driven by out of area placements and high-cost packages of care. Demand remained high across the system, with additional funding largely offset by increased activity, resulting in forecast deficit positions across both West Yorkshire and South Yorkshire collaboratives.

RA highlighted that, whilst pressures remained, there were potential opportunities within other areas of the portfolio, particularly Leeds-hosted services, including CAMHS and adult eating disorders, which were currently forecasting a surplus position. It was noted, however, that access to these surpluses was subject to system arrangements and ongoing discussions and had therefore not been assumed within the Trust's financial forecast at this stage.

AS provided further context on the system position, noting that whilst surpluses existed within certain collaboratives, national expectations and audit considerations could influence how these were managed and distributed, with any potential benefit to the Trust subject to agreement. He also highlighted the broader system challenge, including increasing demand and limited capacity across secure services.

The Committee noted the challenges within the collaboratives. GE acknowledged the inherent volatility in these services and the impact of demand pressures, noting the importance of maintaining oversight of both risks and opportunities. RA provided clarification on the reported position. GE concluded that the variability in collaborative performance reinforced the need for continued scrutiny and a clear understanding of movements across the year.

7.5 Value for Money (VFM) update

RA presented an update on the VFM programme and advised that the report remained in development, with the aim of providing greater clarity and transparency on delivery, risk and underlying assumptions. Delivery was reported as broadly in line with plan for the year to date; however, a proportion of schemes were currently assessed as high risk, with c.£4.8m–£5m of uncertainty identified, particularly in relation to delivery in the second half of the year.

RA highlighted that further work was underway to improve the presentation and robustness of the VFM position, particularly in distinguishing clearly between recurrent and non-recurrent savings and ensuring that risks and assumptions were explicit. This was important in understanding the underlying run rate and ensuring that non-recurrent measures did not mask longer-term financial pressures.

AS reinforced the need to strengthen alignment between VFM reporting and overall financial performance, including avoiding double counting across workforce and productivity initiatives. He advised that not all schemes were expected to deliver as originally planned and that alternative mitigations would be required, with improved transparency supporting better tracking of the position.

The Committee discussed the report. GE noted the importance of understanding the relationship between delivery of individual schemes and the overall financial position, and of ensuring clarity on how risks and mitigations were being managed. JB sought assurance that central assumptions represented real, deliverable actions rather than balancing figures, highlighting the potential impact should these reduce. RA confirmed that, whilst some elements remained subject to refinement, there was confidence that delivery actions were being identified and progressed.

GE concluded by emphasising the importance of maintaining focus on delivery and ensuring that the programme supported the Trust's overall financial sustainability.

FIP/26/17 Investment (agenda item 8)

8.1 Mental Health Investment Progress report

AS presented an update on the Mental Health Investment position and advised that, whilst commissioners continued to meet the Mental Health Investment Standard, the level of funding flowing to the Trust had reduced compared to previous years. A proportion of investment was now being directed towards system pressures, including Section 117 placements, which were being counted within the standard, resulting in a reduced level of new investment available to the Trust.

AS highlighted that the remaining investment was more targeted, with funding focused on priority areas including Mental Health Support Teams in schools, Talking Therapies and ADHD pathways, particularly in relation to reducing waiting times. He confirmed that, whilst the overall level of investment had reduced, the funding received remained valuable and aligned to national priorities.

AS also advised that discussions with commissioners were ongoing regarding the allocation of funding for Mental Health Support Teams, with indications that the current distribution may be subject to further review to ensure alignment with national expectations. This may result in additional investment flowing to the Trust, although this remained subject to confirmation.

The Committee noted the update. GE reflected that, whilst the level of investment had reduced, the more targeted nature of the funding was appropriate. He emphasised the importance of ensuring that available investment was effectively utilised to support priority areas.

FIP/26/18 Any other business (agenda item 9)

9.1 Planning priorities update

Izzy Worswick (IW) provided an update on the Trust's planning position following feedback from NHS England and advised that the plan had been assessed as compliant with conditions. These included

the requirement for a Board-approved workforce reduction plan, a sickness reduction plan, minimal unidentified savings from Month 1, and participation in a regional review of out of area placements. IW advised that work was progressing to address the conditions, with both the workforce reduction plan and sickness reduction plan developed and scheduled for review through People Remuneration Committee (PRC) and Board. She confirmed that previously unidentified savings had now been addressed through the VFM programme, with ongoing work to manage delivery risks and mitigations. In relation to out of area placements, IW noted that numbers remained low and were subject to ongoing operational scrutiny, with one case subject to external constraints.

The Committee discussed the update. GE sought clarification on the relationship between the establishment review and the workforce reduction plan. AS advised that these were distinct but interrelated, noting that the establishment review was primarily driven by quality and safety considerations, whereas the workforce reduction plan was focused on delivering financial requirements. AS further noted that the current establishment review remained under consideration and was not yet ready for Board approval.

JB emphasised the importance of ensuring alignment between the establishment review and the workforce reduction plan prior to Board consideration, highlighting the need for consistency and clarity to support effective governance. AS confirmed that this alignment was being actively reviewed.

GE thanked IW for the update. He also thanked members and attendees for their valuable contributions and expressed his appreciation for the high quality of the meeting papers.

GE closed the meeting.

Trust Board 28 July 2026 Agenda item 10.1

Private/Public paper:	Public		
Title:	Board Assurance Framework (BAF) Quarter 1 – 2026/27		
Lead Director:	Dawn Lawson – Director of Strategy, Inclusion and Change/Deputy Chief Executive		
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:	To provide Trust Board with assurance that a system of control is in place to identify potential risks to the delivery of the Trust’s strategic objectives. The paper provides an update in relation to the current status of strategic risks, including progress on actions.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	All risks		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The Board Assurance Framework allows Trust Board members to monitor risks against the Trust’s strategic objectives and in doing so enables the Board 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. This in turn contributes to the objectives of the Integrated Care Partnerships, Integrated Care Boards, and place-based partnerships.		
Any background papers / previously considered by:	Reviewed quarterly by the Executive Management Team (EMT). Quarterly reports to Trust Board. The BAF was considered at EMT on 21 May 2026 and 9 July 2026		

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 provide assurance on the management of strategic risks, and against the delivery of the Trust's strategic objectives, in addition to supporting the Board to identify areas where there is need for more focused attention, which in turn informs agendas for Board Committees, or development sessions.

The Q1 2026-27 BAF report is presented to Board aligned to the Trust's 2026/27 strategic aims.

Our Strategic Aims		
1. We will live our values		
2. We will be the best we can be	Best Quality	Best Place to Work and Learn
	Best Partner	Best Value
3. We will be ambitious		

As part of the Head of Internal Audit Opinion process, the Trust's BAF is reviewed by the Trust's internal auditors, 360 Assurance, after each quarterly presentation to Trust Board.

The Trust has 16 strategic risks for Q1 of 2026/27:

- We will live our values – 2
- We will be the best we can be:
 - Best Quality - 4
 - Best Place to Work and Learn – 1
 - Best Partner - 4
 - Best Value - 2
- We will be ambitious - 3

Quarter 1 2026/27

Following approval of the Risk Appetite Statement by Trust Board members in March 2026, which included the risk appetite matrix for the BAF, this has now been incorporated into the Board Assurance Framework for Q1 2026-27.

On 21 May 2026 the new key was presented to EMT showing risk appetite scale descriptions including Orange Book and Trust risk scale descriptions and risk appetite score ranges for each description. A further key shows the application of risk appetite according to risk type. At appendix 1 is a table showing risks, their risk category, risk appetite and current rating.

EMT supported the application of the new risk appetite statement to the BAF.

In the main document risk headings now include risk number, risk description, risk owner, risk type, risk appetites for assurance and likelihood and current risk scores for assurance and likelihood.

In line with normal process the head of corporate governance has met with all executive directors to review BAF controls and assurances to ensure they remain relevant and up to date, making any changes where required.

Any gaps in control and assurance and associated actions have also been reviewed. Where actions have been completed, where appropriate, controls and assurances have been added to the relevant BAF risks.

On 9 July 2026, following individual director review, the Executive Management Team (EMT) reviewed the BAF for Quarter 1 2026/27 to consider changes to the operating environment and risk scores since the last report to Trust Board in April 2026.

The following matters were considered for their potential impact upon on the Trust's strategic risks:

- Achievement of NHS Oversight Framework (NOF) segmentation 1 in Q4
- Integrated Care Board (ICB) changes and development of place provider partnerships
- Financial performance, and the Trust plan to break even for 2026-27
- Performance against the new NHS Oversight Framework for 2026/27

All strategic risks were reviewed with a particular focus on the below:

2.4 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.

EMT considered the fact that some Trust services had been operating at OPEL (operational pressure escalation level) 4 in recent weeks, 4 being the highest level on the OPEL scale. An assurance level of "adequate" was deemed appropriate at this time given the controls in place and the Trust's management of demand to date. The likelihood rating of "likely" was also agreed to continue to be accurate at this time but it was noted that persistent levels of high demand may impact on the likelihood rating in future quarters.

4.2 Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.

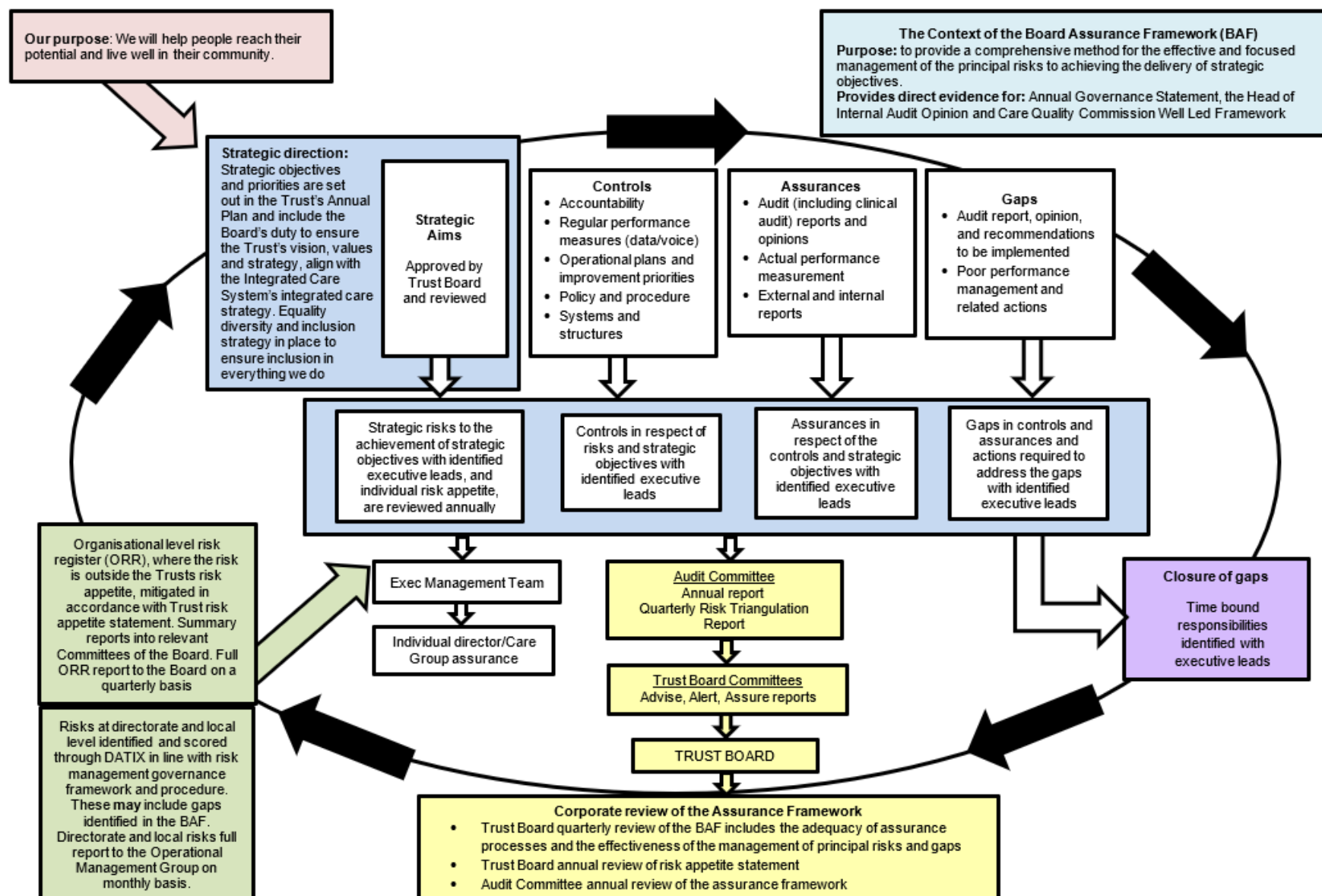
EMT discussed the evolution of Place Provider Partnerships (PPP) and considered the current risk scores of "adequate" for assurance, and "possible" for likelihood. It was agreed that these scores accurately reflect the current position given the current stage of development of PPPs and the Trust's level of involvement in all places. It was agreed a further assessment will need to be taken in Q2 and beyond to consider the progression of PPPs and the Trust's position within them.

5.1 Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.

EMT noted that the Trust was currently in line with plan but a real focus on the Trust's efficiency plan will be required to reach the Trust's financial target for

	the year. The assurance score of “adequate” and “likely” score for likelihood are appropriate for Q1 but these ratings will be kept under close scrutiny as the Trust progresses through Q2. Board members are asked to note a track changes version of the full BAF is available in the reading room on Team Engine.
Recommendation:	Trust Board members are asked to: • DISCUSS this report. • RECEIVE the updates to strategic risks • APPROVE the Board Assurance Framework and proposed ratings for Q1, including risk appetite.

Board Assurance Framework – Structure and Process



Board Assurance Framework (BAF) – 2026/27

Overview of current assurance and likelihood ratings:

The individual risk assurance and likelihood ratings are summarised below:

Strategic Aim	Strategic risk	2026/27									
		25/26									
		Q4		Q1		Q2		Q3		Q4	
		A	L	A	L	A	L	A	L	A	L
1. We will live our values	1.1 Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience. (DSC)	A	L	A	L						
	1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience. (CPO)	A	P	A	P						
2.Be the best we can be: Best Quality	2.1 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	U	A	U						
	2.2 The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.	A	P	A	P						
	2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents.	S	P	S	P						
	2.4 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.	A	L	A	L						
2. Best Place to work and learn	3.1 Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.	A	U	A	U						
2.Be the best we can be: Best partner	4.1 Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place	A	L	A	L						
	4.2 Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.	A	P	A	P						
	4.3 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	A	P	A	P						
	4.4 Wider demand and finance pressures result in an insufficient focus on environmental sustainability meaning the Trust does not achieve its national net zero targets.	A	P	A	P						

Strategic Aim	Strategic risk										
		25/26		2026/27							
		Q4		Q1		Q2		Q3		Q4	
		A	L	A	L	A	L	A	L	A	L
2. Be the best we can be: Best Value	5.1 Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.	A	P	A	P						
	5.2 Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision.	A	P	A	P						
3. We will be ambitious	6.1 Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care.	A	P	A	P						
	6.2 System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience.	A	P	A	P						
	6.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.	A	P	A	P						

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, Inclusion and Change (Deputy Chief Executive), COO = Chief Operations Officer

Committees: AC = Audit Committee, QSC = Quality and Safety Committee, FIP = Finance, Investment & Performance Committee, MHA = Mental Health Act Committee, PRC = People & Remuneration Committee CC = Commissioning 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

Assurance ratings:

Substantial (S)	The assurances noted on the current BAF demonstrate that the controls are effectively managing the risk/cause.
Adequate (A)	Assurances are in place and no material issues have been identified with the effectiveness of controls. Assurances are reflecting the need to fully embed the controls.
Limited (L)	Levels of assurance noted on the current BAF do not demonstrate that the controls in place are not effectively managing the risk/cause. Action is required to address gaps in control and assurance.
None (N)	No assurance can be taken or is available to demonstrate that the current controls are working. Action is required to address/improve controls and provide assurance.

Risk Likelihood ratings:

Rare (R)	This will probably never happen/recur.
Unlikely (U)	Not expected to happen/recur but is possible.
Possible (P)	Might happen/recur occasionally.
Likely (L)	Will probably happen/recur but is not a persistent issue.
Almost certain (AC)	Will undoubtably happen/recur, possibly frequently.

Risk Appetite**Scale Descriptions**

Orange Book Risk Appetite Scale Descriptions	Trust risk appetite scale description	BAF assurance		BAF likelihood
		Trust Risk appetite score range		Trust Risk appetite score range
Averse: Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.	Low	Substantial (S)		Rare (R)
Minimalist: Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.	Moderate	Substantial (S)	Adequate (A)	Unlikely (U)
Cautious: Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.	High	Adequate (A)		Possible (P)
Open: Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.	Extreme	Limited (L)		Likely (L)
Eager: Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.	Extreme+	None (N)		Almost certain (AC)

Risk Appetite Application

Risk type and description	BAF Risk Appetite Assurance Score Range		BAF Risk Appetite Likelihood Score Range	
Clinical Safety and Quality (CSQR) risks: Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce	Substantial	Substantial (S) Adequate (A)	Rare	Unlikely
Business (BR) risks: Risks which might affect the Trust's ability to achieve its plans or damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation.	Adequate		Possible	
Compliance (CR) risks: Failure to comply with its licence, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation.	Substantial	Substantial (S) Adequate (A)	Rare	Unlikely
Financial (FR) risks: Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.	Substantial	Substantial (S) Adequate (A)	Rare	Unlikely
Technology (TR) risks: Risks arising from technology not delivering the expected outcomes due to inadequate or deficient system/process development and performance or inadequate resilience.	Adequate		Possible	
Information (IR) risks: Risks arising from a failure to produce robust, suitable and appropriate data/information and to exploit data/information to its full potential.	Substantial	Substantial (S) Adequate (A)	Rare	Unlikely
Security (SR) risks: Risks arising from a failure to prevent unauthorised and/or inappropriate access to key Trust systems and assets, including people, platforms, information and resources. This encompasses the subset of cyber security.	Substantial	Substantial (S) Adequate (A)	Rare	Unlikely

Strategic aim 1: We will live our values		Lead Director(s)	Monitoring and assurance	Overall Assurance/Likelihood rating							
Links to ORR (risk ID numbers): 1820		As noted below.	EMT, QSC, PRC, Trust Board	2026/27							
				Q1		Q2		Q3		Q4	
				A	L	A	L	A	L	A	L
				A	P	L					
Strategic risks – to be controlled, consequence of non-controlling and current assessment											
Ref	Description	Risk Owner	Risk Type	Risk Appetite				Assurance/Likelihood rating			
				A	L	A	L	A	L		
1.1	Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience.	DSC	CSQR	S	S	R	U	A	L		
1.2	Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience.	CPO	CSQR	S	S	R	U	A	P		

Rationale for current assurance level (Strategic Aim 1 – We will live our values)											
- The Trust's segmentation within the NHS Oversight Framework (NOF) for quarter 4 2025/26 is 1. - The Trust has in place a People Management / Leadership programme - 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, and working carers. Staff networks will attend at PRC 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, supported by 2 part-time guardians in order to support raising concerns in relation to patient care of staff experience. FTSU themes are triangulated with staff data e.g. staff survey, an annual report is taken through Audit Committee. A Freedom to Speak Up steering group is in place. - Freedom To Speak Up training in place for all staff and managers to ensure that staff know how to raise concerns. - We have in place an EDI Action Plan which focusses on addressing WRES and WDES data and findings - The Trust continues to build on and improve a positive partnership with Staff side, including fortnightly formal meetings with the Chief People Officer and bi-monthly Trust partnership forums including members of EMT. - A series of engagement events are in place for 2026/27 with recommendations and actions being progressed. - 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.											

- Values based recruitment and appraisal processes are embedded within the Trust.
- Regular engagement between the chief people officer and the executive team with staff governors to ensure staff voice is represented and gather insight into staff experience.
- Organisational Development team is in place to support and improve staff experience within the Trust.
- Board development programme being developed for 2026/27 which is driven by Trust values and recognises the Board's 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 took place in regard to the Trust strategy refresh including great place to work and engagement with Trust staff
- Priorities for 26/27 have been developed and have been integrated into the IPR via EMT and Trust Board.
- Patient experience and engagement survey toolkit in place.
- Accessible Information Standard internal audit actions completed and implemented.
- Trust health inequalities approach developed drawing on the Kings Fund framework and relevant aspects of Core20plus5.
- 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
- People strategy in place. Approved by Trust Board in December 2025
- People priorities for 2026 for safe and healthy and inclusion and compassion will be rolled out in 2026
- All leaders /managers have two performance objectives in their appraisal in line with the people priorities for 2026
- New appraisal process which puts person at the centre is being rolled out in 2026
- Staff survey engagement scores have been maintained for 2026.

Strategic aim 2: Be the best we can be: Best Quality		Lead Director(s)	Monitoring and assurance	Overall Assurance/Likelihood rating								
				2026/27								
Links to ORR (risk ID numbers): 1530, 1078, 1368, 1568, 1757, 1614, 1689, 1159, 1424, 852, 1888, 2012, 1839, 695, 1650, 1624, 1545		As noted below.	EMT, AC, QSC, PRC, Trust Board	Q1		Q2		Q3		Q4		
				A	L	A	L	A	L	A	L	
				A	P							
Strategic risks – to be controlled, consequence of non-controlling and current assessment												
Ref	Description		Risk Owner	Risk Type	Risk Appetite				Assurance/Likelihood rating			
					A		L		A		L	
2.1	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.		COO	CSQR	S	S A	R	U	A		U	
2.2	The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.		DFR	IR	S	S A	R	U	A		P	
2.3	Failure to create a learning environment leads to lack of innovation and to repeat incidents.		DNQ	CSQR	S	S A	R	U	S		P	
2.4	Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.		COO	CSQR	S	S A	R	U	A		L	

Rationale for current assurance level (Strategic aim 2: The best we can be: Best Quality)

- The Trust's segmentation within the NHS Oversight Framework (NOF) for quarter 4 2025/26 is 1.
- Clinical Strategy approved by Trust Board in March 2025
- A band 7 Speech and Language Therapist is in place to take a lead role in our approach to dysphagia.
- Business intelligence development plan is being aligned to Trust strategic objectives and priority programmes including health intelligence data and reporting.
- Trust developing overarching operational data quality improvement plan which will be monitored by the Improving Clinical Information Group (ICIG) and Operational Management Group (OMG)

Rationale for current assurance level (Strategic aim 2: The best we can be: Best Quality)

- Improvement work around the FIRM risk assessment and care planning continues. This is being led by a task and finish group with an anticipated finish date of July 2026, however, further work to embed the changes will then take place.
- Waiting list management in SystmOne is complete and a waiting list report is presented to the Finance, investment and performance (FIP) committee on a regular basis.
- Integrated Performance Report (IPR) summary metrics re improving the quality and experience of all that we do – IPR for month 2 26/27 shows: Friends & Family (F&F) Test MH – Green F&F Test Community – Green, safer staff fill rates – green, IG confidentiality breaches – green.
- Investment in estates and facilities and IT infrastructure. The Trust estates strategy is place.
- Clinical services monitor Operational Pressures Escalation Levels (OPEL) 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 Institute for Healthcare Improvement (IHI) training. This includes any response to CQC actions.
- Themes from serious incident investigations are identified through the patient safety oversight group and improvements are reported through the Quality and 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 (PSIRF) established within the Trust. PSIRF includes an enhanced analysis of thematic learning as part of the framework.
- Trio leadership model bringing together clinical, operational and governance roles working together at service line level, with shared accountability for delivery.
- Regular analysis and reporting of incidents through patient safety oversight group, 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 – asset register and board assurance framework - significant assurance.
- The Trust Care Quality Commission (CQC) assessment remains as an overall rating of “good”. In May 2023 inspections of forensic and adult mental health inpatient services took place, the outcomes of which were “requires improvement” for both. CQC action plan updates are presented to Trust Board every public performance meeting. In 2019 the CQC conducted a review of the Trust which resulted in an overall rating of “good”.
- High compliance with internal audit actions.
- Bed occupancy and patient acuity has been consistently high, particularly in adult acute, older peoples and psychiatric intensive care units (PICU).
- Cyber awareness tested with staff by means of a survey and phishing exercise.
- 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.
- “The care group quality and safety report” is presented to QSC meetings to provide assurance on the quality impact of operational pressures in care groups.
- Patient safety improvement group in place maintains strategic oversight of themes and learning from patient safety incidents and Trustwide actions.
- 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 equality diversity inclusion (EDI) lead to ensure the Trust is in keeping with national race standards and indicators in the medical directorate.
- Patient carer and race equality framework (PCREF) is being rolled out across the Trust.
- Triangle of care (TOC) has been rolled out across all inpatient wards and is now being rolled out across all services.

Strategic aim 2: Be the best we can be: Best Place to Work and Learn			Lead Director(s)	Monitoring and assurance	Overall Assurance/Likelihood rating								
					2026/27								
Links to ORR (risk ID numbers): 1729, 1157, 1887, 1840, 1151, 1432,			As noted below.	EMT, AC, PRC, QSC, Trust Board, FIP	Q1		Q2		Q3		Q4		
					A	L	A	L	A	L	A	L	
					A	U							
Strategic risks – to be controlled, consequence of non-controlling and current assessment													
Ref	Description			Risk Owner	Risk Type	Risk Appetite			Assurance/Likelihood rating				
						A		L		A		L	
3.1	Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.			CPO	CSQR	S	S → A	R	U → U	A		U	

Rationale for current assurance level (strategic aim 2: Be the best we can be: Best Place to Work and Learn)									
- The Trust's segmentation within the NHS Oversight Framework (NOF) for quarter 4 2025/26 is 1. - Vacancies are present across the Trust with variance dependent on location and service line, but the overall vacancy figure is lower than in previous years. Vacancies are reviewed through a vacancy control process and panels (at local and corporate levels). Turnover is stable. - A recruitment plan for care support workers in place for 2026/2027 - Temporary staffing scrutiny and management group in place to review overtime and agency and bank usage. - Use of bank for non-clinical roles at standard rates in preference to agency - Medical locums to manage to provide safe cover for any vacancies. - Temporary staffing 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 inspections of forensic and adult mental health inpatient services took place, the outcomes of which were "requires improvement" for both. CQC action plan updates are presented to Trust Board every public performance meeting. In 2019 the CQC conducted a review of the Trust which resulted in an 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. - The exit process for leavers from the Trust has now been revised following an internal audit process. Outcomes of exit interviews are reported into People and Remuneration Committee (PRC). - Staff survey results for 2025 have shown the Trust benchmarks well in comparison to similar local organisations and overall shows a positive position. Many of our results compare favourably at a national level. - The Trust has a full board of both executive and non-executive roles. Plans are being developed to recruit to end of term vacancies through Nominations Committee. - People strategy in place. Approved by Trust Board in December 2025. - Updates on the Resident doctor ten-point plan are received by People and Remuneration Committee at every other meeting.									

Strategic aim 2: Be the best we can be: Best Partner				Lead Director(s)		Monitoring and assurance		Overall Assurance/Likelihood rating							
2026/27															
Links to ORR (risk ID numbers): 275, 812,				As noted below.		EMT, QSC, Trust Board		Q1		Q2		Q3		Q4	
								A	L	A	L	A	L	A	L
								A	P						
Strategic risks – to be controlled, consequence of non-controlling and current assessment															
Ref	Description					Risk Owner	Risk Type	Risk Appetite				Assurance/Likelihood rating			
								A		L		A		L	
4.1	Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place.					DFR	FR	S	S A	R	U	A		L	
4.2	Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.					CEO-DSC	FR	S	S A	R	U	A		P	
4.3	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.					DSC	BR	A		P		A		P	
4.4	Wider demand and finance pressures result in an insufficient focus on environmental sustainability meaning the Trust does not achieve its national net zero targets.					DFR	CR	S	S A	R	U	A		P	

Rationale for current assurance level (Strategic aim 2: Be the best we can be: Best Partner)									
- The Trust's segmentation within the NHS Oversight Framework (NOF) for quarter 4 2025/26 is 1. - Income arrangements are secured for 2026/27 and will remain predominantly on a block basis until 2027/28. The Trust submission included a longer-term plan including three years of revenue is complete. - Financial arrangements for adult secure lead provider collaboratives in South and West Yorkshire are predominantly on a cost per case and cost and volume basis. We are now entering the last year of contract which expires March 2027. Emerging thinking from NHSE continues to evolve. No definitive outcome confirmed at this stage. . - The Trust plan continues to forecast for breakeven in 2026/27. - Integrated Performance Report (IPR) summary metrics reflect the strategic priorities for 2026/27. - Cash balance at month 2 of 2026/27 is £59.1m.									

Rationale for current assurance level (Strategic aim 2: Be the best we can be: Best Partner)									
- Place provider partnership arrangements are establishing in each place and the Trust is fully engaged in all places in the Trusts geography. - Positive well-led results following Care Quality Commission (CQC) review (2019), with revised preparation for the next inspection taking place. - The Trust is lead provider for the adult secure provider collaborative and is a partner in the CAMHS and eating disorder collaboratives in West Yorkshire. The Trust is the lead provider in South Yorkshire and Bassetlaw for the adult secure lead provider collaborative. The Trust is coordinating provider for forensic CAMHS for Yorkshire and Humber region. - Mental health investment standard for 26/27 invested with the Trust continues to be lower than the historic investment - Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. - Standing financial instructions and scheme of delegation are in place, approved by Trust Board and Members Council in January 2025. - Cheswold Park Hospital is now fully integrated into the forensic service line - The Trust Care Quality Commission (CQC) assessment remains as an overall rating of good. In May 2023 inspections of forensic and adult mental health inpatient services took place, the outcomes of which were “requires improvement” for both. CQC action plan updates are presented to Trust Board every public performance meeting. In 2019 the CQC conducted a review of the Trust which resulted in an overall rating of “good”. - Coordinating provider for maternal mental health across Yorkshire and the Humber - The Trust is part of the Mental Health Learning Disability and Autism provider collaborative in the South Yorkshire Integrated Care System. - A range of executive and board arrangements with Trusts, integrated care boards and other stakeholders in each of the places where the Trust operates. - Trust involvement and engagement with West Yorkshire and South Yorkshire Integrated Care Systems, especially on mental health is strong. - The Trust has been involved in the development of place-based plans and priority setting. - 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, carers and families 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 (EMT) meeting (quarterly) - Integrated Performance Report (IPR) summary metrics month 2 26/27 - 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 –green, clinically ready for discharge (previously delayed transfers of care) – red. - Older people’s transformation public consultation completed and received positive feedback with significant engagement and involvement of local communities. Following on from approval, a new governance structure has been established to oversee the implementation phase of work. This is being led by a SWYPFT governance group which oversees the implementation work-strands and reports into the senior governance structures. The start date for capital works has been delayed in order to ensure compliance with new fire safety legislation. - Compliance with the public sector equality duty maintained through Equality Impact Assessments (EIAs) – including a tracker and IPR monitoring monthly. - Approach developed and implemented with Voluntary Community Sector partners in each of our places to strengthen insight involvement and co-production as part of our ‘Connecting people’ approach. - Equality data and insight bank as well as a Trust wide EIA, mental health EIA tool and approach developed.									

Strategic aim 2: Be the best we can be: Best Value		Lead Director(s)	Monitoring and assurance	Overall Assurance/Likelihood rating							
				2026/27							
Links to ORR (risk ID numbers): 1080, 1511, 1957, 1114, 1956, 1585, 1217		As noted below.	EMT, AC, CC, FIP, Trust Board	Q1		Q2		Q3		Q4	
				A	L	A	L	A	L	A	L
				A	P						
Strategic risks – to be controlled, consequence of non-controlling and current assessment											
Ref	Description			Risk Owner	Risk Type	Risk Appetite		Assurance/Likelihood rating			
						A	L	A		L	
5.1	Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.			COO	BR	A	P	A		P	
5.2	Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision.			DFR	BR/TR	A	P	A		P	

Rationale for current assurance level (Strategic aim 2: Be the best we can be: Best Value)									
- The Trust’s segmentation within the NHS Oversight Framework (NOF) for quarter 4 2025/26 is 1. - Income arrangements are secured for 2026/27 and will remain predominantly on a block basis until 2027/28. The Trust submission included a longer term plan including three years of revenue is complete.									

Rationale for current assurance level (Strategic aim 2: Be the best we can be: Best Value)									
- Financial arrangements for adult secure lead provider collaboratives in South and West Yorkshire are on a cost per case and cost and volume basis. We are now entering the last year of contract which expires March 2027. Emerginthinking from NHSE is a re-tender for contracts from 2027 which presents an element of risk. - The Trust was required to deliver a break-even plan for 25/26 and are on track to deliver this. The Trust plan continues to forecast for breakeven in 2026/27 - Integrated Performance Report (IPR) summary metrics reflect the strategic priorities for 2026/27. - Cash balance at month 2 of 2026/276 is £59.1m. - Partnership arrangements are established within each place. - Positive well-led results following Care Quality Commission (CQC) review (2019), with revised preparation for the next inspection taking place. - The Trust is lead provider for the adult secure provider collaborative and is a partner in the CAMHS and eating disorder collaboratives in West Yorkshire. The Trust is the lead provider in South Yorkshire and Bassetlaw for the adult secure lead provider collaborative. The Trust is coordinating provider for forensic CAMHS for Yorkshire and Humber region. - Mental health investment standard for 26/27 invested with the Trust continues to be lower than the historic investment - 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 in place, approved by Trust Board in January 2025. - Digital dictation is now in place across the Trust. - Electronic Prescribing Medicines Administration (EPMA) digital system in place in place to support safe and efficient prescribing and administration. - Standing financial instructions and scheme of delegation are in place, approved by Trust Board and Members Council in January 2025. - Cheswold Park Hospital is now fully integrated into the forensic service line									

Strategic aim 3: We will be ambitious				Lead Director(s)		Monitoring and assurance		Overall Assurance/Likelihood rating							
								2026/27							
Links to ORR (risk ID numbers):				As noted below.		EMT, Trust Board, Commissioning Committee		Q1		Q2		Q3		Q4	
								A	L	A	L	A	L	A	L
								A	P						
Strategic risks – to be controlled, consequence of non-controlling and current assessment															
Ref	Description					Risk Owner	Risk Type	Risk Appetite			Assurance/Likelihood rating				
								A		L		A		L	
6.1	Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care.					DFR	BR	A		P		A		P	
6.2	System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience.					DSC	BR	A		P		A		P	
6.3	Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.					DSC	BR	A		P		A		P	

Rationale for current assurance level (Strategic aim 3: We will be ambitious)									
- The Trust's segmentation within the NHS Oversight Framework (NOF) for quarter 4 2025/26 is 1. - Coordinating provider for maternal mental health across Yorkshire and the Humber. - The Trust is lead provider for the adult secure provider collaborative and is a partner in the CAMHS and eating disorder collaboratives in West Yorkshire. The Trust is the lead provider in South Yorkshire and Bassetlaw for the adult secure lead provider collaborative. The Trust is coordinating provider for forensic CAMHS for Yorkshire and Humber region. - The Chief Operating Officer is the Senior Responsible Owner for Cheswold Park Hospital transition into the Trust. - Integrated Care Boards are in place and are functioning fully and the Trust is maintaining a proactive contribution in each place. - Health and Wellbeing Board place-based plans have been contributed to through board discussions, commented on and where appropriate, agreed. - Active and full membership of Health and Wellbeing Boards. - The Trust is part of the Mental Health Learning Disability and Autism provider collaborative in the South Yorkshire Integrated Care System. - A range of executive and board arrangements with Trusts, integrated care boards and other stakeholders in each of the places where the Trust operates. - Trust involvement and engagement with West Yorkshire and South Yorkshire Integrated Care Systems, especially on mental health is strong.									

- The Trust has been involved in the development of place-based plans and priority setting.
- The Trust is part of the Provider Collaborative established in Calderdale led by Calderdale and Huddersfield NHS Foundation Trust (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.
- The Board are fully briefed on opportunities presented by the 10 Year Plan for Health.
- The Trust officially launched its Teaching Trust status with the University of Leeds at its annual members meeting on 17 September 2025. The University of Leeds approved the application based on the Trusts strong history of partnership working around student education and research and development. The partnership is one of very few nationally where Teaching Trust status has been achieved by a Trust that provides community services alongside mental health, learning disability, and autism services.

Strategic risk 1.1 (Strategic Aim 1 - We will live our values)

Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience

Controls (Strategic Risk 1.1 - Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience)			
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 / DSC	1.1, 2.1, 4.1, 4.2, 6.2
C15	Equality Diversity and Inclusion 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)	DSC	1.1, 1.2, 2.1, 2.4, 3.1, 4.1, 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. (E, I)	DSC / DNQ / CMO	1.1, 2.1 4.1, 4.2
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 voluntary and community sector (VCS) partners in each of our places to strengthen insight involvement and co-production. (I, E)	DSC	1.1, 2.1, 4.3
C30	Process to review and assure Equality Impact Assessments (EIAs)with report to Quality and Safety Committee (I). (I)	DSC	1.1, 2.1, 4.3
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	1.1, 4.3
C34	Provision of information, leaflets and posters which meet the Accessible Information Standard. (I)	DSC	1.1, 4.3
C35	Translation and interpretation service in place as well as inequalities interactive tool. (I)	DSC	1.1, 2.1, 4.3
C47	The Patient Safety Oversight Group meets weekly to review recent patient safety risks. All red and amber incidents from across the organisation are reviewed including the undertaking of proportionate investigations. In addition, all incidents relating to protected characteristics or staffing, irrespective of grading are also reviewed. (P,N,I,E)	DNQ / CMO	1.1, 2.2, 2.4, 3.1
C52	Patient experience reporting includes learning from complaints, concerns, compliments and friends and family test results. (I)	DNQ	1.1, 2.3, 3.1
C53	The Trusts is aligned to the Patient Safety Incident Response Framework (PSIRF) in line with national standards. (I)	DNQ	1.1, 2.3, 3.1
C110	Values-based appraisal process in place with new monitoring arrangements monitored through business intelligence systems and the integrated performance report. (P,N,I)	CPO	1.1, 3.1
C115	Diversity, inclusion and belonging lead in place as part of the Trust's overall leadership and management development arrangements. Workforce elements fall under the CPO. (I)	CPO	1.1, 1.2
C131	Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) process integrated and used at gateways in transformation and change programmes. (P, I)	DSC	1.1, 4.3
C136	Inclusive Leadership Board Development (ILDB) programme on inequalities completed. (P, I)	CPO	1.1, 1.2
C138	Trust wide Equality Impact Assessment together with the inequalities data developing systemic analysis and plans to address Trust inequality priorities. (P, I)	DSC	1.1, 4.3
C155	PRC engagement with staff networks and is reported to Trust Board through the triple A report. (P, I)	DSC	1.1, 1.2
C156	Freedom to Speak up Guardians in place. (P, I)	CPO/DNQ	1.1, 1.2
C157	Values based recruitment processes in place. (P, I)	CPO	1.1, 1.2
C189	Trust Board development programme being developed for 2025/26 building on the leadership through a values-based culture and strengthening delivery of the Trusts strategic objectives. (P, I, E)	CPO/CEO	1.1, 1.2
C191	Trust medical appraisal and revalidation process aligns to general medical council report. (Fair to refer 2019) (P,I,E)	CMO	1.1
C194	Waiting list management in SystmOne is in place.	DFR	1.1
C196	Micro aggression guidance is in place, which includes reference to all protected characteristics.	DSC/DNQ	1.1
C212	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. (P,N,I)	CMO	1.1
C263	Operational equality dashboards now in place (P, N,I)	DSC	1.1, 2.2, 4.3
C264	Patient carer race equality framework (PCREF) implementation plan in place (P,N,I,E)	DSC	1.1, 2.2, 4.3
C265	Health inequalities toolkit in place to reduce barriers to access to services (P,N,I,E)	DSC	1.1, 2.1, 2.3, 4.3
C266	Hearing impaired and deaf toolkit in place to reduce barriers to access to services (P,N,I,E)	DSC	1.1, 2.1, 2.3, 4.3
C269	Care group level patient safety oversight groups (PSOG) in place to review local incidents and learning which then feed into Trustwide PSOG (P,N,I,E)	DNQ/CMO	1.1,2.2, 2.4, 3.1
C270	People strategy in place. Approved by Trust Board December 2025 (P, I, E)	CPO	1.1, 1.2, 3.1, 6.3
C271	A design and planning tool has now been developed to include health inequalities to enable staff to mitigate the impact of health inequalities as business as usual (P,N,I)	DSC	1.1
C272	An Equality Diversity and Inclusion action plan is place following approval at Trust Board on 28 October 2025. (P,N,I)	DSC/CPO	1.1/1.2

Controls (Strategic Risk 1.1 - Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience)			
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
C275	Updated Trust EDI infrastructure in place to ensure delivery of the six new EDI objectives Governance arrangements reconfigured to support this. (P,I)	DSC	1.1/1.2
C276	An equality interactive tool dashboard is now in place which provides insight to ensure improvements and service change. (P,N,I,E)	DSC	1.1, 1.2, 2.1, 2.4, 4.3
C277	As part of NHS England's Mental Health Bill Quality Improvement Plan, the Trust has piloted advance choice documents in the Horizon Centre for the learning disability community to enable them to make decisions about their care prior to their admission as a mental health inpatient. It should be noted the advance choice document is applicable to all mental inpatients not just those with a learning disability. (P,N,I, E)	CMO	1.1,1.2,2.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Becoming an anti-racist Trust is a strategic objective in our new Equality, Diversity and Involvement Strategy. The Trust has continued to progress implementation of the Patient and Carer Race Equality Framework (PCREF). A PCREF implementation plan and supporting communications plan are in place and being delivered, with an Internal Oversight Group being refreshed and development of an External Advisory Group underway as part of Community Connectors Trust approach. Key supporting infrastructure has also been reviewed and strengthened, including the Trust's EDI Governance Framework; our involvement approach, Equality Impact Assessment (EIA) process, appraisal process, and workforce training arrangements. Work continues to be co-produced with ethnic minority staff, communities and allies to embed anti-racist practice and address racial inequalities across the organisation. Externally we are also working with West Yorkshire Race Equity Steering Group (RESG) to develop specific Anti-racism training across the system in a collaborative way. Further we are currently reviewing the Lord Mann report and aligning alongside our PCREF commitments. Progress update to be reported in October 2026.	October 2026	DSC
The Trust is looking to embed the advanced choice document into the Trust's learning disability and/or autism service dynamic support register (DSR) process which will streamline with care (education) and treatment reviews (C(E)TR). On 1st April 2026 the Trust LD service took over management and responsibility for DSRs and C(E)TRs for Calderdale, Kirklees and Wakefield. Some time is therefore required to get the transition completed and review the process across the three places in more detail. The recent changes within the ICB have impacted on the pace of this work. Further update to be provided in October 2026.	October 2026	CMO

Assurance (Strategic Risk 1.1 - Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience)				
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	Service user experience and waiting time reports are reviewed by QSC, and MHA. CQC Mental Health Act visits occur on a regular basis and are reported into QSC and MHAC.	Patient experience reports and integrated performance report (IPR) data on access and waiting times included in the new Equality and Inclusion interactive tool. (P) (I)	DNQ	1.1, 2.1, 4.1, 4.2, 4.3
A33	Patient experience (including complaints) reports to Trust Board and QSC.	Annual reports to Board / EMT and quarterly into QSC. (P, N) (I)	DNQ	1.1, 2.1, 2.4
A35	EDI dashboard presented to Quality and Safety Committee	Regular reports and papers provided. (P) (I)	DSC	1.1, 2.1
A52	Annual health inequalities analysis included in the EDI annual report.	Reported into Quality and Safety Committee, (I, E, P,N)	DSC	1.1
A74	Staff survey results reported to Trust Board via People and Remuneration Committee and action plans produced as applicable.	Reported to PRC every other meeting. (P, N) (I)	CPO	1.1, 1.2, 3.1
A80	Healthcare inequalities dashboard.	OMG, EMT, QSC review and 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	1.1, 2.4
A84	Inequalities data supported by staff network groups is used to improve the experience 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	1.1, 3.1
A86	Positive 2024 NHS staff survey results that demonstrate the Trust benchmarks well against peer organisations.	Annual NHS staff survey results monitored by EMT, PRC and Trust Board. (P,N, I, E)	CPO	1.1,1.2
A89	Waiting list report including analysis in relation to protected characteristics.	Reported into FIP committee. (I, E, P, N)	DSC/COO	1.1
A111	PCREF compliance reports	Quarterly national reports to EMT,QSC and NHSE (P,N,I,E)	DSC	1.1, 2.1, 4.3
A115	Summary update from care group Patient Safety Oversight Group's (PSOG)	Weekly updates sent to Trustwide PSOG which is then fed into EMT and QSC and reported into Trust Board via triple A from QSC (P,N,I)	DNQ/CMO	1.1,2.2, 2.4, 3.1
A116	Following WRES and WDES results a clear action plan was produced to address the key findings. EDI action plan was submitted and approved at board on 28 th October.	This will be monitored through PRC to ensure delivery of the actions on a quarterly basis (P, N, I, E)	CPO	1.1,1.2
A117	EDI dashboard	Updates on the dashboard will be presented to each Quality and Safety Committee meeting (P,N,I)	DSC/DFR	1.1, 1.2, 2.1, 2.4, 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

Strategic risk 1.2 (Strategic Aim 1 - We will live our values)

Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience.

Controls (strategic risk 1.2 - Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience.)				
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)	
C15	Equality and Inclusion 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, 1.2, 2.1, 2.4, 3.1, 4.1, 4.3	
C103	Education and training governance group in place to agree and monitor annual training plans. (I)	CPO	1.2, 3.1	
C115	Diversity, inclusion and belonging lead in place as part of the Trust's overall leadership and management development arrangements. Workforce elements fall under the CPO. (I)	CPO	1.1, 1.2	
C136	Inclusive Leadership Board Development (ILDB) programme on inequalities completed, with future board development programme being established. (P, I)	CPO	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 meetings take place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3	
C154	Regular and consistent updates and communications throughout the Trust via the View and The Brief. (P, I)	DSC	1.1, 1.2	
C155	PRC engagement with staff networks and is reported to Trust Board through the triple A report. (P, I)	CPO	1.1, 1.2	
C156	Freedom to Speak up Guardians in place. (P,I)	CPO/DNQ	1.1, 1.2	
C157	Values based recruitment processes in place. (P, I)	CPO	1.1, 1.2	
C158	Values based appraisal system. (I, E, P, N)	CPO	1.1	
C179	Developed internal transfer system which is now to be promoted and embedded. (P) (I)	CPO	1.1	
C189	Trust Board development programme being developed for 2025/26 building on the leadership through a values-based culture and strengthening delivery of the Trusts strategic objectives. (P, I, E)	CPO/CEO	1.1, 1.2	
C270	People strategy in place. Approved by Trust Board December 2025 (P, I, E)	CPO	1.1, 1.2, 3.1, 6.3	
C271	A design and planning tool has now been developed to include health inequalities to enable staff to mitigate the impact of health inequalities as business as usual (P,N,I)	DSC	1.1	
C272	An Equality Diversity and Inclusion action plan is place following approval at Trust Board on 28 October 2025. (P,N,I)	DSC/CPO	1.1, 1.2	
C275	Updated Trust EDI infrastructure in place to ensure delivery of the six new EDI objectives Governance arrangements reconfigured to support this.	DSC	1.1/1.2	
C276	An equality interactive tool dashboard is now in place which provides insight to ensure improvements and service change. (P,N,I,E)	DSC	1.1/1.2/2.1/2.4/4.3	
C277	As part of NHS England's Mental Health Bill Quality Improvement Plan, the Trust has developed advance choice documents for the learning disability community to enable them to make decision about their care as a mental health inpatient before admission. (P,N,I, E)	CMO	1.1,1.2,2.1	

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
The Trust is looking to embed the advanced choice document into the Trust's learning disability and/or autism service dynamic support register (DSR) process which will streamline with care (education) and treatment reviews (C(E)TR). On 1st April 2026 the Trust LD service took over management and responsibility for DSRs and C(E)TRs for Calderdale, Kirklees and Wakefield. Some time is therefore required to get the transition completed and review the process across the three places in more detail. The recent changes within the ICB have impacted on the pace of this work. Further update to be provided in October 2026.	October 2026	CMO

Assurance (strategic risk 1.2 - Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience.)				
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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
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	1.2, 2.3, 3.1, 4.1, 4.2, 5.1, 6.3
A74	Staff survey results reported to Trust Board and / or People and Remuneration Committee and action plans produced as applicable.	Reported to PRC every other meeting. (P, N) (I)	CPO	1.1, 1.2, 3.1
A86	Positive 2025 NHS staff survey results that demonstrate the Trust benchmarks well against peer organisations.	Annual NHS staff survey results monitored by EMT, PRC and Trust Board. (P,N, I, E)	CPO	1.1, 1.2
A116	Following WRES and WDES results a clear action plan is being produced to address the key findings. EDI action plan was submitted and approved at board on 28 th October.	This will be monitored through PRC to ensure delivery of the actions on a quarterly basis (P, N, I, E)	CPO	1.1, 1.2
A117	EDI dashboard	Updates on the dashboard will be presented to each Quality and Safety Committee meeting (P,N,I)	DSC/DFR	1.1, 1.2, 2.1, 2.4, 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

Strategic risk 2.1 (Strategic Aim 2: Best we can be - Best Quality) 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 2.1 - 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.)			
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 / DSC	1.1, 2.1, 4.1, 4.2, 6.2
C02	Operational Management Group (OMG) meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	COO	2.1, 2.3, 2.4, 4.1, 4.2
C03	Senior representation on West Yorkshire and South Yorkshire mental health collaborative and associated workstreams. (I, E)	COO	2.1, 4.1
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	2.1, 2.4, 4.1
C06	Trust performance management system in place with KPIs covering national (including NHS oversight framework) and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	2.1, 2.4, 4.1
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	2.1, 4.1
C15	Equality and Inclusion 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, 1.2, 2.1, 2.4, 3.1, 4.1, 4.3
C17	Member of South Yorkshire mental health, learning disability and autism programme board. Partner in emerging South Yorkshire provider alliance. (I, E)	DSC	2.1, 4.1
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. (E, I)	DSC / DNQ / CMO	1.1, 2.1 4.1, 4.2
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	2.1, 2.4, 4.2
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	1.1, 2.1, 4.3
C27	Governors supported to involve people at a locality level, toolkit in place. (I, E)	DSC	2.1, 4.3
C28	Toolkit in place to capture patient stories. (I)	DSC	2.1, 4.3
C30	Process to review and assure Equality Impact Assessments (EIAs) with report to Quality and Safety Committee (I). (I)	DSC	1.1, 2.1, 4.3
C31	Joint Service and Needs Assessment (JSNA) data reflected in all service EIAs. (I)	DSC	2.1, 4.3
C35	Translation and interpretation service in place as well as inequalities interactive tool. (I)	DSC	1.1, 2.1, 4.3
C37	All of us in mind group in place with governance structure (I, P, N)	DSC	2.1
C38	Trust website meets Accessible Information Standard. (I)	DSC	2.1
C40	Photo symbol package available to staff from the communications team for Trust documents and leaflets. (I)	DSC	2.1
C41	Patient experience and engagement toolkit in place. (I)	DSC	2.1
C126	Commissioning intentions are factored into operating plans as part of the planning process. (P, I)	DFR, COO, DSC	2.1, 4.1, 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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C145	Service user survey results reported to Quality and Safety Committee and Trust Board and action plans produced as applicable. (P, N, I).	DNQ	2.1, 2.4, 4.1, 4.2, 4.3
C148	All services have a baseline Equality Impact Assessment (EIA) in place. (P) (I)	DSC	2.1
C185	Improving access to care priority programme established (P, I)	DSC	2.1
C186	Dashboard and business intelligence tools in place to help address health inequalities (P, I)	DSC	2.1
C204	Chief Medical Officer is the executive sponsor of learning disabilities service for the Trust (P,I,E)	CMO	2.1
C208	All of you campaign – To improve the recording of equality data through campaign, SystmOne improvements and tools on intranet page. (P, I, E)	DSC	2.1
C260	Priority programmes approved by Trust Board April 2026 (P, I)	DSC	2.1, 4.3
C101	The Trust engaged with the national Culture of Care improvement programme during 2024/25 (P,N,I,E)	DNQ/CMO	2.1
C263	Operational equality dashboards now in place (P,N,I)	DSC	1.1, 2.2, 4.3
C264	Patient carer race equality framework (PCREF) implementation plan in place (P,N,I,E)	DSC	1.1, 2.2, 4.3
C265	Health inequalities toolkit in place to reduce barriers to access to services (P,N,I,E)	DSC	1.1, 2.1, 2.3, 4.3
C266	Hearing impaired and deaf toolkit in place to reduce barriers to access to services (P,N,I,E)	DSC	1.1, 2.1, 2.3, 4.3
C273	Medical devices is now part of the director of finance, estates and resources portfolio as approved by EMT. The medical device safety officer role has been taken on by deputy director of estates. A whole-time band 5 colleague has been appointed to oversee medical device servicing. (P, N, I)	DFR	2.1

Controls (strategic risk 2.1 - 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.)			
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
C276	An equality interactive tool dashboard is now in place which provides insight to ensure improvements and service change. (P,N,I,E)	DSC	1.1/1.2/2.1/2.4/4.3
C277	As part of NHS England's Mental Health Bill Quality Improvement Plan, the Trust has developed advance choice documents for the learning disability community to enable them to make decision about their care as a mental health inpatient before admission. (P,N,I, E)	CMO	1.1,1.2,2.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
The Trust is looking to embed the advanced choice document into the Trust's learning disability and/or autism service dynamic support register (DSR) process which will streamline with care (education) and treatment reviews (C(E)TR). On 1st April 2026 the Trust LD service took over management and responsibility for DSRs and C(E)TRs for Calderdale, Kirklees and Wakefield. Some time is therefore required to get the transition completed and review the process across the three places in more detail. The recent changes within the ICB have impacted on the pace of this work. Further update to be provided in October 2026.	October 2026	CMO
The Trust is working with CKW commissioners to support reduction of waiting lists for Adult ADHD assessments. The process will be to offer people on the waiting list to be assessed by commissioned independent practitioners. The commissioner led standard operating procedure has been devised and SWYPFT services are working to undertake this process. Currently the timescale for completion is still to be determined.	October 2026	COO

Assurance (strategic risk 2.1- 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.)				
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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
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	2.1, 2.4, 4.1, 4.2, 4.3, 5.1
A20	Service user experience and waiting time reports are reviewed by QSC, and MHA. CQC Mental Health Act visits occur on a regular basis and are reported into QSC and MHAC.	Patient experience reports and integrated performance report (IPR) data on access and waiting times included in the new Equality and Inclusion interactive tool. (P) (I)	DNQ	1.1, 2.1, 4.1, 4.2, 4.3
A24	Investment Appraisal report – covers bids and tender 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)	DFR	2.1, 4.2, 5.1, 6.3
A33	Patient experience (including complaints) reports to Trust Board and QSC	Annual reports to Board / EMT and quarterly into QSC. (P, N) (I)	DNQ	1.1, 2.1, 2.4
A34	Quality strategy and clinical strategy review updates report into QSC.	Routine reports into QSC via IPR and annual report scheduled in 2025/26 work plan. (P) (I)	DNQ	2.1, 2.4
A35	EDI dashboard presented to Quality and Safety Committee	Regular reports and papers provided. (P) (I)	DSC	1.1, 2.1
A110	Insight report	Reported submitted to EMT and EDI operations group March and September each year.	DNQ	2.1
A112	Culture of care steering group	Periodically reports into EMT and QSC through the executive trio report (P, N, I, E)	DNQ/CMO	2.1
A111	PCREF compliance reports	Quarterly national reports to EMT, QSC and NHSE (P,N,I,E)	DSC	1.1, 2.1, 4.3
A117	EDI dashboard	Updates on the dashboard will be presented to each Quality and Safety Committee meeting (P,N,I)	DSC/DFR	1.1, 1.2, 2.1, 2.4, 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
There is a new national quality strategy to be published shortly which will inform the refresh of the Trust Quality Strategy which is due at the end of 2026.	January 2027	DNQ

Strategic risk 2.2 (Strategic Aim 2: Best we can be - Best Quality)
The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.

Controls (strategic risk 2.2 - The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.)				
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)	
C42	Access to the model health system and any other associated national productivity packs to enable effective national benchmarking and support decision making. (E, I)	DFR	2.2	
C43	A data warehouse has been established with a business intelligence tool supporting improved decision making and continues to evolve. (I)	DFR	2.2	
C44	Digital strategy in place with quarterly report to Executive Management Team (EMT) and yearly report to Trust Board. New digital strategy approved by Trust Board in January 2025. (I)	DFR	2.2, 5.2	
C45	Risk assessment and action plan for data quality assurance in place. (I)	DFR	2.2	
C46	Datix Risk management and incident reporting systems support review of all incidents for learning and action. (I)	DNQ	2.2, 2.3, 3.1	
C47	The Patient Safety Oversight Group meets weekly to review recent patient safety risks. All red and amber incidents from across the organisation are reviewed including the undertaking of proportionate investigations. In addition, all incidents relating to protected characteristics or staffing, irrespective of grading are also reviewed. (P,N,I,E)	DNQ / CMO	1.1, 2.2, 2.4, 3.1	
C48	Improving Clinical Information and Information Governance Group (ICIG) reviews clinical information systems and data quality. (I)	DNQ / DFR	2.2	
C49	Internal process to impact assess and review potential new systems from a technical and information governance (IG) standpoint. (I)	DFR	2.2	
C50	Change control process in place for operational / service level requests / changes, for system-wide changes and developments. (I)	DFR/COO/DNQ/DSC	2.2	
C51	National benchmarking data is reviewed at the benchmarking group and then analysed and taken to OMG, EMT and Finance, Investment and Performance Committee. (I)	DFR	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 meeting stake place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3	
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	2.2, 4.3	
C172	Substantive data quality and waiting list lead in post to ensure the continued development and monitoring of waiting list management across the Trust. (I, P)	DSC	2.2	
C207	Trust IPR metrics are aligned to NHS Oversight Framework (P,N,I,E)	DFR	2.2	
C269	Care group level patient safety oversight groups (PSOG) in place to review local incidents and learning which then feed into Trustwide PSOG (P,N,I,E)	DNQ/CMO	1.1,2.2, 2.4, 3.1	
C278	Digital innovation and programme group (P,N,I)	CMO	2.2	

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Performance and Business information (P & BI) are automating integrated performance reporting to release capacity to undertake analytics so that operational teams have actionable data they can use to support decision making. IPR automation of metrics for national people sections of the IPR is now complete. Work continues on quality metrics, however, this is taking longer than anticipated due to further work being required on the Datix feed and challenges with capacity to validate metrics across P&BI and the quality team but is being monitored closely. Several quality metrics still require validating due to complexity of the metrics and external dependencies. There are also some new metrics and changes for the 2026/27 report. As a result of the automation work already undertaken, P&BI capacity is being provided into some of the Trust priority programme groups such as inpatient improvement group and improving access to care. This capacity provision is planned to continue and will increase.	July 2026	DFR

Assurance (strategic risk 2.2 - The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.)				
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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
A37	Data quality improvement plan monitored through ICIG, and the Executive Management Team (EMT) deviations identified, and remedial plans requested.	Included in monthly IPR to OMG, EMT and Trust Board. (P) (I)	DNQ/DFR	2.2
A38	Progress against SystmOne optimisation reviewed by Clinical Safety Design Group, EMT, QSC and Trust Board (as required).	Monthly priority programmes item schedule for EMT. Included as part of the IPR to EMT, QSC and Trust Board (as required). (P) (I)	DNQ	2.2
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)	DSC	2.2
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 at ICIG and OMG. (P, N) (I)	DNQ/COO	2.2
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	2.2
A42	OMG management and governance processes are documented weekly in OMG minutes.	All OMG minutes are presented to EMT on a regular basis. (I) (P)	COO	2.2
A43	Waiting list reporting including health inequalities data.	Reported in OMG quarterly and improving access to care group quarterly (P, N, I)	DSC	2.2, 2.4, 4.3

Assurance (strategic risk 2.2 - The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.)

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)
A115	Summary update from care group Patient Safety Oversight Group's (PSOG)	Weekly updates sent to Trustwide PSOG which is then fed into EMT and QSC and reported into Trust Board via triple A from QSC (P,N,I)	DNQ/CMO	1.1,2.2, 2.4, 3.1
A118	Digital Innovation and Programme Group	Meets every two months and reports regular updates into EMT (P,N,I)	CMO	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

**Strategic risk 2.3 (Strategic Aim 2: Best we can be - Best Quality)
Failure to create a learning environment leads to lack of innovation and to repeat incidents.**

Controls (strategic risk 2.3 - Failure to create a learning environment leads to lack of innovation and to repeat incidents)

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	2.1, 2.3, 2.4, 4.1, 4.2
C46	Datix Risk management and incident reporting systems support review of all incidents for learning and action. (I)	DNQ	2.2, 2.3, 3.1
C52	Patient experience reporting includes learning from complaints, concerns and compliments. (I)	DNQ	1.1, 2.3, 3.1
C53	The Trusts is aligned to the Patient Safety Incident Response Framework (PSIRF) in line with national standards. (I)	DNQ	1.1, 2.3, 3.1
C54	Quality Improvement network established to provide Trust wide learning platform. (I)	DNQ	2.3, 3.1
C55	Quality Strategy is in place achieving balance between assurance and improvement. (I)	DNQ	2.3
C56	Quality improvement approach and methodology is utilised throughout the Trust underpinned by the model for improvement. (I)	DNQ	2.3, 2.4
C57	Leadership and management arrangements established and embedded at care group and service line level with key focus on being clinically informed and operationally embedded . (I)	COO	2.3, 3.1
C58	Learning lessons reports are shared across care groups via the care group patient safety oversight groups including post incident reviews, and are included in quarterly and annual patient safety oversight reports. (I)	DNQ	2.3
C59	Risk Management Governance Framework in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training. (I)	CEO/DSC	2.3
C60	Patient safety risk summaries are presented to each Executive Management Team (EMT) meeting supported by monthly reports to OMG, quarterly reports to Quality and Safety Committee and Trust Board (Patient Safety Oversight Report). (I)	DNQ	2.3
C61	Web based platform in place with over 2,000 members providing digital opportunities to share, innovate, collaborate and improve. (I)	DSC	2.3, 5.2
C62	Peer lead worker role in place and training toolkit developed. (I)	DSC	2.3
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	2.3
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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C161	Learning process in place through the use of processes such as the Situation, Background, Assessment, Recommendation (SBAR) structure to create short learning case studies which are shared with all staff via the Trust headlines. (P, I)	DNQ	2.3
C173	The use of external experts for patient safety incident investigations and reviews when appropriate. (P, N, I, E)	DNQ	2.3
C174	Internal audit report received demonstrating significant assurance against patient safety incident investigations action planning. (P, I, E)	DNQ	2.3
C261	Alternative injection site training is embedded in the Trusts routine RRPI training, with top up sessions rolled out to specific areas where needed. (P,N,I)	DNQ	2.3
C265	Health inequalities toolkit in place to reduce barriers to access to services (P, N, I, E)	DSC	1.1, 2.1, 2.3, 4.3
C266	Hearing impaired and deaf toolkit in place to reduce barriers to access to services (P, N, I, E)	DSC	1.2, 2.1, 2.3, 4.3
C279	Sexual safety policy in place for both staff and service users (P,N,I,E)	CMO/DNQ	2.3
C280	Information governance (IG) training and action plan on IG hotspots in place. (Linked to ORR risk 852), Bespoke and ad-hoc training is in place (P,N,I)	DFR	2.3
C281	IG communications campaigns, action plans and thematic reviews, including deep dives at Operational management Group. (P,N,I)	DFR	2.3
C282	The Trust met the training requirement for the June 2026 DSPT submission (95.9%) in March 2026 (P,I)	DFR	2.3
C283	The Trust submitted the full DSPT assessment for 2025/26 ahead of the deadline of 30 June 2026 (P,E)	DFR	2.3
Gaps in control – what do we need to do to address these and by when?		Date	Director lead

Controls (strategic risk 2.3 - Failure to create a learning environment leads to lack of innovation and to repeat incidents)			
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
A strategic approach to the oversight of the learning from previous serious incidents and assurance around the embedding of actions is now part of the work of the Patient Safety Improvement Group. The Chief Allied Health Professional has reviewed the scope of incidents that will be included within this work and has also undertaken a broader thematic analysis of actions from all serious incidents in the Trust. The initial report presented to the executive management team has been updated to include learning from national incidents. The updated report went to Quality and Safety Committee in February 2026 with a timeframe for completion of the work being September 2026.		October 2026	DNQ

Assurance (strategic risk 2.3 - Failure to create a learning environment leads to lack of innovation and to repeat incidents.)				
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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
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	1.2, 2.3, 3.1, 4.1, 4.2, 5.1, 6.3
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	2.3, 4.2, 4.3, 5.1, 5.2, 6.3
A22	All red and amber incidents from across the organisation are reviewed through the Patient Safety Oversight Group including the undertaking of proportionate investigations. In addition, all incidents relating to protected characteristics or staffing, irrespective of grading are also reviewed. Dissemination of lessons learnt and good clinical practice across the organisation.	Process in place through the quarterly patient safety oversight reporting including lessons learned to OMG, EMT, Quality and Safety Committee and Trust Board. (P, N) (I)	DNQ	2.3, 4.2
A44	Recent patient safety risk summaries update into each EMT meeting.	Clinical risk scan update into EMT meeting. (P, N) (I)	DNQ	2.3
A45	Assurance reports to Quality and Safety 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	2.3
A46	Priority programmes reported to Board and EMT.	Monthly reports to Board / EMT and bi-monthly into QSC. (P) (I)	DSC	2.3, 3.1
A47	Examples of co-production in recovery colleges and Creative Minds	Reports to Charitable Funds Committee (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	2.3
A48	Inpatient structure provides assurance of operational oversight of record keeping. A working group is in place to focus on improving Trust wide clinical record keeping.	Routine matron checks reported through Care Group governance meetings and escalated through governance reports to QSC (as required). The clinical record keeping working group reports into Clinical Governance Group on a regular basis. (P) (I)	COO/DNQ	2.3
A51	Process in place to review and identify learning from national investigations or reports.	Reports go into the clinical governance group (CCG), EMT, QSC and Trust Board (as required). (E, I, P, N)	DNQ	2.3
A90	A Trustwide approach to shared decision making and co-production is in place to support the delivery of personalised care and innovation.	Reports into QSC (E, I, P)	DNQ	2.3
A94	Service improvement work is now aligned with quality transformation and clinical pathways for Mental Health, Learning Disabilities and Autism, forensics and children and young people's services.	Reports through priority programmes into EMT monthly (I, E, P, N)	COO	2.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
A strategic approach to the oversight of the learning from previous serious incidents and assurance around the embedding of actions is now part of the work of the Patient Safety Improvement Group. The Chief Allied Health Professional has reviewed the scope of incidents that will be included within this work and has also undertaken a broader thematic analysis of actions from all serious incidents in the Trust. The initial report presented to the executive management team has been updated to include learning from national incidents. The updated report went to Quality and Safety Committee in February 2026 with a timeframe for completion of the work being September 2026.	October 2026	DNQ
There will always be information governance (IG) incidents because organisations rely on people, processes and technology that are imperfect and constantly changing. As data volumes and reliance on digital systems grow, human error is unpredictable, therefore the risk of occasional lapses cannot be eliminated, only mitigated through strong controls, culture and continuous improvement. Controls 280 -283 are in place. The mandatory annual DSPT audit by 360 assurance reported as follows: - Overall risk assurance across all five objectives is low, which means none of the reviewed outcomes were rated as not meeting minimum achievement levels; and - Confidence level in the veracity of the Trust's DSPT self-assessment/ final submission is high. For the sixth consecutive year, the Trust has achieved the highest levels of assurance in the audit assessment. The Trust has completed the self-assessment of the contributing outcomes that were not subject to the audit review and met the minimum achievement levels for each. The DSPT was approved for submission which took place on the 29 June 2026 (deadline 30 June 2026). Review further in October 2026.	October 2026	DFR

Strategic risk 2.4 (Strategic Aim 2: Best we can be - Best Quality) Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.

Controls (strategic risk 2.4 - Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.)			
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	2.1, 2.3, 2.4, 4.1, 4.2
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	2.1, 2.4, 4.1
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR/DSC	2.4, 4.1, 4.2, 5.1
C06	Trust performance management system in place with KPIs covering national (including NHS oversight framework) and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	2.1, 2.4, 4.1
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DSC/CEO	2.4, 4.1, 4.3
C15	Equality Diversity and Inclusion 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, 1.2, 2.1, 2.4, 3.1, 4.1, 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	2.1, 2.4, 4.2
C47	The Patient Safety Oversight Group meets weekly to review recent patient safety risks. All red and amber incidents from across the organisation are reviewed including the undertaking of proportionate investigations. In addition, all incidents relating to protected characteristics or staffing, irrespective of grading are also reviewed. (P,N,I,E)	DNQ / CMO	1.1, 2.2, 2.4, 3.1
C56	Quality improvement approach and methodology. (I)	DNQ	2.3, 2.4
C63	Partnership Meeting in place as part of the improving mental health priority programmes, including representatives from community partners and stakeholders. (E, P, N)	COO	2.4
C64	Care closer to home programme incorporating whole system actions with out of area bed reduction reported against trajectory. (I, E)	COO	2.4
C65	Policies and procedures to support safer staffing in place to respond to changes in need. (I)	DNQ	2.4
C66	Trio management system in place monitoring quality, performance and activity on a routine basis. (I)	COO	2.4
C67	Use of trained and appropriately qualified temporary staffing through bank and agency system. (I)	CPO	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 inequalities. This reports through the priority programmes. (I) (ORR 1078, 1132)	COO	2.4
C69	Process to manage and report on progress against the CQC action plans. (I)	DNQ	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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C142	Healthwatch and regulators provide external assurance on standards and quality of care. (I) (P) (N)	DNQ	2.4
C145	Service user survey results reported to Quality and Safety Committee and Trust Board and action plans produced as applicable. (P, N, I).	DNQ	2.1, 2.4, 4.1, 4.2, 4.3
C160	Operational leadership has implemented frequent inpatient staffing meetings to ensure inpatient wards are staffed safely and staff redeployed according to need (P, I)	COO	2.4
C269	Care group level patient safety oversight groups (PSOG) in place to review local incidents and learning which then feed into Trustwide PSOG (P,N,I,E)	DNQ/CMO	1.1,2.2, 2.4, 3.1
C276	An equality interactive tool dashboard is now in place which provides insight to ensure improvements and service change. (P,N,I,E)	DSC	1.1, 1.2, 2.1, 2.4, 4.3

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
The Trust currently does not have safer staffing establishment reviews in place for mental health community services; this is being developed as part of the community services transformation programme.	October 2026	DNQ
There is a current focus on developing a community caseload management tool, which will provide significant data to inform required establishments by team. It has been agreed in EMT to undertake community establishment reviews from Quarter 1 onwards 2026/27, to enable the caseload management data to be used to provide this additional evidence. This will include Intensive Home-Based Treatment Teams, Core and Enhanced Teams. Work is continuing on the caseload management tool. Further review in October 2026		
Safer staffing internal audit identified that the Trust does not have a safer staffing policy. This is now in development with a prospective completion for Q3 2026/27.	October 2026	DNQ

Assurance (strategic risk 2.4 - Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.)				
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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
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	2.1, 2.4, 4.1, 4.2, 4.3, 5.1
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, EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	EMT	2.4, 4.1, 4.2, 4.3, 5.2, 6.3
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality assurance system. Reports on these visits are provided to 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 presented to the Members Council. Quality walkarounds programme in place for 2026/27 are reported into QSC. (P, N) (E)	DNQ	2.4, 4.1, 4.2
A33	Patient experience (including complaints) reports to Trust Board) and QSC	Annual reports to Board / EMT and quarterly into QSC. (P, N) (I)	DNQ	1.1, 2.1, 2.4
A34	Quality strategy and clinical strategy review updates report into QSC Committee.	Routine reports into QSC via IPR and annual report scheduled in 2025/26 work plan. (P) (I)	DNQ	2.1, 2.4
A49	Trust self-assessment process in place through the quality governance team to horizon scan learning from CQC inspection reports from other providers.	Reviewed by EMT to keep appraised of CQC developments and learning in preparation for any forthcoming CQC inspection. (P) (N) (I) (E)	DNQ	2.4
A80	Healthcare inequalities dashboard	OMG, EMT, QSC review and 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	1.1, 2.4
A81	CAMHS referral monitoring	CAMHS governance group monitors referrals numbers to monitor pressure on core CAMHS services (P) (N) (I) (E)	COO	2.4
A43	Waiting list reporting including health inequalities data	Reported in OMG quarterly and improving access to care group quarterly (P, N, I)	DSC	2.2, 2.4, 4.3
A88	Improving mental health oversight group is in place to monitor the improving care priority programmes. The internal oversight group operates within the Trust, reports into EMT and work is shared with the partnership group for support and challenge with feeds back into the Trust.	This group reports into EMT on a bi-monthly basis (P, N, I)	COO	2.4
A95	Care closer to home report	Reported into every EMT meeting (I, E, P, N)	COO	2.4, 5.1
A115	Summary update from care group Patient Safety Oversight Group's (PSOG)	Weekly updates sent to Trustwide PSOG which is then fed into EMT and QSC and reported into Trust Board via triple A from QSC (P,N,I)	DNQ/CMO	1.1,2.2, 2.4, 3.1
A117	EDI dashboard	Updates on the dashboard will be presented to each Quality and Safety Committee meeting (P,N,I)	DSC/DFR	1.1, 1.2, 2.1, 2.4, 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
There is a gap in commissioned capacity to meet demand in children's neurodevelopmental services in Kirklees. There is no agreed solution., this remains a national issue. The Trust has changed its pathways to increase capacity and improve flow, but cannot influence future demand, but will continue to work with commissioners to try to resolve issues. The Trust is working with CKW commissioners to establish safe processes to support children on the waiting list for neurodevelopmental services to have access to independent assessments, which will therefore reduce the waiting list. To be reviewed again in October 2026.	October 2026	COO
In all areas demand for adult ADHD services is beyond commissioned capacity, however, the service is meeting current commissioned activity. 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. Work continues to be led by the West Yorkshire and South Yorkshire ICS's. An internal triage process in some WY places has been introduced and discussions with commissioners are taking place around service modelling which will feed into the national review project. The Trust is working with CKW commissioners to support reduction of waiting lists for Adult ADHD assessments. The process will be to offer people on the waiting list to be assessed by commissioned independent practitioners. The commissioner led standard operating procedure has been devised and SWYPFT services are working to undertake this process. Currently the timescale for completion is still to be determined.	October 2026	COO

Strategic risk 3.1 (Strategic Aim 2: Best we can be - Best place to work and learn)
Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.

Controls (strategic risk 3.1 - Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.)			
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
C15	Equality Diversity and Inclusion 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, 1.2, 2.1, 2.4, 3.1, 4.1, 4.3
C46	Datix Risk management and incident reporting systems support review of all incidents for learning and action. (I)	DNQ	2.2, 2.3, 3.1
C47	The Patient Safety Oversight Group meets weekly to review recent patient safety risks. All red and amber incidents from across the organisation are reviewed including the undertaking of proportionate investigations. In addition, all incidents relating to protected characteristics or staffing, irrespective of grading are also reviewed. (P,N,I,E)	DNQ / CMO	1.1, 2.2, 2.4, 3.1
C52	Patient experience reporting allows staff to learn from complaints, concerns and compliments. (I)	DNQ	1.1, 2.3, 3.1
C53	The Trusts is aligned to the Patient Safety Incident Response Framework (PSIRF) in line with national standards. (I)	DNQ	1.1, 2.3, 3.1
C54	Quality Improvement network established to provide Trust wide learning platform. (I)	DNQ	2.3, 3.1
C57	Leadership and management arrangements established and embedded at care group and service line level with key focus on being clinically informed and operationally embedded . (I)	COO	2.3, 3.1
C108	A leadership and management programme is in place (P,I)	CPO	3.1
C102	Annual learning needs analysis undertaken linked to service and financial plans. (I)	CPO	3.1
C103	Established education and training governance group agrees and monitors annual training plans. (I)	CPO	1.2, 3.1
C104	People processes in place ensuring defined job description, roles and competencies to meet the needs of service, pre-employment checks done regarding qualifications, DBS and work permits. (I)	CPO	3.1
C105	Mandatory clinical supervision and training standards set and monitored for service lines. (I)	DNQ	3.1
C106	Medical leadership programme in place with external facilitation as and when required. (I)	CMO	3.1
C107	People strategy and annual delivery plan approved by PRC, supported by the people promise plan. (I)	CPO	3.1
C110	Values-based appraisal process in place with new monitoring arrangements monitored through business intelligence systems and the integrated performance report. (P,N,I)	CPO	1.1, 3.1
C111	Values-based Trust Welcome Event in place covering mission, vision, values, key policies and procedures. (I)	CPO	3.1
C112	Trust Workforce annual 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	3.1
C113	Good partnership working with a range of Higher Education Institutions (HEIs) to discuss the appropriateness of undergraduate and post graduate programmes. (E)	CPO /DNQ/CMO	3.1
C114	Appraisal process to discuss individuals' intentions regarding future career development with a view to maximise opportunities within the Trust and promote staff retention. Improved exit questionnaire process implemented. (I)	CPO	3.1
C116	Provision of appropriate personal protective equipment (PPE) in line with national guidance. (I)	DNQ	3.1
C117	Access to wellbeing offers. (I)	CPO	3.1
C118	Comprehensive Occupational Health Service offer. (P,I)	CPO	3.1
C121	Promotion and accessible offer of flu vaccination programme for all staff within the Trust with clear targets. (I)	DNQ	3.1
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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C165	The Trust is a General Medical Council (GMC) sponsor for international fellows which contributes to the sustainable workforce model. (P, E, I)	CMO	3.1
C178	Temporary staffing scrutiny group in place which is chaired by the chief operating officer to ensure agency standards are fully adhered to. (P, I)	COO	3.1
C180	Diversity, inclusion and belonging lead in place. (P) (I)	CPO	3.1
C183	Wellbeing capacity within the Organisational Development (OD) team is in place. (P, I)	CPO	3.1
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). (P,I,E)	CMO	3.1
C210	Vacancy oversight procedures are in place with a weekly panel chaired by the Chief People Officer. (P,N, I)	CPO	3.1, 4.1, 5.1

Controls (strategic risk 3.1 - Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.)				
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)	
C211	CMO presents a monthly webinar across the Trust to engage medical staff and provide updates on clinical practice, changes across the ICS, wellbeing information and key Trust updates including information from the Brief. (P, I)	CMO	3.1	
C220	Enhanced training package for managers in respect of sickness absence implemented following internal audit recommendation to ensure high levels of competence in managing sickness absence. (P, I)	CPO	3.1	
C159	Teaching Trust status will allow the Trust to recruit high calibre staff and help promote retention of staff (P,I, E)	CMO	3.1	
C269	Care group level patient safety oversight groups (PSOG) in place to review local incidents and learning which then feed into Trustwide PSOG (P,N,I,E)	DNQ/CMO	1.1,2.2, 2.4, 3.1	
C270	People strategy in place. Approved by Trust Board December 2025 (P, I, E)	CPO	1.1, 1.2, 3.1, 6.3	
C285	Updates on the resident doctor 10-point plan received by People and Remuneration Committee every other meeting (P, N, I)	CMO	3.1	
C286	Trust plan approved by Trust Board in January 2026 (P,N,I,E)	CPO/DFR/DSC	3.1, 6.3	

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Current performance in relation to clinical and managerial supervision is below Trust target across a number of teams since the implementation of the new standards. Therefore a review has been commissioned of the impact of the changes made.	October 2026	DNQ

Assurance (strategic risk 3.1- Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.)				
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, identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
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	1.2, 2.3, 3.1, 4.1, 4.2, 5.1, 6.3
A46	Priority programmes reported to Board and EMT.	Monthly reports to Board / EMT and bi-monthly into QSC. (P) (I)	DSC	2.3, 3.1
A50	The vacancy oversight group has been established to consider all vacancies across the Trust taking into account finance, quality and safety.	Weekly meetings chaired by interim chief people officer (P,N, I)	CPO	3.1, 4.1, 5.1
A53	Sickness/absence reporting being closely monitored by the People Directorate business partners and care groups. A sickness reduction plan for 2026/2027 has been developed and signed off by PRC and the Board. (I) (P) (N)	Reported into the People and Remuneration Committee on a quarterly basis as a minimum. (P,N,I)	CPO	3.1
A66	Annual Mandatory Training report goes to PRC and Quality and Safety Committee (QSC) Committee.	QSC Committee receive annual report (P) (I)	CPO	3.1
A67	Appraisal uptake included in IPR.	Monthly IPR goes to the Trust Board and EMT. (P) (I)	CPO	3.1
A68	ESR competency framework for all clinical posts.	Monitored through mandatory training report. (P) (I)	CPO	3.1
A69	Mandatory training compliance is part of the IPR.	Monthly IPR goes to the Trust Board and EMT. (P) (I)	CPO	3.1
A71	Safer staffing reporting is included in IPR and safer staffing reported to Quality and Safety Committee (QSC) and Trust Board.	Monthly IPR goes to the Trust Board and safer staffing reports go to EMT six monthly, QSC and Trust Board. (P)	DNQ	3.1
A72	People Strategy and delivery plan.	Quarterly report to the PRC Committee. (P) (I)	CPO	3.1
A73	Annual appraisal and objective setting in place.	Included as part of the IPR to EMT and Trust Board. (P) (I)	CPO	3.1
A74	Staff survey results reported to Trust Board via, People and Remuneration Committee and action plans produced as applicable.	Reported to PRC every other meeting. (P, N) (I)	CPO	1.1, 1.2, 3.1
A76	Routine scan of NHS based national guidance as part of horizon scanning.	Discussed fortnightly at people leadership team. (PLT). (P, I, E)	CPO	3.1
A83	Temporary staffing scrutiny group report providing details of spend, governance arrangements, trends, hotspots and quality assurance.	Reported into PRC and FIP. (P, N, I)	COO	3.1
A84	Inequalities data supported by staff network groups is used to improve the experience 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	1.1, 3.1
A113	Teaching Trust Joint Partnership Board (P, I, E)	Meets quarterly and is chaired by the Appointed Associate NED for UoL. (P,N ,I, E)	CMO	3.1
A115	Summary update from care group Patient Safety Oversight Group's (PSOG)	Weekly updates sent to Trustwide PSOG which is then fed into EMT and QSC and reported into Trust Board via triple A from QSC (P,N,I)	DNQ/CMO	1.1,2.2, 2.4, 3.1
A120	Resident doctor 10 point plan updates	Reports are received by People and Remuneration Committee at every other meeting (P, N, I)	CMO	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
Turnover and retention of staff within the Trust is currently in a good position. Some gaps still exist, particularly in some Health Care Support Worker, and Allied Health Professional and medical roles which have regional and national shortages. This is being closely monitored through Temporary staffing group and PRC. Reviewed in July 2026, work continues further update in October 2026.	October 2026	CPO

Strategic risk 4.1 (Strategic Aim 2: Best we can be - Best partner)
Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place

Controls (strategic risk 4.1 - Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place)			
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 / DSC	1.1, 2.1, 4.1, 4.2, 6.2
C02	Operational Management Group (OMG) meetings identify and rectify performance issues and learn from good practice in other areas. (I)	COO	2.1, 2.3, 2.4, 4.1, 4.2
C03	Senior representation on West Yorkshire and South Yorkshire mental health, learning disability and autism collaborative and associated workstreams. (I, E)	COO	2.1, 4.1
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	2.1, 2.4, 4.1
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	2.4, 4.1, 4.2, 5.1
C06	Trust performance management system in place with KPIs covering national (including NHS oversight framework) and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	2.1, 2.4, 4.1
C07	Director leads in place to support revised service offer through priority programmes and work streams, overseen by EMT. (I)	DSC	4.1, 4.2, 4.3
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	2.1, 4.1
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DSC/CEO	2.4, 4.1, 4.3
C11	Governors' engagement and involvement on Members' Council and working groups, holding Non-Executive Directors (NEDs) to account. (I)	CEO	4.1
C13	Priority programmes supported through programme/change management approach. (I)	DSC	4.1
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	4.1, 4.2
C15	Equality, Diversity and Inclusion 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, 1.2, 2.1, 2.4, 3.1, 4.1, 4.3
C16	Operational leadership arrangements provide a link to each place and have oversight of service pathways to attempt to minimise unwarranted variation. (E)	COO	4.1
C17	Member of South Yorkshire mental health, learning disability and autism programme board. Partner in South Yorkshire provider alliance. (I, E)	DSC	2.1, 4.1
C18	Meetings with Healthwatch organisations in each place. (E)	DSC	4.1
C19	Process and approach in place to for extensive engagement on the Trust's strategic direction. (I, E)	DSC	4.1
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. (E, I)	DSC / DNQ / CMO	1.1, 2.1 4.1, 4.2
C123	Trust Board strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives. (P, I)	CEO	4.1, 4.2
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates Trust Action Group (TAG) receive quarterly updates. (P) (I)	CEO	4.1, 4.2, 4.3, 5.2
C126	Commissioning intentions are factored into operating plans as part of the planning process aligned to national guidance. (P, I)	DFR, COO, DSC	2.1, 4.1, 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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C144	Audit of compliance with policies and procedures in line with approved plan co-ordinated through the quality governance team in line with Trust agreed priorities (P, N, I).	DNQ	4.1, 4.2, 4.3
C145	Service user survey results reported to EMT, Quality and Safety Committee and Trust Board and action plans produced as applicable. (P, N, I).	DNQ	2.1, 2.4, 4.1, 4.2, 4.3
C146	Business cases for expansion / change of services reviewed for approval by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework. (P, N, I).	DFR/COO	4.1, 4.2, 5.1, 6.3
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	4.1
C181	Operational and care group structures are in place to reflect care pathways (I, P)	COO	4.1, 4.2
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. (E, P, N)	DSC	4.1

Controls (strategic risk 4.1 - Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place)				
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)	
C201	South Yorkshire Mental Health Learning Disability and Autism Provider Collaborative in place. (E, P, N)	DSC	4.1	
C210	Vacancy oversight procedures are in place with a weekly panel chaired by the Interim Chief People Officer (P,N,I)	DFR	3.1, 4.1, 5.1	
C213	Trust clinical strategy in place approved by Trust Board in March 2025. (I, P)	CMO/DNQ/COO	4.1, 4.2	
C221	Director of finance, estates and resources attends all West Yorkshire ICS finance meetings and attends South Yorkshire ICS finance meetings when required (P,N,I,E)	DFR	4.1	
C267	Director of finance chairs national HFMA (healthcare financial management association) mental health interest group, and along with peers supports dialogue with NHSE to support mental health strategies. (P,E)	DFR	4.1	

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Levels of engagement with primary care networks could differ by place and lead to inconsistent development of services. The Trust is working in partnership to develop the detail of the local transformation development plan. We continue to work with primary care networks in each of our places to harness the benefits of the Additional Roles Reimbursement Scheme (ARRS) mental health practitioners implemented in each place. This is within the context of mental health community transformation in each place. Regional and national conversations are taking place regarding modelling and implementation. The Trust will continue to engage with primary care through the community transformation programme and place based integrated care forums. Work continues and we are awaiting clarity on the national position following the release of the NHS ten-year plan. Reviewed in July 2026 and awaiting further information from the centre.	October 2026	DSC

Assurance (strategic risk 4.1 - Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place)				
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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
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	1.2, 2.3, 3.1, 4.1, 4.2, 5.1, 6.3
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	2.1, 2.4, 4.1, 4.2, 4.3, 5.1
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, EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	DSC	2.4, 4.1, 4.2, 4.3, 5.2, 6.3
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality assurance system. Reports on these visits are provided to 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 presented to the Members Council. Quality walkarounds programme in place for 2025/26 are reported into QSC. (P, N) (E)	DNQ	2.4, 4.1, 4.2
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. (P, N) (I).	DFR/DSC	4.1, 4.2, 5.1, 5.2, 6.3
A14	Mental Health Investment Standard income and reporting of performance.	Mental Health Investment Standard agreed with Wakefield, Calderdale, Kirklees, and Barnsley for 26-27 and is reported into FIP. (P) (I) (E).	DFR	4.1, 5.1
A16	Update reports on West Yorkshire and South Yorkshire ICS progress.	Routine report into EMT and Board. (P) (I)	DSC	4.1
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	4.1, 4.2
A19	The Trust is a partner in integrated care partnership arrangements in each place.	Meeting minutes and papers provided and circulated to Trust Board (P) (I, E)	DSC	4.1
A20	Service user experience and waiting time reports are reviewed by QSC, and MHA. CQC Mental Health Act visits occur on a regular basis and are reported into QSC and MHAC.	Patient experience reports and integrated performance report (IPR) data on access and waiting times included in the new Equality and Inclusion interactive tool. (P) (I)	DNQ	1.1, 2.1, 4.1, 4.2, 4.3
A50	The vacancy oversight group has been established to consider all vacancies across the Trust taking into account finance, quality and safety	Weekly meetings chaired by interim chief people officer (P,N, I)	DFR	3.1, 4.1, 5.1
A97	Outcome of monthly regional finance meetings report into EMT verbally and written report to FIP	Reports presented to EMT when system meetings have taken place and papers reported into FIP (P,N,I,E)	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
The Trust needs to develop and introduce a Trust sustainability impact assessment to support the sustainability agenda. As an initial step, a sustainability-related question has been incorporated into the EIA process to strengthen this connection. As the EIA review progresses, we will continue to consider SIA development in parallel, particularly in relation to the digitalisation of resources and processes, with the aim of creating a more streamlined, consistent and seamless approach for colleagues. Progress update in October 2026.	October 2026	DSC

Strategic risk 4.2 (Strategic Aim 2: Best we can be - Best partner) Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.

Controls (strategic risk 4.2 - Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.)			
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 / DSC	1.1, 2.1, 4.1, 4.2, 6.2
C02	Operational Management Group (OMG) meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	COO	2.1, 2.3, 2.4, 4.1, 4.2
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	2.4, 4.1, 4.2, 5.1
C07	Director lead in place to support revised service offer through priority programmes and work streams, overseen by EMT. (I)	DSC	4.1, 4.2, 4.3
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	4.1, 4.2
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. (E, I)	DSC / DNQ / CMO	1.1, 2.1 4.1, 4.2
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	2.1, 2.4, 4.2
C22	Operational management structure reflects an approach ensuring consistent delivery of services. (I)	COO	4.2
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. (P,I,E)	CMO	4.2, 4.3
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	4.1, 4.2
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	4.1, 4.2, 4.3, 5.2
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, DSC	2.1, 4.1, 4.2
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 and CQC. (P) (I)	DNQ	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 meeting take place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C144	Audit of compliance with policies and procedures in line with approved plan co-ordinated through the quality governance team in line with Trust agreed priorities. (P, N, I).	DNQ	4.1, 4.2, 4.3
C145	Service user survey results reported to Quality and Safety Committee and Trust Board and action plans produced as applicable. (P, N, I).	DNQ	2.1, 2.4, 4.1, 4.2, 4.3
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).	DFR/COO	4.1, 4.2, 5.1, 6.3
C149	Operational structure includes oversight of pathways across the organisation that reach into place and neighbourhoods. Stakeholder collaboration continues as part of this process. (P, N, I).	DSC/COO	4.2
C190	The Trust has been fully engaged in place-based plans including the planning process. (P,I,E)	DSC	4.2
C193	Trust plans are aligned to operational and quality plans through place governance structures (P,I,E)	DNQ	4.2
C181	Operational and care group structures are in place to reflect care pathways (I, P)	COO	4.1, 4.2
C202	Trust clinical strategy in place approved by Trust Board in March 2025. (P,I,)	CMO/DNQ/COO	4.1, 4.2

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Older people's transformation -following approval, a new governance structure has been established to oversee the implementation phase of work. This is being led by a SWYPFT governance group which oversees the implementation work-strands and reports into the senior governance structures. The start date for capital works has been delayed in order to ensure compliance with new fire safety legislation. The Trust is expecting the gross maximum price from the contractor in September 2026 which will then go to Trust Board for approval.	October 2026	CMO

Assurance (strategic risk 4.2 - Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.)				
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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
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	1.2, 2.3, 3.1, 4.1, 4.2, 5.1, 6.3
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	2.1, 2.4, 4.1, 4.2, 4.3, 5.1
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, EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	EMT	2.4, 4.1, 4.2, 4.3, 5.2, 6.3
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality assurance system. 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 presented to the Members Council. Quality walkarounds programme in place for 2025/26 are reported into QSC. (P, N) (E)	DNQ	2.4, 4.1, 4.2
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. (P, N) (I).	DFR/DSC	4.1, 4.2, 5.1, 5.2, 6.3
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	4.1, 4.2
A20	Service user experience and waiting time reports are reviewed by QSC, and MHA. CQC Mental Health Act visits occur on a regular basis and are reported into QSC and MHAC.	Patient experience reports and integrated performance report (IPR) data on access and waiting times included in the new Equality and Inclusion interactive tool. (P) (I)	DNQ	1.1, 2.1, 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	2.3, 4.2, 4.3, 5.1, 5.2, 6.3
A22	All red and amber incidents from across the organisation are reviewed through the Patient Safety Oversight Group including the undertaking of proportionate investigations. In addition, all incidents relating to protected characteristics or staffing, irrespective of grading are also reviewed. Dissemination of lessons learnt and good clinical practice across the organisation.	Process in place through the quarterly patient safety oversight reporting including lessons learned to OMG, EMT, Quality and Safety Committee and Trust Board. (P, N) (I)	DNQ	2.3, 4.2
A23	Benchmarking of services (including model health system) and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment and Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR	4.2, 5.1, 5.2, 6.3
A24	Investment Appraisal report – covers bids and tender 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)	DFR	2.1, 4.2, 5.1, 6.3
A26	Trust people strategy in place and to be rolled out in 2026.	Update reports into EMT and People and Remuneration Committee. (P) (I)	CPO	4.2
A119	Longer term planning process	Update reports into EMT and FIP (P,N,I,E)	DFR	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

Strategic risk 4.3 (Strategic Aim 2: Best we can be - Best partner)
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 4.3 - 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)			
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
C07	Director leads in place to support revised service offer through priority programmes and work streams, overseen by EMT. (I)	DSC	4.1, 4.2, 4.3
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DSC/CEO	2.4, 4.1, 4.3
C15	Equality, Diversity and Inclusion 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, 1.2, 2.1, 2.4, 3.1, 4.1, 4.3

Controls (strategic risk 4.3 - 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)			
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
C23	Strategic priorities and underpinning programmes supported through robust programme and change management approaches and in line with the Integrated Change Framework. Extensive engagement from communities has been undertaken in the recent strategy refresh and is vital in helping the development of the underpinning programmes (I)	DSC	4.3
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	4.3
C25	Participate in national benchmarking activity for mental and community health services and act on areas of significant variance. (I)	DFR	4.3
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 voluntary and community sector (VCS) partners in each of our places to strengthen insight involvement and co-production (I, E) using 'Connecting People'	DSC	1.1, 2.1, 4.3
C27	Governors supported to involve people at a local level. Toolkit in place. (I, E)	DSC	2.1, 4.3
C28	Toolkit in place to capture patient stories. (I)	DSC	2.1, 4.3
C29	Process in place to demonstrate compliance with the public sector equality duty. (I)	DSC	4.3
C30	Process to review and assure Equality Impact Assessments (EIAs)with report to Quality and Safety Committee (I)	DSC	1.1, 2.1, 4.3
C31	Joint Service and Needs Assessment (JSNA) data reflected in all service EIAs. (I)	DSC	2.1, 4.3
C32	Joint Service and Needs Assessment (JSNA) data used to identify involvement approaches. (I)	DSC	4.3
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	1.1, 4.3
C34	Provision of information, leaflets and posters which meet the Accessible Information Standard. (I)	DSC	1.1, 4.3
C35	Translation and interpretation service in place as well as inequalities interactive tool. (I)	DSC	1.1, 2.1, 4.3
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. (P,I,E)	CMO	4.2, 4.3
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	4.1, 4.2, 4.3, 5.2
C127	Communication leads network established in places and across ICSs (P, I, E)	DSC	4.3
C128	Senior level representation at Health and Wellbeing Boards in each place. (P, E)	DSC	4.3
C129	Ongoing meetings with Healthwatch organisations in each place. (P, I, E)	DSC	4.3
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	4.3
C131	Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) process integrated and used at gateways in transformation and change programmes. (P, I)	DSC	1.1, 4.3
C138	Trust wide Equality Impact Assessment together with the inequalities data developing systemic analysis and plans to address Trust inequality priorities (P, I)	DSC	1.1, 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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
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	2.2, 4.3
C144	Audit of compliance with policies and procedures in line with approved plan co-ordinated through the quality governance team in line with Trust agreed priorities. (P, N, I, E).	DNQ	4.1, 4.2, 4.3
C145	Service user survey results reported to Quality and Safety Committee and Trust Board and action plans produced as applicable. (P, N, I).	DNQ	2.1, 2.4, 4.1, 4.2, 4.3
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	4.3
C163	Approach to capturing insight and service user feedback from a range of stakeholders in place (insight report) (P, E, I)	DSC	4.3
C164	The EIA tools have been created, including the Trust wide EIA and literature (P, I)	DSC	4.3
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	4.3
C171	Health Intelligence support role in place (I, P)	DSC	4.3
C184	Targeted programmes are being delivered through linked charities (I, E, P)	DSC	4.3
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	4.3
C203	The process through which the Trust engaged and consulted internally and external stakeholders and members of the public to inform the older people's inpatient service transformation programme and Trust strategy refresh. (P, N, I, E)	CMO	4.3
C209	The Trust will continue to roll out the enhanced equality and diversity training to all senior staff identified as essential to job role on a twice-yearly basis. This is being led by the equality and involvement team. (P, I)	DSC	4.3
C260	Priority programmes approved by Trust Board April 2025 (P, I)	DSC	2.1, 4.3
C242	Trust communications approach for health inequalities priorities in place in line with the public sector equality duty. (P,I,E)	DSC	4.3
C263	Operational equality dashboards now in place (P,N,I)	DSC	1.1, 2.2, 4.3
C264	Patient carer race equality framework (PCREF) implementation plan in place (P,N,I, E)	DSC	1.1, 2.2, 4.3
C265	Health inequalities toolkit in place to reduce barriers to access to services (P,N, I, E)	DSC	1.1, 2.1, 2.3, 4.3
C266	Hearing impaired and deaf toolkit in place to reduce barriers to access to services (P,N ,I,E)	DSC	1.1, 2.1, 2.3, 4.3

Controls (strategic risk 4.3 - 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)			
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
C268	Accessible information standard updates are reported to Audit Committee (P,N,I)	DSC	4.3
C276	An equality interactive tool dashboard is now in place which provides insight to ensure improvements and service change. (P,N,I,E)	DSC	1.1, 1.2, 2.1, 2.3, 4.3

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

Assurance (strategic risk 4.3 - 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)				
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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
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	2.1, 2.4, 4.1, 4.2, 4.3, 5.1
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, EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	EMT	2.4, 4.1, 4.2, 4.3, 5.2, 6.3
A20	Service user experience and waiting time reports are reviewed by QSC, and MHA. CQC Mental Health Act visits occur on a regular basis and are reported into QSC and MHAC.	Patient experience reports and integrated performance report (IPR) data on access and waiting times included in the new Equality and Inclusion interactive tool. (P) (I)	DNQ	1.1, 2.1, 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	2.3, 4.2, 4.3, 5.1, 5.2, 6.3
A43	Waiting list reporting including health inequalities data	Reported in OMG quarterly and improving access to care group quarterly (P, N, I)	DSC	2.2, 2.4, 4.3
A91	West Yorkshire older people's mental health work stream steering groups provides updates	Regular updates from the steering group are presented to West Yorkshire mental health learning disability and autism partnership board (P/N/E)	CMO	4.3
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	4.3
A111	PCREF compliance reports	Quarterly national reports to EMT, QSC and NHSE (P,N,I,E)	DSC	1.1, 2.1, 4.3
A114	Accessible information standard updates	Bi-annual reporting to the Audit Committee (P,N,I)	DSC	4.3
A117	EDI dashboard	Updates on the dashboard will be presented to each Quality and Safety Committee meeting (P,N,I)	DSC/DFR	1.1, 1.2, 2.1, 2.4, 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

Strategic risk 4.4 (Strategic Aim 2: Best we can be - Best partner)	
Wider demand and finance pressures result in an insufficient focus on environmental sustainability meaning the Trust does not achieve its national net zero targets.	

Controls (strategic risk 4.4 - Wider demand and finance pressures result in an insufficient focus on environmental sustainability meaning the Trust does not achieve its national net zero targets.)			
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
C222	Trust sustainability and responsibility strategy (SRS) in place with annual reporting process to Trust Board (I, E, P)	DSC	4.4
C223	Trust green plan in place (renewed September 2025) and integrated into Trust sustainability strategy (I, E, P)	DFR/DSC	4.4
C224	Carbon impact (tonnes CO2) from business miles is included in the integrated performance report (IPR) (P, N, I, E)	DFR	4.4
C225	Sustainability and Carbon Neutral is included in annual capital programmes	DFR	4.4
C226	Oversight of the Trust sustainability strategy by Transformation, Innovation and Sustainability Committee (P, I)	DSC	4.4

Controls (strategic risk 4.4 - Wider demand and finance pressures result in an insufficient focus on environmental sustainability meaning the Trust does not achieve its national net zero targets.)			
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
C227	Green Champion Network in place across the Trust (P, I, E)	DSC	4.4
C228	Sustainability metrics monitored via Trust National Greener NHS data, submission (P, N, I, E)	DSC	4.4
C229	Trust lease car scheme ensures use of purchase or lease vehicles that are ultra-low emissions vehicles or zero emission vehicles	CPO	4.4
C230	Non-Executive Director Champion ensures objective oversight of SRS strategy	DSC	4.4

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Following presentation of the sustainability annual report at Trust Board it was identified that Trust gas usage had increased in year 24-25. This increase is being investigated to establish if the increase is as a result of billing changes or an actual increase in gas usage. It has been identified that there are different billing methods by Trust site, many of which are estimates and at year end actual meter readings show more usage than estimated resulting in additional billing. Work is ongoing to establish if there is a direct correlation to usage.	October 2026	DFR/DSC

Assurance (strategic risk 4.4 - Wider demand and finance pressures result in an insufficient focus on environmental sustainability meaning the Trust does not achieve its national net zero targets.)				
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)
A87	Annual reporting against the Sustainability and Responsibility Strategy	Annual reporting goes to EMT, Equality, Inclusion and Involvement Committee and Trust Board (P,N,I,E)	DSC	4.4
A98	Carbon impact (tonnes CO2)	Included in monthly integrated performance reports to Trust Board and published on the Trust website (P, N, I, E)	DFR	4.4
A99	Bi-annual sustainability updates	Bi-annual reporting will report into Transformation, Innovation and Sustainability Committee (P, N, I)	DSC	4.4
A100	Reporting against National Greener NHS data,	Report into Transformation, Innovation and Sustainability Committee (P, N, I, E)	DSC	4.4

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 5.1 (Strategic Aim 2: Best we can be - Best value)	
Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.	

Controls (strategic risk 5.1 - Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.)			
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	2.4, 4.1, 4.2, 5.1
C79	Finance managers aligned to Care Groups acting as integral part of local management teams. (I)	DFR	5.1
C80	Standardised process in place for producing business cases supporting full benefits realisation. (I)	DFR	5.1
C81	Standing Orders, Standing Financial Instructions, Scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities. (I)	DFR	5.1
C82	Annual financial planning process, value for money programmes VFMP), Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) process. (I)	DFR/ DNQ/ DSC	5.1
C83	Financial control and financial reporting processes. (I)	DFR	5.1
C84	Regular financial reviews at Executive Management Team (EMT). (I)	DFR	5.1
C85	Patient level costing in place, in addition a process to identify loss making services is in place and scrutinised as part of the value for money group. (P, N, E, I)	DFR	5.1
C86	Weekly Operational Management Group (OMG) chaired by Chief Operating Officer providing overview of operational delivery, services / resources, identifying and mitigating pressures / risks. The OMG workplan has been aligned to focus on the key areas of operational delivery and finance. (I)	COO	5.1, 6.3
C87	Finance, Investment and Performance Committee (FIP) chaired by a non-executive director with recent and relevant financial experience. (I)	DFR	5.1
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	5.1

Controls (strategic risk 5.1 - Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.)				
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)	
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3	
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, E).	DFR/COO	4.1, 4.2, 5.1, 6.3	
C197	The Trust is aligned to the NHSE framework for enhanced financial controls. (P, N,I, E)	DFR	5.1	
C206	Monthly meeting between the DOF and COO with all care groups to review finance and performance. (P, N, I)	DFR/COO	5.1	
C210	Vacancy oversight procedures are in place with a weekly panel chaired by the Interim Chief People Officer (P, N, I)	DFR	3.1, 4.1, 5.1	
C214	Revised arrangements for VFMP to include executive directors as SROs reporting into CEO on a regular basis. (P, N,I)	All	5.1	
C219	Approval limits reduced to aid additional scrutiny of non-pay expenditure. (P, N, I)	DFR	5.1	
C284	Electronic Prescribing Medicines Administration (EPMA) digital system in place in place to support safe and efficient prescribing and administration (P, I)	CMO	5.1,5.2	

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Trust has previously not fully achieved its recurrent VFMP (Linked to ORR risk 1076). The Trust needs to continue to fully develop recurrent VFM pipeline including QIA and consider the impact of not having enough recurrent schemes in 2026/27. 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 VFM at every meeting. Review further October 2026	October 2026	All execs

Assurance (strategic risk 5.1 - Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.)				
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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
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	1.2, 2.3, 3.1, 4.1, 4.2, 5.1, 6.3
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	2.1, 2.4, 4.1, 4.2, 4.3, 5.1
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. (P, N) (I).	DFR/DSC	4.1, 4.2, 5.1, 5.2, 6.3
A14	Mental Health Investment Standard income and reporting of performance.	Mental Health Investment Standard agreed with Wakefield, Calderdale, Kirklees, and Barnsley for 26-27 and is reported into FIP. (P) (I) (E).	DFR	4.1, 5.1
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	2.3, 4.2, 4.3, 5.1, 5.2, 6.3
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment and Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any required actions are identified. (P, N) (I, E)	DFR	4.2, 5.1, 5.2, 6.3
A24	Investment Appraisal report – covers bids and tender 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)	DFR	2.1, 4.2, 5.1, 6.3
A50	The vacancy oversight group has been established to consider all vacancies across the Trust taking into account finance, quality and safety	Weekly meetings chaired by interim chief people officer (P,N, I)	DFR	3.1, 4.1, 5.1
A58	Monthly focus of key financial and performance issues including VFM delivery, out of area beds and agency costs at Operational Management Group (OMG).	Standing agenda item for OMG (P, N) (I)	COO	5.1, 6.3
A95	Care closer to home report.	Reported into every EMT meeting (I, E, P, N)	COO	2.4, 5.1
A121	Electronic Prescribing Medicines Administration (EPMA) digital system (internal inpatient-implemented) and Electronic Prescription Service (EPS) (external - implementation phase)	Quarterly reports into digital tag (P,I,E)	CMO	5.1, 5.2
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

Assurance (strategic risk 5.1 - Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.)					
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)
There was a plan to reduce bank and agency staff spend throughout 2025/26.Reduction in agency use was achieved in line with plan, but bank use was more challenging and planned reductions were not delivered. The temporary staffing group continue to review this position on a fortnightly basis with an action plan in place to address the gap. The gap will remain throughout financial year 2026/27 but will be subject to quarterly review to assess delivery. Reviewed in July 2026 and to review further October 2026.		October 2026			COO/CPO/DFR

Strategic risk 5.2 (Strategic Aim 2: Best we can be - Best value)
Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision

Controls (strategic risk 5.2 - Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision)				
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. (P, I)	DSC/COO		5.2
C44	Digital strategy in place with quarterly report to Executive Management Team (EMT) and bi-annual reports to Trust Board. (P, I)	DFR		2.2, 5.2
C61	Web based platform in place with over 2,000 members providing digital opportunities to share, innovate, collaborate and improve. (I)	DSC		2.3, 5.2
C95	Director portfolios clearly identify director level leadership for strategic priorities. (P), (I)	CEO		5.2, 6.3
C96	Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (P), (I)	DSC		5.2, 6.3
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		5.2, 6.3
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/DSC		5.2, 6.3
C99	Robust prioritisation process developed and used which takes into account multiple factors including capacity and resources. Process used to set 202/27 priorities and approved by Trust Board. (P), (I)	DSC		5.2, 6.3
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		5.2, 6.3
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		4.1, 4.2, 4.3, 5.2
C134	Workforce strategic groups established and are being reviewed alongside the new operational model and people directorate structure. (P, I)	DHR		5.2
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		1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C151	Integrated Change Framework includes escalation process for issues / risks to be brought to the attention of the Executive Management Team. (P, I)	DSC		5.2, 6.3
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		5.2, 6.3
C169	Digital Strategy and Innovation Group meets quarterly to assess potential new and emerging digital opportunities (P, I)	DSC		5.2
C200	Creativity and creative practitioner roles have been implemented in inpatient services with positive outcomes. (I, P)	DSC		5.2
C274	Digital Dictation is now in place across the Trust (P, I)	DFR		5.2
C284	Electronic Prescribing Medicines Administration (EPMA) digital system in place in place to support safe and efficient prescribing and administration (P,I)	CMO		5.1, 5.2

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
In line with the NHS 10-year plan, digital infrastructure and innovation need to be considered as part of the Trusts estates strategy and planning, service transformation and Trust planning as the Trust progresses into 2026/27 and beyond. These matters have been considered as part of the planning process for 2026/267 and we continue to strive for the best balance between expenditure in physical estates structure and digital infrastructure. Review further in October 2026.	October 2026	DSC/DFR

Assurance (strategic risk 5.2 - Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision)				
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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2

Assurance (strategic risk 5.2 - Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision)				
Assurance ref	Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)	Guidance / reports	Director lead	Strategic risk(s)
A09	Transformation 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, EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	EMT	2.4, 4.1, 4.2, 4.3, 5.2, 6.3
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. (P, N) (I).	DFR/DSC	4.1, 4.2, 5.1, 5.2, 6.3
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	2.3, 4.2, 4.3, 5.1, 5.2, 6.3
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment and Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR/COO	4.2, 5.1, 5.2, 6.3
A121	Electronic Prescribing Medicines Administration (EPMA) digital system (internal inpatient-implemented) and Electronic Prescription Service (EPS) (external - implementation phase)	Quarterly reports into digital tag (P,I,E)	CMO	5.1, 5.2

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 6.1 (Strategic Aim 3: We will be ambitious) Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care.

Controls (strategic risk 6.1 - Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care.)			
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
C231	Executive Director Lead for Commissioning (Director of Finance and Resources) (P, N, I)	DFR	6.1
C232	Specialised Mental Health Learning Disability and Autism Commissioning Hubs established in West Yorkshire and South Yorkshire, and manage commissioning functions of the specialised provided collaboratives the Trust leads (adult secure and FCAMHS) (P, N, E)	DFR	6.1
C233	South Yorkshire Adult Secure Provider Collaborative Oversight Group in place to oversee the work of the South Yorkshire Specialised MHLDA Commissioning Hub. (P, N, E)	DFR	6.1
C234	West Yorkshire Provider Collaborative Board in place to oversee the work of the West Yorkshire Adult Secure Provider Collaborative (P, N, E)	DFR	6.1
C235	Commissioning Hubs have dedicated resource for quality oversight (P, E)	DFR	6.1
C236	Annual programme of commissioner quality monitoring visits (P, N, E)	DFR	6.1
C237	Commissioning Committee in place, with clear terms of reference, to provide oversight of Trust's commissioning activities (P, I)	DFR	6.1
C238	Regular AAA report from Commissioning Committee to Board ensures oversight of Trust's Commissioning activity at Board level (P, N, I, E)	DFR	6.1
C239	Established performance reporting arrangements in place to oversee operations (referrals, admissions, occupancy and demographics), finance, contracting and quality (P, N, I, E)	DFR	6.1
C240	Commissioning intentions overseen by Commissioning Committee (P, N, I, E)	DFR	6.1
C241	Stakeholder map in place which identifies key Trust representatives to oversee developments in each place. (P, I, E)	DSC	6.1, 6.2
C243	Clinical escalation processes in place (P, I)	CMO	6.1
C262	Achievement of Level 1 of the Lead Provider Collaborative Quality Maturity Framework (P, I, E)	DFR	6.1
C263	Escalation processes effectively used to resolve discharge delays in adult secure pathways (P, N, I, E)	DFR	6.1
C287	West Yorkshire and South Yorkshire commissioning hub input into the commissioning committee have been aligned (P, I, E)	DFR	6.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Partnership working with ICB at place level and regional level continues to address delays in discharge impacting on adult secure patient care and patient flow. Ongoing dialogue continues with ICB commissioners. Contract expiry is March 2027 and at this time we are awaiting confirmation of NHS England's future intentions. Review further in October 2026.	October 2026	DFR/CMO

Assurance (strategic risk 6.1 - Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care.)				
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)
A101	Annual commissioning intentions for West Yorkshire Adult Secure Provider Collaborative and South Yorkshire and Bassetlaw Adult Secure Provider Collaborative	Reports provided to Commissioning Committee and for approval by Trust Board following scrutiny by Provider Collaborative Board/Oversight Group. (P, I, E)	DFR	6.1
A102	Commissioner quality monitoring feedback monitored and scrutinised through Provider Collaborative Board/Oversight Group, and clear plans in place with providers to address any quality issues	Reports provided to each Commissioning Committee meeting. (P, N, I, E)	DFR	6.1
A103	Performance report to Commissioning Committee provide assurances on quality, contracting and finance and identify emerging issues and actions to be taken.	Reports provided to each Commissioning Committee meeting. (P, N, I, E)	DFR	6.1

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

Strategic Risk 6.2 (Strategic Aim 3: We will be ambitious)
System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience.

Controls (strategic risk 6.2 - System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience.)			
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
C241	Stakeholder map in place which identifies key Trust representatives to oversee developments in each place. (P, I, E)	DSC	6.1, 6.2
C245	Framework in place to ensure feedback from stakeholders, both internal and external (including feedback loop) is collected, responded to, analysed and acted upon. (P,N,I,E)	DSC	6.1
C246	Senior/Executive representation at system/place meetings. (P,N,I, E)	CEO/DSC	6.1
C247	Trust Coordination Meeting in place to ensure feedback from system/place meetings and oversight of the Trust contribution.(P,N,I, E)	CEO	6.1
C248	Senior level representation at ICB Board/Committees and Health and Wellbeing Boards in each place. (P,N,I,E)	CEO/DSC	6.1
C249	Senior representation at South Yorkshire MHLDA Partnership Board and West Yorkshire MHLDA Partnership Board (P,N,I, E)	CEO	6.1
C250	Full engagement in West Yorkshire Committees in Common (P,N,I, E)	CEO	6.1
C251	Trust Board strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives. (P,I)	CEO/DSC	6.1
C252	Formal contract negotiation meetings with integrated care boards, NHSE and provider collaboratives underpinned by national agreements to support strategic review of services and promotion of the Trust's role. (P,N,I, E)	DFR	6.1
C253	Agreed Trust priority programmes ensure time and resource focused on key areas, with progress reported to EMT and Trust Board through the Integrated Performance Report (IPR), and report on progress against the Trust Strategy. (P,I)	DSC	6.1
C254	Annual business planning process (P,N,I, E)	DFR/DSC	6.1
C255	Partnership arrangements established within each place. (P,N,I, E)	DSC	6.1
C256	Established Members' Council, with governor representation from each Place supports engagement with our communities and promotion of the Trust's role. (P,N,I, E)	DSC	6.1
C257	Community Connectors support engagement with our communities, and promotion of the Trust role, (P,N,I, E)	DSC	6.1
C258	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (P,N,I, E)	DSC	6.1
C259	Executive Directors act as SROs for some system-wide work programmes. (P,N,I, E)	CEO	6.1

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

Assurance (strategic risk 6.2 - System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience.)				
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)
A106	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Regular reports to EMT and Trust Board through the IPR (P, N, I, E)	DSC	6.2
A107	Strong and robust partnership working with local partners, working through integrated partnerships in Barnsley, Calderdale, Kirklees and Wakefield	Regular update and reporting to EMT and Trust Board (P, N, I, E)	DSC	6.2
A108	Lead role in system-wide work programmes and developments	Reports on progress presented to EMT and Trust Board as required. (P, N, I, E)	DSC	6.2
A109	Report on progress against Trust Strategy to EMT and Board evidences progress as planned against strategic aims	Regular update and reporting to EMT and Trust Board (P, N, I)	DSC	6.2

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 6.3 (Strategic Aim 3: We will be ambitious)
Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions

Controls (strategic risk 6.3 - Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions)			
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	5.1, 6.3
C95	Director portfolios clearly identify director level leadership for strategic priorities. (P), (I)	CEO	5.2, 6.3
C96	Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (P), (I)	DSC	5.2, 6.3
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	5.2, 6.3
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	5.2, 6.3
C99	Robust prioritisation process developed and used which takes into account multiple factors including capacity and resources. Process used to set 2025-26 priorities. (P), (I)	DSC	5.2, 6.3
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	5.2, 6.3
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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
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, E).	DFR/COO	4.1, 4.2, 5.1, 6.3
C151	Integrated Change Framework includes escalation process for issues / risks to be brought to the attention of the Executive Management Team. (P, I)	DSC	5.2, 6.3
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	5.2, 6.3
C215	The Chief Operating Officer is the Senior Responsible Owner for Cheswold Park Hospital transition into the Trust. (P,I,E)	COO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C217	Cheswold Park Hospital planned integration has been completed and is now part of BAU in the forensic care group. (P,I)	COO/DNQ/CMO	6.3
C218	Cheswold Park Hospital has a clinical and managerial structure in place as part of the forensic care group. (P,I)	DNQ/COO/CMO	6.3
C270	People strategy in place. Approved by Trust Board December 2025 (P, I, E)	CPO	1.1, 1.2, 3.1, 6.3
Gaps in control – what do we need to do to address these and by when?		Date	Director lead

Controls (strategic risk 6.3 - Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions)				
Control ref	Systems and processes – what are we currently doing about the strategic risk?		Director lead	Strategic risk(s)
	The Trust's workforce plan remains a gap and needs to be developed in order to demonstrate the required skills needed to efficiently and effectively provide commissioned services. This plan needs to be within the financial envelope and meet the clinical strategy. The initial workforce plans for care groups and other services have been developed to support the annual plan submission in February 2026. Establishment reviews are required to ensure the Trust has the right staff in the right roles in the right numbers with recruitment and training plans in place to support them.		October 2026	CPO/COO/DNQ/CMO

Assurance (strategic risk 6.3 - Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions)				
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	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
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	1.2, 2.3, 3.1, 4.1, 4.2, 5.1, 6.3
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	2.4, 4.1, 4.2, 4.3, 5.2, 6.3
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. (P, N) (I).	DFR/DSC	4.1, 4.2, 5.1, 5.2, 6.3
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	2.3, 4.2, 4.3, 5.1, 5.2, 6.3
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment and Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR/COO	4.2, 5.1, 5.2, 6.3
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)	DFR	2.1, 4.2, 5.1, 6.3
A58	Monthly focus of key financial issues including VFM delivery, out of area beds and agency costs at Operational Management Group. (OMG).	Standing agenda item for OMG and Finance, Investment and Performance Committee. (P, N) (I)	COO/DFR	5.1, 6.3

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

Appendix 1 Q1 BAF risks risk appetite ratings including risk appetite domains

Assurance ratings:

Substantial (S)	The assurances noted on the current BAF demonstrate that the controls are effectively managing the risk/cause.
Adequate (A)	Assurances are in place and no material issues have been identified with the effectiveness of controls. Assurances are reflecting the need to fully embed the controls.
Limited (L)	Levels of assurance noted on the current BAF do not demonstrate that the controls in place are not effectively managing the risk/cause. Action is required to address gaps in control and assurance.
None (N)	No assurance can be taken or is available to demonstrate that the current controls are working. Action is required to address/improve controls and provide assurance.

Risk Likelihood ratings:

Rare (R)	This will probably never happen/recur.
Unlikely (U)	Not expected to happen/recur but is possible.
Possible (P)	Might happen/recur occasionally.
Likely (L)	Will probably happen/recur but is not a persistent issue.
Almost certain (AC)	Will undoubtably happen/recur, possibly frequently.

Risk Appetite Application

Risk type and description	BAF Risk Appetite Assurance Score Range		BAF Risk Appetite Likelihood Score Range	
Clinical Safety and Quality (CSQR) risks: Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce	Substantial	 Substantial (S) Adequate (A)	Rare	 Unlikely
Business (BR) risks: Risks which might affect the Trust's ability to achieve its plans or damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation.	Adequate		Possible	
Compliance (CR) risks: Failure to comply with its licence, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation.	Substantial	 Substantial (S) Adequate (A)	Rare	 Unlikely
Financial (FR) risks: Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.	Substantial	 Substantial (S) Adequate (A)	Rare	 Unlikely
Technology (TR) risks: Risks arising from technology not delivering the expected outcomes due to inadequate or deficient system/process development and performance or inadequate resilience.	Adequate		Possible	
Information (IR) risks: Risks arising from a failure to produce robust, suitable and appropriate data/information and to exploit data/information to its full potential.	Substantial	 Substantial (S) Adequate (A)	Rare	 Unlikely
Security (SR) risks: Risks arising from a failure to prevent unauthorised and/or inappropriate access to key Trust systems and assets, including people, platforms, information and resources. This encompasses the subset of cyber security.	Substantial	 Substantial (S) Adequate (A)	Rare	 Unlikely

Strategic Aim	Strategic risk	25/26 Q4 rating		Risk appetite category	Category risk appetite for assurance	Category risk appetite for likelihood	Inside or outside of risk appetite based on proposed Q1 rating
		Assurance	Likelihood				
1. We will live our values	1.1 Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience. (DSC)	Adequate	Likely	Clinical Safety and Quality risks: Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce.	Substantial-Substantial/Adequate	Rare-Unlikely	Outside of risk appetite for both assurance and likelihood

Appendix 1 Q1 BAF risks risk appetite ratings including risk appetite domains

Strategic Aim	Strategic risk	25/26 Q4 rating		Risk appetite category	Category risk appetite for assurance	Category risk appetite for likelihood	Inside or outside of risk appetite based on proposed Q1 rating
		Assurance	Likelihood				
				Rationale - This risk category includes ensuring that equality, involvement and inclusion is central to everything the Trust does to reduce inequalities, tackle stigma and eliminate discrimination.			
	1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience. (CPO)	Adequate	Possible	<u>Clinical Safety and Quality risks:</u> Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce. Rationale - This risk category includes ensuring that equality, involvement and inclusion is central to everything the Trust does to reduce inequalities, tackle stigma and eliminate discrimination.	Substantial-Substantial/Adequate	Rare-Unlikely	Outside of risk appetite for both assurance and likelihood
2.Be the best we can be: Best Quality	2.1 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.	Adequate	Unlikely	<u>Clinical Safety and Quality risks:</u> Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce. Rationale - This risk category includes ensuring that equality, involvement and inclusion is central to everything the Trust does to reduce inequalities, tackle stigma and eliminate discrimination.	Substantial-Substantial/Adequate	Rare-Unlikely	Outside risk appetite for assurance Inside risk appetite for likelihood
	2.2 The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.	Adequate	Possible	<u>Information risks:</u> Risks arising from a failure to produce robust, suitable and appropriate data/information and to exploit data/information to its full potential. Rationale - This risk category includes failure to understand and analyse Trust data results in a poor understanding of the communities we serve impacting on service provision.	Substantial-Substantial/Adequate	Rare-Unlikely	Outside of risk appetite for both assurance and likelihood
	2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents.	Substantial	Possible	<u>Clinical Safety and Quality risks:</u> Risks arising as a result of clinical or	Substantial-Substantial/Adequate	Rare-Unlikely	Inside risk appetite for assurance

Appendix 1 Q1 BAF risks risk appetite ratings including risk appetite domains

Strategic Aim	Strategic risk	25/26		Risk appetite category	Category risk appetite for assurance	Category risk appetite for likelihood	Inside or outside of risk appetite based on proposed Q1 rating
		Q4 rating					
		Assurance	Likelihood				
				healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce. Rationale - This risk category includes risks to meeting recognised clinical and/or environmental standards e.g. FIRM (Formulation informed risk management), record keeping, infection prevention and control, NICE guidance and compliance with Patient Safety Incident Response Framework.			Outside risk appetite for likelihood
	2.4 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.	Adequate	Likely	<u>Clinical Safety and Quality risks:</u> Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce. Rationale - This risk category includes risks to meeting recognised clinical and/or environmental standards e.g. FIRM (Formulation informed risk management), record keeping, infection prevention and control, NICE guidance and compliance with Patient Safety Incident Response Framework.	Substantial-Substantial/Adequate	Rare-Unlikely	Outside of risk appetite for both assurance and likelihood
	3.1 Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.	Adequate	Unlikely	<u>Clinical Safety and Quality risks:</u> Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce. Rationale - This risk category includes workforce risk - inability to attract and retain appropriately qualified staff to deliver Trust plans.	Substantial-Substantial/Adequate	Rare-Unlikely	Outside risk appetite for assurance Inside risk appetite for likelihood
2.Be the best we can be: Best	4.1 Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place	Adequate	Likely	Financial risks: Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.	Substantial-Substantial/Adequate	Rare-Unlikely	Outside of risk appetite for both assurance and likelihood

Appendix 1 Q1 BAF risks risk appetite ratings including risk appetite domains

Strategic Aim	Strategic risk	25/26 Q4 rating		Risk appetite category	Category risk appetite for assurance	Category risk appetite for likelihood	Inside or outside of risk appetite based on proposed Q1 rating
		Assurance	Likelihood				
				Rationale - This risk category includes risk of wider financial system pressures on the Trust ability to deliver its own operational and financial plan.			
	4.2 Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.	Adequate	Possible	<u>Financial risks:</u> Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income. Rationale - This risk category includes risk of impact of wider financial system pressures on the Trust's ability to deliver its own operational and financial plan.	Substantial-Substantial/Adequate	Rare-Unlikely	Outside of risk appetite for both assurance and likelihood
	4.3 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	Adequate	Possible	<u>Business risks:</u> Risks which might affect the Trust's ability to achieve its plans or damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation. Rationale – This risk category includes developing partnerships that enhance the Trust's current and future services.	Adequate	Possible	Inside risk appetite for both assurance and likelihood
	4.4 Wider demand and finance pressures result in an insufficient focus on environmental sustainability meaning the Trust does not achieve its national net zero targets.	Adequate	Possible	<u>Compliance risks:</u> Failure to comply with its licence, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation. Rationale – this risk category includes delivering the Trust Social Responsibility and Sustainability strategy in line with the NHS Long Term and Green plans.	Substantial-Substantial/Adequate	Rare-Unlikely	Outside of risk appetite for both assurance and likelihood
2. Be the best we can be: Best Value	5.1 Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.	Adequate	Possible	<u>Business risks:</u> Risks which might affect the Trust's ability to achieve its plans or damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation. Rationale – This risk category includes missed opportunities; the Trust fails to identify opportunities for growth impacting on business sustainability and development.	Adequate	Possible	Inside risk appetite for both assurance and likelihood

Appendix 1 Q1 BAF risks risk appetite ratings including risk appetite domains

Strategic Aim	Strategic risk	25/26 Q4 rating		Risk appetite category	Category risk appetite for assurance	Category risk appetite for likelihood	Inside or outside of risk appetite based on proposed Q1 rating
		Assurance	Likelihood				
	5.2 Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision.	Adequate	Possible	1. <u>Business risks</u>: Risks which might affect the Trust's ability to achieve its plans or damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation. Rationale – This risk category includes lack of appropriate Estates and Facilities structures and systems to deliver high quality, modern safe services. And/or 2. <u>Technology risks</u>: Risks arising from technology not delivering the expected outcomes due to inadequate or deficient system/process development and performance or inadequate resilience. Rationale – this risk category failure to utilise new technology effectively (including AI) reduces quality of service delivery. The risk appetite is the same for both Business and Technology risks.	Adequate	Possible	Inside risk appetite for both assurance and likelihood
3. We will be ambitious	6.1 Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care.	Adequate	Possible	<u>Business risks</u>: Risks which might affect the Trust's ability to achieve its plans or damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation. Rationale – This risk category includes decisions external to the Trust (e.g. decommissioning) impact on ability to deliver effective services	Adequate	Possible	Inside risk appetite for both assurance and likelihood
	6.2 System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on	Adequate	Possible	<u>Business risks</u>: Risks which might affect the Trust's ability to achieve its plans or damage to the Trust's public reputation which could impact on commissioners' decisions to	Adequate	Possible	Inside risk appetite for both assurance and likelihood

Appendix 1 Q1 BAF risks risk appetite ratings including risk appetite domains

Strategic Aim	Strategic risk			Risk appetite category	Category risk appetite for assurance	Category risk appetite for likelihood	Inside or outside of risk appetite based on proposed Q1 rating
		25/26					
		Q4 rating					
		Assurance	Likelihood				
	opportunities to provide high-quality joined-up care and positive staff experience.			place contracts with the organisation. Rationale – This risk category includes developing partnerships that enhance the Trust’s current and future services, and reputational risk, negative impact on perceptions of service users, staff, and the wider system, including commissioners and providers (in carrying out the role of lead/coordinating provider for services across West and/ or South Yorkshire), and the public.			
	6.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.	Adequate	Possible	Business risks: Risks which might affect the Trust’s ability to achieve its plans or damage to the Trust’s public reputation which could impact on commissioners’ decisions to place contracts with the organisation. Rationale – This risk category includes reputational risk, negative impact on perceptions of service users, staff, and the wider system, including commissioners and providers (in carrying out the role of lead/coordinating provider for services across West and/ or South Yorkshire), and the public.	Adequate	Possible	Inside risk appetite for both assurance and likelihood

**Trust Board
28 July 2026
Agenda item 10.2**

Private/Public paper:	Public		
Title:	Quarter 1 Corporate / Organisational Risk Register 2026/27		
Lead Director:	Dawn Lawson – Director of Strategy, Inclusion and Change/Deputy Chief Executive		
Mission/values:	The Organisational Risk Register (ORR) is part of the Trust’s governance arrangements and an integral element of the Trust’s system of internal control, supporting the Trust in meeting its mission and adhering to its values.		
Purpose:	The purpose of this paper is: • To provide assurance that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of key objectives, and that have controls and actions are 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 aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	References to the Board Assurance Framework are included in the Organisational Risk Register (ORR) where applicable.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	Trust Board members 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 Provider 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 (last report 28 April 2026) 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. The ORR was reviewed at EMT most recently on 9th July 2026.														
Executive summary:	Corporate / Organisational Risk Register The Corporate / Organisational Risk Register (ORR) provides Trust Board members with oversight of organisational risks that are significant in nature and have been escalated by the Executive Management Team (EMT). Meetings have taken place with all Executive Directors in May and June 2026 to review risks, controls and actions prior to reports being presented to Trust Board and Board Committees. Risks that could have an impact across the Trust are reported to the Executive Management Team (EMT) monthly as per the Risk Management Framework and a detailed review of the ORR took place at the EMT meeting on 9 July 2026. The discussion at EMT focused on whether changes to the Trust’s operating environment have impacted on risks. For example, the risk register was considered in the context of current mental health inpatient pressures. It involved a focused discussion of all risks. There was a focused discussion on emergent risks and the risk in relation to national nursing job profiles was noted. Future risk in relation to Consultant industrial action was discussed. It was agreed an emergent risk would be developed once more is understood. There was particular focus on risk in relation to Freedom to Speak Up and whether it would be appropriate to recommend a reduction in risk score- see below. We continue to ensure the Board Assurance Framework (BAF) and ORR are aligned to our strategy and plans, so that these act as an enabler to achieving our ambitions. The ORR is aligned to the Trust Strategy and the Trust’s three strategic aims as below: <table><tr><th colspan="3">Our Strategic Aims</th></tr><tr><td colspan="3">1. We will live our values</td></tr><tr><td rowspan="2">2. We will be the best we can be</td><td>Best Quality</td><td>Best Place to Work and Learn</td></tr><tr><td>Best Partner</td><td>Best Value</td></tr><tr><td colspan="3">3. We will be ambitious</td></tr></table> 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.	Our Strategic Aims			1. We will live our values			2. We will be the best we can be	Best Quality	Best Place to Work and Learn	Best Partner	Best Value	3. We will be ambitious		
Our Strategic Aims															
1. We will live our values															
2. We will be the best we can be	Best Quality	Best Place to Work and Learn													
	Best Partner	Best Value													
3. We will be ambitious															

Emergent risks

Following the received update to national nursing job profiles in June 2025, the Trust is progressing a mandated programme of work to ensure all nursing roles are supported by accurate job descriptions and have been evaluated using the new updated national profiles. An initial risk has been identified relating to the potential financial impact from changes to pay banding, which is currently assessed as “likely with moderate impact”.

Risk ID	Risk Owner	Description
1080	Director of Finance	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.

On 9 July 2026, EMT reviewed this risk and considered the proposal to change the risk appetite category from Strategic (8-12), which has been removed as part of the risk appetite refresh, to Security (1-6). Due to this change, it is proposed to reduce the risk level target from 10 to 6. On 14 July the Audit Committee were supportive of the move to the Security risk category and lower risk appetite.

Risk level: <15 Risks outside the risk appetite

Risk ID	Risk Owner	Description
1757	Director of Finance	Failure to maintain and monitor medical devices to the required standard in line with relevant legislation may lead to patient harm.

On 9 July 2026, EMT reviewed this risk and supported the proposal to change the risk appetite category from Clinical (1-6) to Compliance (1-6) as this risk wording relates to compliance with relevant legislation. If approved by Trust Board, the risk appetite score range remains the same at 1-6.

Risk ID	Risk Owner	Description
1689	Director of Strategy and Change	Risk that the Trust does not address health inequalities under its control in the provision of services potentially exacerbating existing health inequalities for our service users.

On 9 July 2026, EMT reviewed this risk and supported the proposal to transfer this risk to the Quality and Safety Committee (QSC) as QSC is now responsible for the health inequalities agenda following the step down of the equality, inclusion and involvement committee (EIIC).

Risk ID	Risk Owner	Description
852	Director of Finance	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.

On 9 July 2026, EMT reviewed this risk and supported the proposal to change the risk appetite category from Compliance (1-6) to the new Information category (1-6) as this risk is related to the effective use of data and information. If accepted, the risk appetite score range remains the same at 1-6.

Risk ID	Risk Owner	Description
1157	Chief People Officer	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 meet the needs of the population.

Following the closure of the Equality, Inclusion and Involvement Committee (EIIC), on 9 July 2026, EMT supported the proposal to transfer this risk to the People and Remuneration Committee (PRC) as this risk relates to the Trust workforce.

Risk ID	Risk Owner	Description
1839	Chief Operating Officer	Lack of provision across the system prevents transferring people that are clinically ready for discharge.

On 9 July 2026, EMT reviewed this risk and approved the proposal to change the risk appetite category from Strategic (8-12) which has been removed as part of the risk appetite refresh, to Clinical Safety and Quality category (1-6) due to the potential impact on new admissions due to delayed discharges from inpatient services. If accepted, the risk appetite score range will reduce to 1-6. Risk target score remains at 6 which is within the proposed new risk appetite.

Risk ID	Risk Owner	Description
1887	Director of Nursing and Quality	Risk that teams and individual members of staff do not feel confident that the Trust has a culture where 'Speaking Up' is encouraged; individuals are supportively heard; staff do not suffer personal detriment following reports; or receive feedback on action(s) taken which demonstrate listening and learning.

On 9 July 2026 EMT discussed the number of controls and work that continues to take place to mitigate this risk and promote ways for staff to "speak up" and considered the risk score, and whether it would be appropriate to recommend a reduction in risk score given the controls in place. Following discussion EMT recommended the risk score should remain at 9 at this time. The rationale for this is that the Trust does see some anonymous reporting in relation to Freedom to Speak Up (FTSU), and staff survey metrics indicate greater confidence in some groups over others in raising concerns. Work to understand levels of confidence and improve psychological safety of those raising concerns forms part of the Trust's FTSU action plan.

Risk level: Organisational level risks within the risk appetite

Risk ID	Risk Owner	Description
812	Director of strategy and change	Risk that place based or collaborative commissioning arrangements adversely impact on the quality and sustainability of Trust services.

On 9 July 2026, EMT reviewed this risk and approved the proposal to change the risk appetite category from Strategic (8-12) which has been removed as part of the risk appetite refresh, to the Business category (8-12) in line with the review risk appetite criteria. If accepted, the risk appetite score range will remain the same. It was noted that the current risk target score was outside of risk appetite and therefore it is proposed to increase the risk target score from 6 to 8.

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

On 21 May 2026, EMT reviewed this risk and approved the proposal to change the risk appetite category from Strategic (8-12) which has been removed as part of the risk appetite review, to the Business category (8-12) in line with the review risk appetite criteria. If accepted, the risk appetite score range will remain the same.

Risk ID	Risk Owner	Description
1432	Chief People Officer	Risk of lack of workforce planning and talent management may lead to gaps in key roles and fail to promote diversity

On 21 May 2026, EMT reviewed this risk and approved the proposal to change the risk appetite category from Strategic (8-12) as this category has been removed as part of the risk appetite review, to the Business category (8-12) in line with the review risk appetite criteria. If accepted, the risk appetite score range will remain the same. It was noted that the current risk target score was outside of risk appetite and therefore it is proposed to increase the risk target score from 6 to 8. This was due to the change in risk categorisation.

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 July 2021 to July 2026. The report shows the current figures for July 2026 and the projection if the proposals are accepted by Trust Board.

A summary of findings are below:

- There are **32 risks** in Quarter 1 2026/27 if the proposals are accepted. This is the same number of risks as Quarter 4 2025/26.
- The highest number of risks are aligned to the Trust strategic aim, **Best we can be – Best Quality** (18).
- The lowest number of risks are aligned to the Trust objective, **We will be ambitious** (1)
- If the proposed changes are accepted, there will be **1 red risk** aligned to Trust strategic aim **Best we can be – Best Value**.
- The current accumulative risk score is **309** and this will remain at **309** if the proposals are accepted.

The current average risk score is **9.66** (amber). If the proposed changes are accepted, then this score remain the same.

Recommendation:	Trust Board members are 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 change in risk appetite and reduction in risk level target for risk 1080 • APPROVE the transfer of committee for risk 1689 and 1157 • APPROVE the change in risk appetite category for risks 1757, 852 and 1217 • APPROVE the change in risk appetite category and reduction in risk appetite score range for risk 1839 • APPROVE the change in risk appetite category and increase in risk target score range for risks 812 and 1432

ORGANISATIONAL LEVEL RISK REPORT

Risk appetite:
Clinical Safety and Quality risks (1-6): Risks arising as a result of clinical practice or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain appropriately skilled workforce.
Business risks (8-12): Risks which might affect the Trust's ability to achieve its plans or 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.
Technology risks (8-12): Risks arising from technology not delivering the expected outcomes due to inadequate or deficient system/process development and performance or inadequate resilience.
Information risks (1-6): Risks arising from a failure to produce robust, suitable and appropriate data/information and to exploit data/information to its full potential.
Security risks (1-6): Risks arising from a failure to prevent unauthorised and/or inappropriate access to key Trust systems and assets, including people, platforms, information and resources. This encompasses the subset of cyber security.

Consequence	Likelihood				
	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

Our Strategic Aims		
1. We will live our values		
2. We will be the best we can be	Best Quality	Best Place to Work and Learn
	Best Partner	Best Value
3. We will be ambitious		

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

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

KEY: CE = Chief Executive DFR = Executive director of Finance, estates and resources CPO = Chief People Officer DNQ = Chief nurse and director of quality and professions CMO = Chief medical officer DS = Executive director of strategy, inclusion and change COO = Chief Operating Officer	AC = Audit Committee QSC = Quality and Safety Committee FIP = Finance, Investment & Performance Committee MHA = Mental Health Act Committee PRC = People & Remuneration Committee CC = Commissioning Committee Committee in bold / blue font = Lead Committee/ Lead director Committee in standard / black font = Oversight Committee/ director

Corporate/ Organisational Risk Register - Quarter 1, 2026/27

Trust Board meeting: 28 July 2026

ORGANISATIONAL LEVEL RISK REPORT

Risk level 15+

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequence (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) - Comprehensive security patching regime in place - Annual penetration testing in place - Disaster recovery and business continuity plans annually tested. - NHS Digital Care Certification and cyber essentials plus standards achieved. - Information Governance mandatory training includes cyber security dimensions. - Data Security and Protection Toolkit (DSPT) standards met. - IT Service performance actively monitored and tightly controlled - Immutable backup functionality implemented. - Data retention policy in place - Annual table-top emergency planning exercise - Multi-Factor Authentication (MFA) in place	5 Catastrophic	3 Possible	15	Security (1-6)	Following recent external cyber-attacks work is to be undertaken to ensure procurement and supply chain processes involve checking of third-party suppliers cyber security provision. (DFR review September 2026)	31 July 2026	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	6	Risk level: 15+ BAF SA 2 – Best value	August 2026

ORGANISATIONAL LEVEL RISK REPORT

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequence (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				- Digital Technology Assessment Criteria (DTAC) requirements included in digital/IT procurement process - Deputy Senior Information Risk Owner (SIRO) in place. - Learning process in place from wider NHS cyber-attacks. - Cyber campaign and communications schedule in place 6-monthly cyber security updates to Audit Committee - Annual Phishing campaign in place - Cyber security phase 2 enhancements include Cheswold Park Hospital. - ICS cyber security strategies in place across South Yorkshire and West Yorkshire. - CPH site fully integrated on the SWYPFT network - Rapid 7 SIEM solution implemented. - Windows 10 migration to Windows 11 completed. - Regular reviews take place to continually assess the Trust position in relation to cyber security through										

ORGANISATIONAL LEVEL RISK REPORT

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequence (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 digital TAG and Audit Committee										

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
275	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners.	DFR DS COO	QSC	- Joint arrangements in place to manage delivery of integrated teams. - Care Group / commissioner forums identify risks of decommissioning - EMT and OMG review key indicators on a monthly basis. - Regular review of contracts with local authorities. - Trust representation at Health and Wellbeing board meetings. - Trust inputs into system and Place based planning across West and South Yorkshire - Trust representation in all place-based quality committees - Annual stakeholder map to Trust Board includes future proposals from Local Authorities - Contracts in place for all Trust Services - Trust EDI strategy in place "About me" live across all MH community and inpatient SystmOne units	4 Major	3 Possible	12	1-6 Clinical Safety and Quality risk	- The Trust has contractual offers from all places including specialised which are factored into medium term plans. Ongoing assessments to consider financial risk. (DFR/DS review August 2026). - Value for money group continuing to review loss making services into 2026/27. (DFR review August 2026) - Impact on Lyndhurst ward identified following review of Calderdale Local Authority plans for 2026/27. Future plans to be established with local authority and ICB. (COO review September 2026) - Risk that any variance from financial plan will need to consider contingency actions which may impact on service provision (DFR/COO review August 2026)	30 April 2027	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	Risk level: 15+ BAF SA 2 – Best partner	August 2026

ORGANISATIONAL LEVEL RISK REPORT

				- Value for Money Group, EMT and FIP oversee process for consideration of loss making services - Director of Care Group attends ICB escalation meetings on weekly basis. - Physical health care group meetings in place to support patient flow. - Contract extension with local authorities on Yorkshire wide smoking cessation services approved.										
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/risk share in place with NHS providers for West Yorkshire - South and West Yorkshire Commissioning Hubs in place - Monthly financial management and control reports to Provider Collaborative Boards in West Yorkshire and South Yorkshire. - Quarterly contract meetings in place with sub-contracted partners. - Monthly patient safety and quality meetings in West and South Yorkshire. - Clinical Leadership roles in place for West and South Yorkshire - Dedicated provider collaborative risk registers in place - Quality assurance processes in place - Trust Commissioning Committee in place - West Yorkshire Sub-contracts in place - Financial efficiency programme for provider collaboratives is in	4 Major	3 Possible	12	1-6 Financial risk	- NHS England have delegated specialised budgets to ICBs from 1 April 2025, Ongoing discussions with NHSE with regards contract renewal post 2027. (DFR review August 2026) - Strategic commissioning work is starting to take place across a larger geographical footprint to look at some of the higher risk pathways across Yorkshire and Humber to take a combined approach. Yorkshire wide workshop took place in March 2026 and five priority workstreams have been agreed. Proposal now presented and supported by Commissioning Committee. Detailed delivery plan now in development. (DFR review October 2026)	31 March 2027	CC Executive Management Team (monthly) Trust Board	4	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best value The Trust has been lead provider for over 3 years now and whilst there remains a financial risk, it has never been material and is manageable. Similarly, clinical risks identified as a result of quality monitoring have occurred on occasion but are part of a well-managed oversight process working with	August 2026

ORGANISATIONAL LEVEL RISK REPORT

				place for 2026/27. Ongoing monitoring to be delivered through the value for money programme.									the provider collaborative members.	
1957	Risk that the Trust's financial viability will be further impacted by ongoing unfunded pressures.	DFR	FIP	- Value for money board meet weekly and non-pay review groups in place. - Monthly senior budget holders and management accountant meetings. - Monthly OMG focus on performance and finance. - Mental health investment standard. - Trust fully engaged with ICS finance and funding. - Monthly finance updates presented to EMT and FIP with regular updates to Trust Board. - Trusts financial performance scrutinised through the Finance, Investment and Performance Committee - Future risk modelled into 26/27 medium term financial planning processes.	3 Moderate	3 Possible	9	1-6 financial risk	Pay review pressure now known. Mitigating actions discussed as part of overarching value for money programme. (DFR review August 2026)	31 March 2027	FIP Executive Management Team (EMT) (monthly) Operational Management Group (OMG) Trust Board	4	BAF SA 2 – Best value	August 2026
1114	Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided	DFR	FIP	- Board, Committee and EMT oversight of value for money schemes. - Value for money board meet weekly and non-pay review groups in place - Active engagement in West Yorkshire and South Yorkshire Systems (ICS) and place-based plans. - Mental Health Investment Standard funding. - Use of national and internal benchmarking information support productivity improvements.	4 Major	3 Possible	12	1-6 Financial risk	2026/27 value for money programme established. Ongoing assessment of risk to delivery of all schemes. (DFR review August 2026)	31 March 2027	Executive Management Team (monthly) FIP (monthly) Operational Management Group Trust Board (quarterly)	4	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best value	August 2026

ORGANISATIONAL LEVEL RISK REPORT

				- Operational and financial plan in place for 2025/26 - Efficiency delivery and monitoring group in place. - Monthly operational management group focus on performance and finance. - Staff engagement supported by head of communications 8 key lines of enquiry identified for value for money programme 2025/26. - Finance update report provided to each FIP meeting. - Weekly executive meetings in place. - Integrated Care Board (ICB) level cost controls have been implemented - Draft medium term financial sustainability plan approved by Trust Board and submitted to NHSE. - The financial plan to support the annual plan (which includes workforce plans) submitted to and approved by Board on 16 December 2025. - Development and implementation of Board approved workforce reduction/efficiency plans to support financial planning.										
1530	There is a risk that capacity in services to meet existing waiting lists and current levels of demand and acuity is placing pressure on	COO	QSC	- Trust is a key partner in both Integrated Care Systems to manage demand - Where demand cannot be met escalation is through the Operational Management Group (OMG) via waiting list reports - Quality impact of increased demand is	3 Moderate	4 Likely	12	1 – 6 Clinical Safety and Quality risk	- National project for mental health inpatient flow completed. Further recommendations for GIRFT (Getting It Right First Time) plans with mental health Emergency departments. (COO review September 2026) - Quality Improvement Programmes in place to improve the Children and young people waiting lists. (COO review September 2026)	March 2027	QSC Executive Management Team (EMT) (monthly) Operational Management Group (OMG)	6	Risk level: 15+ BAF SA 2 – Best Quality	August 2026

ORGANISATIONAL LEVEL RISK REPORT

	access to and delivery of services.			overseen in the Clinical Governance Group - Care pathways are designed to be flexible to respond to changes in demand. - Regular engagement with commissioners provides opportunity to consider changes required to meet demand. - Regular reports to EMT, OMG and FIP - People waiting are offered contact information should their needs escalate - Waiting lists are reported on SystmOne Learning disability waiting list report - ADHD waiting list initiatives - Deprivation data and ethnicity data is included in waiting list reports into OMG and FIP. - New mental health care plan captures the views of service users and inequalities - OPEL and demand meetings in place in the mental health care group to manage pressures on flow. - Waiting well processes in place - Productivity working group in place to identify opportunities for improvements/efficiencies - Director of Care Group attends ICB escalation meetings on weekly basis in order to escalate patients clinically ready for discharge to enhance patient flow. - Actions to manage the impact of demand are							Trust Board			

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ORGANISATIONAL LEVEL RISK REPORT

1078	There is risk that young people will suffer harm as a result of waiting for treatment or neurodevelopmental assessment in the form of unmet needs, access to services and support which might impact on longer term health, education and social outcomes as well as family life.	COO	QSC	- Incidents reported on Datix and reviewed through patient safety oversight group - Children waiting for a neurodevelopmental assessment with mental health needs are supported by core (CAMHS) - Children and young people on waiting lists are reviewed frequently and can be prioritised according to their level of need and risk. - Routine waiting well checks and support are offered to children who are waiting. - Active participation in Integrated Care System - CAMHS work - Performance dashboard in place including ethnicity monitoring to monitor waits. - Children and Young people's governance Group in place - Discussions with Commissioners taken place to ensure that resources are prioritised. - Investment received within CYP service lines to improve waits and clinical pathways. - Recruitment to care groups to support with meeting service delivery needs.	4 Major	3 Possible	12	1-6 Clinical Safety and Quality risk	- Focus on pathway improvements continues, to maximise capacity and improve service user experience. Work is required to streamline services. (COO review September 2026) - Working with CKW ICB to establish a transfer to alternative providers to support the waiting list. (COO review September 2026)	31 March 2027	OMG QSC Executive Management Group – monthly Individual district performance reports reviewed by care group Trust Board	6	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality	August 2026
1368	Risk that there is limited access to CAMHS inpatient beds due to regional and national demand and capacity issues. This	COO	QSC	- Community options continue to be explored. - Protocol in place for admission of children and younger people on to adult wards. - Bed management processes - CAMHS in-reach support to mental health wards and acute	3 Moderate	3 Possible	9	1-6 Clinical Safety and Quality risk	SWYPFT to continue to be part of provider collab to support system wide improvement. (COO review September 2026)	April 2027	QSC Executive Management Team (EMT) (monthly) Operational Management Team (OMG)	4	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality	August 2026

ORGANISATIONAL LEVEL RISK REPORT

	could result in young people being cared for in an adult or secure wards or secure CAMHS estate impacting on the quality and experience of their care.			hospitals in the event a child is placed there. - Regular report to board (Integrated Performance Report) - Safeguarding team provides scrutiny of all under 18 admissions. - Leeds and York care provider collaborative board and system wide operational cell (West Yorkshire) provides oversight of CYP admissions - 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. - COO appropriately escalates to partners where an appropriate solution for a child is not available. - Person centred plan put in place when children are admitted to adult beds - Trust involvement in collaborative work across West Yorkshire ICS in relation to Tier 4 beds - A pathway is in place for children and young people to access secure beds. - Additional health complexities in the community are being managed within services - Associate director of operations meets with provider collaborative and operational leads to support unblocking pathways and creating capacity - Children and young people's mental health							Trust Board			

ORGANISATIONAL LEVEL RISK REPORT

				transformation programme in place across the West Yorkshire system to develop alternatives to inpatient care. This work is led by the children and young people's provider collaborative where SWYPFT are a partner.										
1757	Failure to maintain and monitor medical devices to the required standard in line with relevant legislation may lead to patient harm.	DFR	QSC	- Medical devices data reviewed monthly and shared with medical devices TAG. - The Electrical Biomedical Medical Engineering (EBME) equipment / infection prevention and contract is in place - Equipment registers in place - Purchasing process in place - Medical devices and safety alert group monitor EBME compliance figures quarterly - Medical devices intranet pages in place - Medical devices lifecycle flowchart in place - Medical Devices Policy In place. - Monthly updates are provided to Care Group leads with a request for their action plan to improve - Quarterly update provided to OMG and EMT - Trustwide servicing programme - Weekly review of the asset register data for medical devices - Medical devices annual report governance process in place. - Monthly performance to Care Groups to	4 Major	3 Possible	12	Compliance (1-6)	- Metrics for medical devices for the integrated performance report still under consideration. (DFR Review August 2026) - Report into EMT to provide a view of how the Trust prioritises the risk level of medical devices and when medical devices remain unfound for a significant period (DFR review August 2026) - All Care groups requested to review equipment schedules. (DFR review August 2026).	February 2027	Clinical governance / care group clinical governance QSC Safety and resilience Task Action Group Operational Management Group (OMG) Medical Devices Task Action Group Executive Management Team (EMT) Trust Board	6	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality	August 2026

ORGANISATIONAL LEVEL RISK REPORT

				highlight un-serviced items - Monthly meetings with Care Groups as part of OMG to act as a control point - Review of other servicing contracts for medical devices to take place Q1 2026/27. - Update to EMT and QSC at bi-monthly intervals, as per QSC workplan. - Medical Devices Safety Officer role taken on by the Deputy Director of Estates and Facilities. - Monthly dedicated performance reports in place with Mid Yorkshire as main contractor. - Estates and Facilities oversee the servicing contract. - Medical Devices Safety Officer to chair the Medical Devices and Safety Alerts Group, with Assistant Director of Nursing, Quality and Professions (physical health) as co-chair. - Central database cleansing completed and approved by the Medical Devices group. - Review of servicing contracts for medical devices undertaken. - Review of required workforce for medical devices undertaken. - Process developed to ensure robust oversight of medical devices.										
1614	National staff shortages in some clinical staff groups resulting in vacancies which could lead to the delivery of	DNQ CPO	PRC	- All Datix reports relating to staffing issues go to the weekly patient safety oversight group and escalated to Executive Management Team as appropriate. - Inpatient transformation programme taking	4 Major	2 Unlikely	8	1-6 Compliance risk	- Establishment reviews have been completed across all MH and forensic wards. Executives reviewing the findings with a view to presenting a report to EMT in July. (DNQ review August 2026) - SafeCare to be reviewed within operational services to support staffing and deployment. Pilot in	31 March 2027	Operational Management Group Executive Management Team Trust Board	6	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality	August 2026

ORGANISATIONAL LEVEL RISK REPORT

potentially reduced quality, unsafe and / or reduced services, increased out of area placements, breaches in regulations or inability to recruit to newly commissioned services.				place to improve clinical pathways and patient experience - Internal reporting includes waiting lists, length of stay, complaints, concerns and compliments - Quality Walkarounds in place to ensure staff and service user voice is heard - Use of temporary staffing to address staffing issues where there is clinical need - Safer staffing groups to ensure oversight and escalation of staffing and recruitment. - Safer staffing levels for inpatient services agreed and monitored. - Freedom to speak up process in place - Quality focused updates from in-patient areas are presented to the Clinical Governance Group - Safe practice protocol during seclusion and restraint in place when working with reduced substantive staff - SafeCare in place in Forensics and Barnsley Mental Health Inpatients, Calderdale and Kirklees adult rehab/recovery and older people services - Recruitment and retention plan agreed - Monthly safer staffing reports to Trust Board and Operational Management Group via Integrated Performance Report - Biannual safer staffing report to QSC and Trust Board - Medical staff bank in place.				forensic services expanded to mental health care group with a review of benefits and challenges ahead of full implementation. (COO review September 2026) - Learning from SafeCare implementation in Forensics is being reviewed to inform the approach to implementation across the MH care group. (DNQ review August 2026) - The AMD for Workforce and Development, the Director of Services MH and the recruitment team are working together to consider new roles in accordance with workforce plan and organisational priorities to optimise retention and recruitment into substantive consultant vacancies. (CMO review August 2026) - Recruitment plan for care support workers 2026/27 has been developed and will be discussed at the temporary staffing group. (CPO review August 2026)		QSC PRC Safer staffing inpatient and community group Clinical Strategy Implementation Group Trustwide AHP Group				

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ORGANISATIONAL LEVEL RISK REPORT

				Strategy and runs from 2025-2030. AHP Professional Leads and accountable owners meet 6 weekly to report back on delivery of their actions										
1689	Risk that the Trust does not address health inequalities under its control in the provision of services potentially exacerbating existing health inequalities for our service users.	DS	QSC	- Equality, Diversity and Inclusion strategy and annual action plans in place - Equality Impact Assessments (EIA) including action tracker in place - SystmOne equality data provides oversight of equality data to understand our population - Annual Equality Report - Equality Involvement and Inclusion Committee and sub-committee - Equality dashboard - Making Data Count approach established - Improving access to care priority programme established - Equality Delivery System (EDS) - EDI training, development and awareness sessions in place - Work with partners in each place to address inequalities - Targeted programmes to address inequalities through linked charities - Key priority programme for 2025/26 is reducing inequalities - EIIC review dashboard as part of routine monitoring (waiting times and access) - EIIC receive care group case studies of actions taken to address inequalities. Studies to the EIIC demonstrate	3 Moderate	3 Possible	9	1-6 Compliance risk	Board approved the priorities to address health inequalities this year. This enables targeted work to address defined challenges. Work continues on IPR metrics to reflect progress. (DS review August 2026)	30 April 2027	Recovery and reset monthly Executive Management Team QSC quarterly meeting and bi-monthly sub-committee Executive Management Team Trust Board	6	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality	August 2026

ORGANISATIONAL LEVEL RISK REPORT

				- impact and continuous improvement. - Trustwide involvement in place-based health inequalities programmes - Comms plan around health inequalities in place - Accessible Information Standard review has taken place for patients and service users who are deaf. - Dedicated Change Manager in place to address health inequalities										
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. - 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 - Fire safety awareness training mandatory for all staff and compliance monitored. - Emergency procedures in place to ensure early recovery from unforeseen incident involving fire. - Use of sprinklers across all Trust buildings	4 Major	3 Possible	12	1-6 Compliance risk	Review of impact of Building Safety Act being undertaken on a capital scheme by scheme basis. (DFR review August 2026)	30 April 2027	Executive Management Team Estates Trust Action Group (monthly) Safety Trust Action Group (Quarterly) Operational Management Group (monthly) AC Trust Board	6	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality	August 2026

Organisational Risk Register Quarter 1 2026/27

ORGANISATIONAL LEVEL RISK REPORT

852	Risk of information governance breach and / or non-compliance with General Data Protection Regulations (GDPR) leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.	DFR	AC	- Annual internal audit report of Data Security and Protection Toolkit. - Trust information governance mandatory training for all staff has a compliance target of 95% - Designated Caldicott guardian and Senior Information Risk Owner (SIRO) (and deputies) in post. - Qualified and experienced data protection officer in post - Policies and procedures compliant with General Data Protection Regulation (GDPR). - Improving Clinical Information and Governance (ICIG) group in place - Communications and awareness plan in place. - Data protection impact assessment process - Proactive monitoring of incidents and 'hot-spot-areas by information governance manager. - Confidentiality clause in staff contracts - Data protection included in induction checklists - Processes in place for rectifying inaccurate or incomplete data - Trust communications in place to ensure data alignment between SystmOne and the NHS Spine - Communications disseminated for awareness regarding data sharing in Microsoft excel. - Trust achieved mandatory IG training target of 95% compliance for 2025-26.	4 Major	2 Unlikely	8	Information risk (1-6)	- Information governance e-learning packages reviewed nationally and will be rolled out by staff groups by the Trust once implemented into ESR. (DFR review September 2026) - Process to improve how positive consent to share is captured and evidenced digitally to be rolled out. (DFR review August 2026) - Work with IM&T to ensure that IG issues/risks are captured and incorporated into AI related groups/projects. (DFR review August 2026) - VFM scheme that reduces postage and looks to integrate patient comms via the NHS App or Patient knows best should reduce human errors. (DFR review September 2026) - Terms of reference for ICIG under review to ensure aligned with the UK Data Use and Access Act 2025 and Trust policy and procedures. (DFR review August 2026)	November 2026	ICIG Operational Management Group Executive Management Team AC Trust Board	4	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality The UK GDPR has been significantly updated in 2026 under the Data (Use and Access) Act 2025, introducing new lawful bases, relaxed cookie rules, enhanced automated decision-making provisions, and stricter ICO enforcement.	August 2026

ORGANISATIONAL LEVEL RISK REPORT

				- DPO continues to work with teams following incidents to promote learning and prevent future incidents. - Following all incidents, communications are circulated to all staff reminding them of their responsibilities under the UK Data Use and Access Act 2025 and Trust policy and procedures. - DSPT submitted to NHSE digital on 29 June 2026 Overall risk assurance across all five objectives is low, which means none of the reviewed outcomes were rated as not meeting minimum achievement levels; and Confidence level in the veracity of the Trust's DSPT self-assessment/ final submission is high. For the sixth consecutive year, the Trust has achieved the highest levels of assurance in the audit assessment.										
1319	Risk that there will be no bed available in the Trust for someone requiring mental health admission to hospital therefore, they will need to be admitted to an out of area bed or undesignated bed or remain in an inappropriate environment	COO	QSC	- Bed management process and OPEL actions aligned to the UEC planning guidance and appropriate escalations to exec Trio - Ongoing partnership work with commissioners and acute colleagues - Agreed governance structure including improving mental health oversight group and improvement mental health partnership group - Workstreams in place to address specific areas	3 Moderate	3 Possible	9	1-6 Clinical Safety and Quality risk	- All beds managed and overview of all bed flow is undertaken by the mental health care group on a daily basis. Any service users cared for out of area have a full review for quality and safety and returned back to the Trust as soon as possible. (COO review September 2026). - Review required of data for each place to understand use of beds vs commissioned activity. (COO review September 2026)	31 March 2027	OMG QSC EMT Trust Board	4	Risk level: Risk level <15 Risks outside the risk appetite	August 2026

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ORGANISATIONAL LEVEL RISK REPORT

				- clinicians from across the Trust. - National and regional ED Improvement programme completed to understand delays in transfer / admission to a MH bed from ED or acute wards - Care closer to home project has become business as usual and all bed flows are managed according to capacity and demand.										
1585	The current NHS capital regime could result in the Trust not having sufficient allocation to complete all its capital plans 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 Trust digital strategy in place. Trust Board receives 6 monthly updates on current 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 25/26 agreed - Overarching Integrated Care Board (ICB) capital allocation tracker in place. - Trust Board receives 6 monthly updates on current estates strategy - Approved Trust Estates strategy in place. Trust Board receives 6 monthly updates - Monitoring of in-year capital spend to ensure delivery against plan - NHSE made four year allocations for capital which supports longer term planning.	3 Moderate	3 Possible	9	1-6 Financial risk	- Review of 26/27 capital programme underway. Awaiting guaranteed maximum price for older people's service programme and Cheswold safety scheme. (DFR review August 2026) - In light of above, medium term capital plan phasing to be reviewed. (DFR review September 2026)	31 March 2027	Executive Management Team (monthly) FIP (monthly) Trust Board	4	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best value	August 2026

ORGANISATIONAL LEVEL RISK REPORT

				Discretionary capital funding bids now decided. Trust able to formulate a plan based on capital allocations.										
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.	CPO	PRC	- Annual Equality Report - Equality, Diversity and Inclusion strategy in place - Equality Impact Assessment. - Development and delivery of joint WRES, WDES and EDS2 action plans - Review of recruitment with staff networks as and when needed. - Bullying and harassment policy in place - freedom to speak up processes in place - Staff networks in place eg, Disability Network, LGBT+ network, carers network. - Ongoing engagement with regional partners and regional lead from NHS England with regards to disparity in representation across nurse bandings - Microaggression resource in place via Trust intranet. - Staff networks provided with a budget and protected time to deliver actions. - Equality dashboards for EIIC to track data, progress and improvements. - A process is in place to use staff survey data to improve staff experience with a focus on feedback from all diverse groups. Local teams work on action plans and involve staff networks - The Trust has diverse interview panels in	3 Moderate	3 Possible	9	1-6 Compliance risk	- Role of Equity Guardians and wider champion roles to support the Equality Strategy will be reviewed once the staff networks appointments have been made. (CPO review August 2026) - Staff networks and supporting arrangements to be finalised early July 2026 and communicated to workforce (CPO review August 2026) - EDI ops group focussed on developing a #all of us campaign aimed at supporting staff who suffer harm at work. (CPO review August 2026) - EDI action plan – actions to be reviewed at PRC in July. (CPO review August 2026)	31 March 2027	Executive Management Team (EMT) (quarterly) PRC Trust Board	6	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best place to work and learn	August 2026

ORGANISATIONAL LEVEL RISK REPORT

				- place with a focus on BAME representation - Equality, Diversity and Inclusion action plan approved by Trust Board - Newly established EDI operational group in place to ensure strategic and operational alignment of EDI priorities - EDS2 actions developed										
1839	Lack of provision across the system prevents transferring people that are clinically ready for discharge	COO	QSC	- Patient flow processes establish barriers to discharge on admission - Routine multidisciplinary reviews - 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 - Barriers to discharge reports link into place-based multi-agency discharge meetings. - Clinically ready for discharge issues continue to be escalated through to MADE meetings, improvement work and the partnership group. - Where MADE meetings have not reached a solution, a gold command meeting will be established. - A secondary care pathway in West Yorkshire is in place to share learning of themes to barriers to discharge to inform future work streams. Similar work has	3 Moderate	4 Likely	12	Clinical Safety and Quality risk (1-6)	- Horizon assessment and treatment unit options appraisal submitted to the West Yorkshire contracting and finance workstream. (COO/DFR review September 2026) - Continue to have ICB escalation process in place to seek transfer of care. (COO review September 2026)	September 2027	Executive Management Team Operational Management Group QSC Trust Board	6	Risk level: Organisation al level risks within the risk appetite BAF SA 2 – Best Quality	August 2026

ORGANISATIONAL LEVEL RISK REPORT

				- commenced in South Yorkshire. - Specific leadership at associate director level for patient flow. - Patient flow dashboard - Bed management process and OPEL action actions aligned to the UEC planning guidance and appropriate escalations to exec Trio. - Weekly review with commissioners to progress those who are clinically ready for discharge via MADE meetings										
1887	Risk that teams and individual members of staff do not feel confident that the Trust has a culture where 'Speaking Up' is encouraged; individuals are supportively heard; staff do not suffer personal detriment following reports; or receive feedback on action(s) taken which demonstrate listening and learning.	DNQ	AC	- Freedom to speak up structure in place with one Working Time Equivalent (WTE) guardian supported by two further guardians 6 weekly oversight meetings with Lead Director DNQ, non-executive lead for FTSU supported by Deputy Director of Corporate governance - Exec Director Lead meets regularly with FTSU guardian - Trust communications (View and Headlines) in relation to speaking up and updates via Trust intranet encourage openly raising concerns - FTSU guardian identifies and escalates detriment from any speaking up process - Staff are signposted to other areas of the Trust for support, eg occupational health - Focused intervention from executive TRIO into areas of concern - FTSU newsletter in place - FTSU data triangulated with staff survey results	3 Moderate	3 Possible	9	1 – 6 Compliance risk	- Final approval of Freedom to Speak Up Internal Operating Framework via OMG in June 2026, following which intranet links will be updated. (DNQ review August 2026) - A small sample of Freedom to Speak Up cases reviewed as part of a sample to check improvements have been embedded as part of learning. To be presented to FTSU Oversight meeting June 2026 and Audit Committee in July 2026. (DNQ review August 2026).	31 March 2027	FTSU steering group QSC PRC EMT Trust Board	6	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 1 – We will live our values	August 2026

ORGANISATIONAL LEVEL RISK REPORT

				- FTSU self-assessment tool and action plan in place - FTSU reports into Audit Committee and Trust Board - FTSU guardian has regular visits to services to promote freedom to speak up - FTSU promoted at welcome events - Freedom to Speak Up communications plan in place. - Freedom to Speak Up policy review completed 2026 - Review of Freedom to Speak Up strategy approved and intranet updated - Mandatory training speak up training available on ESR along with Listen up and follow up. - FTSU training incorporated into face to face line manager training on concerns and complaints, delivered by FTSUG										
1888	Risk that individuals do not feel safe from sexual harm whilst being cared for, working for, or visiting the Trust.	CPO DNQ	QSC PRC	- The Trust has signed the NHS England sexual safety charter - All appropriate and relevant policies in place. - Trust safeguarding team oversee all patient related sexual safety incidents via Datix. - The People Directorate oversee all staff sexual safety incidents reported through the internal reporting portal. - Incidents are reported monthly into the IPR. - The Trust reports via the Joint Safeguarding Strategic and Operational Subgroup, EMT, PRC and QSC Committee.	4 Major	2 Unlikely	8	1-6 Clinical Safety and Quality risk	- Comms strategy under review post staff survey as part of ongoing safe and healthy workstream and within the Best Place to work and Learn Trust priority. (DNQ review August 2026) - Governance processes in place to identify emerging themes/trends related to sexual safety and develop actions as appropriate through the Sexual Safety Oversight Group which feeds into Clinical Governance Group and Quality and Safety Committee. (CPO/DNQ review August 2026) - Level 1 eLearning continues to be promoted prior to becoming mandatory training, to raise awareness of zero tolerance Trust stance and	31 August 2026	QSC PRC Executive Management Team (EMT) Joint Safeguarding Strategic and Operational Subgroup sexual safety improvement group Quality and Safety	4	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality	August 2026

ORGANISATIONAL LEVEL RISK REPORT

				- Quarterly sexual safety oversight group ensure findings from incidents are embedded into practice based on NHSE Sexual Safety in Healthcare Organisational Charter. - Trust intranet information page on sexual safety in healthcare in place - Sexual Safety Annual Reporting process in place - National eLearning package for sexual safety available to all staff - Bespoke face to face training package in place when required. - Implementation of the 2025/26 work plan complete following the previous case note audit - Senior leadership guide to sexual abuse disclosures in the NHS in place - Sexual safety incidents reviewed through the Service User Sexual Safety Group - Datix guidance in place for sexual safety incidents - Post incident review process includes the sharing of completed actions. - Quality improvement standards in place for mixed gender wards. - Incident dashboard developed to identify themes/trends. - Sexual safety oversight group in place reporting into QSC and PRC - Sexual Safety Charter approved by EMT - Trust policy and procedure are aligned to the national policy.				understanding of what behaviours are considered inappropriate. (DNQ review August 2026) - Service user sexual safety to be considered as part of women's clinical pathway workstream. (COO review September 2026) - Process mapping exercise to map out how staff can raise concerns around sexual safety and other concerns re their safety at work. To be reviewed by EDI ops group. (CPO review August 2026). - Standard reporting for PRC, QSC and EMT now agreed – effective from 1st July. (CPO review August 2026).		Committee (QSC) Trust Board			

[illegible]

ORGANISATIONAL LEVEL RISK REPORT

				- Disciplinary outcomes monitored for fairness, transparency and alignment with national standards - Sexual safety oversight group monitor for emerging themes/trends and risk analysis										
2012	There is a variable and fluctuating risk relating to the capacity and sustainability of service delivery within paediatric audiology services due to resource limitation and audiologist availability which could impact on patient safety	COO	QSC	- Waiting times are closely monitored to ensure they are kept to a minimum - Two bank staff are covering the substantive vacant hours and additional bank staff sourced. - Support and advice is in place from Sheffield children's hospital. - Regular communications in place with the ICB around risk and resource implications. - Prioritisation of cases where risks may be greater. - Detailed review of the service and any incidents overseen by the general manager and director of service - New substantive audiologist in post	3 Moderate	3 Possible	9	1-6 Clinical Safety and Quality risk	- Business case submitted to Commissioners for additional resource to meet the demand or alternatives to this provision. Decision tree to be developed and presented to the Value for Money Group (COO review September 2026) - Quality improvement project commenced and is evidencing good outcomes however the outcome will be volatile due to limited resource in this service. QI project embedded to continue to ensure sustainability (COO review September 2026)	February 2027	CYP&F Development and Oversight Meeting (care group meeting) OMG EMT IPR	6	BAF SA 2 – Best Quality	August 2026
2084	Risk of serious harm to inpatients caused by residual ligature anchor points not fully mitigated by current environmental and clinical controls, resulting in potential self-harm incidents	DNQ	QSC	- A programme of annual ligature reviews overseen through the Clinical Environment Risk Group. Capital programme in place to address any identified ligature points - Policies and procedures, and reporting structure in place, for the identification and mitigation of patient safety risks. - Appropriate Operational Management Group (OMG), Clinical Governance Group and	4 Major	2 Unlikely	8	1-6 Clinical Safety and Quality risk	- Improvement programme lead by deputy director of nursing underway to address gaps in assurance in relation to risk assessment and safety planning. Due to be completed July 2026. (DNQ review August 2026) - Independent review of the women's pathway of care underway which will inform learning to reduce likelihood of any further inpatient incidents. (DNQ review August 2026) - Women's pathway of care working group to be established to take forward the findings from the independent review. (DNQ September 2026)	May 2027	Performance & monitoring via Executive Management Team QSC Operational Management Group Trust Board Patient Safety report &	6	BAF SA 2 - Best Quality	August 2026

ORGANISATIONAL LEVEL RISK REPORT

				QSC escalation arrangements in place. • Patient Safety Specialist roles in place • Regular Patient safety learning events • Video of how to use and maintain the ligature cutters is available on the RRPI intranet site. • Ligature procedure updated and available to staff. • Any changes to ligature procedure demonstrated within RRPI training.						incident report as well as monthly reporting in the Integrated Performance Report Patient Safety Incident task and finish group Clinical Environment Risk Group.				
2085	Risk of repeat patient safety incidents and deterioration in the quality of care caused by inconsistent incident review processes, and failure to effectively embed learning across services resulting in recurring incident themes.	DNQ	QSC	• Policies and procedures, and reporting structure in place, for the identification and mitigation of patient safety risks. • Appropriate daily/weekly oversight of patient safety incidents through care group and Trust patient safety oversight groups. • Executive oversight of patient safety reviews and learning through Trust PSOG and Patient Safety Executive Group with escalations to EMT and QSC. . • Care group level PSOGs in place provide opportunities for learning to be identified and shared Trustwide. • Patient Safety Specialist roles in place • Regular Patient safety learning events • Clinical strategy in place. • Care group governance aligned to ensure consistency of	4 Major	2 Unlikely	8	1-6 Clinical Safety and Quality risk	• Improvement programme lead by deputy director of nursing underway to address gaps in relation to assurance in risk assessment and safety planning. Due to be completed July 2026. (DNQ review August 2026) • Patient safety learning and improvement group to be relaunched in June 2026 to strengthen the approach to identifying and sharing learning and oversight of quality improvement initiatives to address safety risks. (DNQ review August 2026) • Awaiting the launch of the national quality strategy to inform the refresh of the Trust Quality Strategy which expires at the end of 2026. (DNQ review August 2026) • Review of incident oversight processes being undertaken to include Datix reporting, daily oversight, thematic analysis and targeted improvement programmes. (DNQ review September 2026).	May 2027	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 Patient Safety Incident task and finish group	6	BAF SA 2 - Best Quality	August 2026

ORGANISATIONAL LEVEL RISK REPORT

				approach across the Trust - Regular patient safety updates to QSC and Trust Board via complex clinical matters report and the quarterly patient safety and learning reports - The Trust has a Patient Safety Incident Response Framework (PSIRF) Policy and Plan. - The Trust's PSIRF is accredited to the national Safety Incident Response Accreditation Network (SIRAN) scheme, delivered by the Royal College of Psychiatrists.							PSOG PSEG			
2086	Risk of unsafe or inappropriate clinical decision making caused by inconsistent completion, quality and accuracy of clinical risk assessments resulting in failure to identify, evaluate and manage individual patient risks effectively.	DNQ	QSC	- Policies and procedures, and reporting structure in place, for the identification and mitigation of patient safety risks. - Appropriate oversight of compliance with risk assessment completion through the integrated performance report, overseen at OMG, EMT, QSC and Trust Board - Formulation of informed risk management (FIRM) assessment training in place - Risk assessment and care plan quality dip sample audits in place across community and inpatient MH - Community MH risk assessment and care planning audit dashboard in place - Care group governance groups	4 Major	2 Unlikely	8	1-6 Clinical Safety and Quality risk	- Improvement plan overseen by the Task and finish group, chaired by Deputy Director of Nursing, to address the findings of the internal audit report. (DNQ review August 2026) - Review of clinical risk training underway. (DNQ review August 2026) - Evaluation of the care process training pilot being undertaken to determine next steps. (DNQ review August 2026) - Approach to undertaking quality assessment of risk assessments and care plans is being developed through the task and finish group. (DNQ review August 2026)	December 2026	Performanc e & monitoring via Executive Manageme nt Team QSC Operational Manageme nt Group Trust Board Risk assessmen t and care planning task and finish group	6	BAF SA 2 - Best Quality	August 2026

ORGANISATIONAL LEVEL RISK REPORT

				oversight of performance in relation to risk assessments and care planning.										
				Monthly reporting to quality and safety committee in relation to progress of actions arising from the internal audit of risk assessments and care plans										
2087	Risk of overuse of restrictive practices caused by inconsistent implementation of reducing restrictive practice approaches, resulting in potential physical or psychological harm to service users.	DNQ	QSC	- Reducing restrictive practice and intervention (RRPI) improvement plan in place - Mandatory RRPI training in place - RRPI incidents reported via Datix and reviewed by the RRPI team who support teams with management plans and overall learning. - RRPI Trust Action Group to oversee restrictive practices and address areas of concern and share good practice - The alternative seclusion exits training rolled out across all Trust mental health and learning disability inpatient wards. - Alternative staff seclusion exit included in four-day initial RRPI training - The Trust has a Patient Safety Incident Response Framework (PSIRF) Policy and Plan. - Link to the RRPI intranet site included in the RRPI newsletter via comms. - RRPI incidents including the use of prone restraint monitored through IPR	3 Moderate	4 Likely	12	1-6 Clinical Safety and Quality risk	- External peer review commissioned and underway to review RRPI policy, training, overall number of restrictive practices and team model. (DNQ review August 2026) - RRPI lead booked to attend professional practice programme through the Restraint Reduction Network (RRN). (DNQ review August 2026) - Review of the team establishment underway to embed trainers across clinical services. (DNQ review August 2026) - To review the ToR for RRPI TAG to ensure robust oversight of incidents across the Trust. (DNQ review August 2026)	December 2026	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 Patient Safety Incident task and finish group Patient Safety Oversight Group	6	BAF SA 2 - Best Quality	August 2026

ORGANISATIONAL LEVEL RISK REPORT

				and QSC and to Trust Board										
				RRPI Training is British Institute of Learning Disabilities (BILD) accredited.										

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
1820	The risk that a negative culture may have a detrimental impact on patient safety and quality of care.	CPO COO CMO DNQ	QSC PRC	- Weekly Trustwide patient safety oversight group receive all staffing and protected characteristic incidents - Seclusion and Segregation oversight group in place - Safer Staffing reporting into monthly Integrated Performance Report - Incident and quality monitoring in place via Care Group Quality and Governance Groups, and the Clinical Governance Group - Quality assurance system in place coordinated by Quality Governance Team, - Freedom to Speak up concerns reported to AC and PRC for oversight and monitoring around culture. - Regular informal and formal meetings with CQC in place include any culture concerns. - Review of themes from complaints - Patient experience annual report presented to Trust Board to identify themes and trends. - Induction process sets out Trust values and behaviours and code of conduct	3 Moderate	2 Unlikely	6	1-6 Clinical Safety and Quality risk	- The Culture of Care National Programme completed 31 March 2026. Four workstreams in place and learning from the approach will be considered to determine how the programme can be mainstreamed across all inpatient areas. A full report will be presented to EMT. (CMO/DNQ review August 2026) - A cultural diagnostic of forensics has now concluded and has been considered by EMT and was submitted to PRC in July. Action plan to follow to address key findings. Learning and approach to be adopted in a tool kit and used in other areas as required. (CPO review August 2026).	May 2027	Operational Management Group Executive Management Team Clinical Governance Group QSC PRC Trust Board Clinical Strategy Implementation Group	3	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 1	August 2026

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
				- Guardian of safe working hours reported to Board annually - Medical appraisal and revalidation report submitted to Board and NHSE annually. - Complaint monitoring in place through the IPR - Supervision database in place and part of Trust performance reporting. - Quality concerns trigger tool in place. - Leadership events with managers and leaders and the CEO/DCEO to engage on current Trust challenges - Culture of Care work reported into Patient Safety Oversight Group to ensure issues are escalated - Compassionate leadership is a key priority in the Trust's Clinical Strategy - Regular deep dives are presented to PRC in relation to sickness and other indicators in the forensic care group - People Strategy approved by Trust Board. - Ward Manager Development Programme led by FoNS (Foundation of Nursing Studies) in place.										
1729	Staff wellbeing may deteriorate leading to increased sickness/absence which will impact on the quality and	CPO DNQ	PRC	- 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.	3 Moderate	2 Unlikely	6	1-6 Compliance risk	A sickness absence reduction plan has been produced in line with NHSE requirements, signed off by EMT and PRC and was approved by Board on 30th June 2026 prior to submission to NHSE. The plan will now be rolled out across care groups and support services during 2026. (CPO review September 2026).	31 March 2027	Safer staffing reports (monthly) Moving forward group	6	BAF SA 2 – Best place to work and learn	August 2026

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
	safety of services			- Support and engagement from all staff networks. - Equality Impact Assessment of staff health and wellbeing offer and occupational health. - Effective supervision practices - Data analysis and hot spot reporting Trust wide - Communications brief with wellbeing 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 - Wellbeing champions appointed in each of the clinical areas - FTSU processes and culture within the Trust influence staff wellbeing as does work on civility and trauma informed approach. - A focus group approach is in place to identify and support managers to deal with areas of high sickness/absence. - All actions completed following internal audit on management of sickness absence returned an outcome of limited assurance. - Care Groups and HR business partners work together to implement actions from the staff survey action plan.					- A HWB offer plan on page has been produced and is currently being finalised through comms team. Once finalised this will be communicated to all staff so they understand where to go for support if needed. (CPO review August 2026). - A cultural diagnostic of forensics has now concluded and considered by EMT, this will be submitted to PRC in July. Action plan to follow to address key findings. Learning and approach to be adopted in a tool kit and used in other areas as required. (CPO review August 2026). - A peer review of restrictive practices and managing violence and aggression is underway which will potentially lead to further quality improvement work and reduction in the use of restrictive practices and incidences of violence and aggression towards staff. (DNQ review August 2026)		PRC Operational Management Group Executive Management Team Trust Board			

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
				- PRC receives an annual report in relation to staff health and wellbeing as per the Committee Workplan - Health and Wellbeing for staff included in the People Strategy										
695	Risk of adverse impact on clinical services if the Trust is unable to achieve the ambitions identified in its strategy	DS	QSC	- Annual priority programmes in place - Service quality metrics in place - Active engagement in West Yorkshire and South Yorkshire Integrated Care Systems - Regular review against the strategy by Trust Board. - Quality improvement process in place for all significant change. - Equality Impact Assessment in place Trustwide - Active stakeholder management to create opportunities for partnership and collaboration which are reflected in corporate objectives. - Trust-wide integrated change process in place - Internal place integration group established - Stakeholder engagement plans in place. - Digital strategy approved by Trust Board. - sustainability impact assessments in place. - Trust clinical strategy includes creative and cultural approaches in clinical services and integrated pathways.	3 Moderate	2 Unlikely	6	1-6 Clinical Safety and Quality risk	Strategy measurement governance process reviewed and agreed by Trust Board in May 2026. Annual review of the strategy will be presented to June Board. (DS Review August 2026)	August 2026	EMT (monthly) Transformation board (monthly) Operational Management Group (weekly) QSC Trust Board	6	Risk level: Organisational level risks within the risk appetite BAF SA 2 – Best Quality	August 2026

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
				- New care includes section on individual needs to ensure disabilities are captured. - Strategy deployment plan, governance approach and measurement approved by Trust Board. "About Me" visualisation live across all MH community and Inpatient SystmOne units - Trust's approach to digital innovation opportunities revised with strong clinical links following Digital Strategy refresh and 10 year plan										
812	Risk that place based or collaborative commissioning arrangements adversely impact on the quality and sustainability of Trust services.	DS	QSC	- System and service transformation overseen Executive Management Team (EMT) and Board. - Quality Impact Assessment process for value for money Programmes in place. - Contracting and business development team in place - Bi-annual Executive Management Team and Trust Board investment appraisal report - Trust engagement with West Yorkshire and South Yorkshire Integrated Care System (ICS) planning process - Systemwide financial control process in place - West Yorkshire Mental Health and Learning Disability collaborative committees in common in place - Established approach to collating and reporting	3 Moderate	3 possible	9	Business risk (8-12)	- To consolidate our place-based expertise and capacity in order to have a role in each of our places as identified under strategic aim of best partner. Given the changing timescales for national policy decision making, this is still ongoing. We have interim arrangements in place and will keep this under review as national timelines become clear. (DS review August 2026) - Proactive engagement in each of our places to understand opportunities and risks associated with the national changes and reduction in ICB funding. (DS review August 2026) - Scoping work underway to determine resources and structure needed to continue to effectively engage in place over the medium term. (DS review August 2026).	August 2026	Bi-monthly focus by EMT on transformation. QSC Executive Management Team (monthly) Trust Board	8	Risk level: Organisational level risks within the risk appetite BAF SA 2 – Best partner	August 2026

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
				- place-based insight from stakeholders in place. - Horizon scanning for new business opportunities. - Trust clinical and quality representation in place on Integrated Care System quality boards - Dedicated capacity and capability to support and associated responsibilities. - Trust clinical strategy in place with implementation plan - Use of workshops with external stakeholders to co-produce changes. - Equality, Diversity and Inclusion strategy in place - Executive Management Team regularly review stakeholder plan - Annual contract negotiation process established with each place - Involvement in the Overview and Scrutiny Committees (OSCs) regarding transformation proposals as required. - Trust transformation plans aligned with ICS place based plans - Ongoing relationships with GP Federations to identify opportunities for collaboration and alignment - Trust senior operational colleagues input into place-based community mental health transformation programmes. - Implementation of Trust EDI strategy includes										

ORGANISATIONAL LEVEL RISK REPORT

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				stakeholder engagement										
1217	Risk that the Trust has insufficient capacity to meet its own strategic and system-wide objectives, potentially resulting in the Trust or system not meeting service users' needs	DS	AC	- Trust strategy in place which identifies strategic ambitions - Annual planning and annual priority setting in place with progress reports via monthly Integrated Performance Report. - Progress against priority programmes overseen via OMG and EMT. - Quality strategy approved and implementation plan established. - Improvement Network established to provide local capacity to support change. - Dedicated capacity and programme structure in place to support integration of Cheswold Park Hospital - Stakeholder map ensures resource is identified to support developments in place. - Progress against Trust strategy is included on the Trust Board workplan - Improvement work against strategic aims reviewed at OMG regularly - Annual planning submission submitted February 2026. - Strategy measurement and governance approach developed in line with Trust Board Committee review.	3 Moderate	4 Likely	12	Business risk (8-12)	- 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 in view of the changing ICB function. (DS review August 2026) - Respond as required to changes in the NHS system as a result of the publication of the NHS 10-year plan. (DS review August 2026) - Following submission of annual plan further detailed work is taking place to understand key actions to be taken and risks for next year (DS review August 2026)	August 2026	Quality Strategy update to QSC AC Operational Management Group (OMG) Executive Management Team (EMT) Trust Board	9	Risk level: Organisational level risks within the risk appetite BAF SA 2 – Best value	August 2026
1432	Risk of lack of workforce planning and talent	CPO	PRC	Leadership and management framework in place.	3 Moderate	3 Possible	9	Business risk (8-12)	Undertake review of data to understand staff group shortages at each level as part of EDI action plan	31 March 2027	PRC	8	Risk level: Organisational level risks within the risk appetite	August 2026

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
	management may lead to gaps in key roles and fail to promote diversity			- Coaching and mentoring offer in place - New appraisal form captures information around development and future career planning - Board succession plan reviewed regularly - Comprehensive management and leadership programmes in place - Shadow Board Programme and Reciprocal mentoring programme in place - Internal transfer process established - Work with places and systems to collaborate on integrated career pathways - West Yorkshire new roles group, chaired by chief nurse and director of quality and professions. - Encouraging diversity is part of talent management processes established with support from staff network groups					- for 2026/27. (CPO review September 2026) - Report submitted to PRC on high level talent management and succession planning of senior leaders. Actions identified. (CPO review September 2026) - Talent management exercise underway by Executives to identify any areas of concern to support development plans. (CEO/CPO review September 2026)		Executive Management Team Trust Board		BAF SA 2 – Best place to work and learn	
2045	Risk that as structural changes, and changes to the role of NHSE and ICB's take place, there is less focus on mental health, learning disabilities and autism leading to contract funding impacting on the Trust's ability to deliver	DFR	FIP	- EMT and Board updated on changes to role of NHSE and ICBs in order to monitor potential impact. - Active engagement in West Yorkshire and South Yorkshire Integrated Care Systems (ICs) and place-based arrangements. - Contracting and business development functions in place. - Contract negotiation processes in place, in order to agree	4 Major	3 Possible	12	8-12 Business risk	- ICB structural changes are in the process of being implemented. (DFR Review August 2026) - Development of place based provider collaborative and delivery of functions previously delivered by ICBs. A full due diligence checklist has been developed and now needs to be completed. (DFR review September 2026) - Once ICB structural changes are implemented, a review of risk and capacity will be undertaken. (DFR review August 2026)	30 August 2026	Trust Board FIP EMT	9	BAF SA 2 NHSE have now instructed ICB's to implement 50% headcount reduction within the 25/26 financial.	August 2026

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
	high quality care			- arrangements for 2026/27 including Mental Health Investment Standard funding - Bi-annual Executive Management Team and Trust Board investment appraisal report. - Regular contact review process in place with commissioners. - Full engagement with ICSs in relation to system finance. - West Yorkshire Mental Health and Learning Disability collaborative committees in common in place. - Established approach to collating and reporting place-based insight from stakeholders in Trust places. - SY ICB Contract Variation for 25/26 is agreed and signed. - Investment priorities identified by Care Group Directors and discussed with Commissioners to be picked up as part of annual planning.										
2063	The risk that an increase in the use of none designated beds, 136 suites and extra care beds to accommodate patients requiring inpatient care, may negatively impact on patient safety and experience and staff capacity and wellbeing, especially if the	COO	QSC	- Daily multi-disciplinary team meetings for discharge planning - Daily (x 3) patient flow meetings for bed management process and 24 hr bed management - Weekly MADE (Multi agency discharge event) meetings - Weekly ICB escalation meetings - Barriers to discharge meeting with system wide partners - Internal governance flow process with escalations	2 Minor	3 Possible	6	Clinical Safety and Quality Risk (1-6)	- Internal oversight from general managers and patient flow managers to ensure the Trust is continually progressing towards compliance with the above (COO review September 2026) - Joint ownership within the ICB to look at barriers to discharge such as housing etc (COO review September 2026) - Oversight of non-designated beds to be reviewed at PSOG on a weekly basis by COO and DNQ. (COO/DNQ review August 2026)	September 2027	EMT QSC Trust Board	2	Target score is Likelihood of 1 Rare and Consequence 2 Minor	August 2026

ORGANISATIONAL LEVEL RISK REPORT

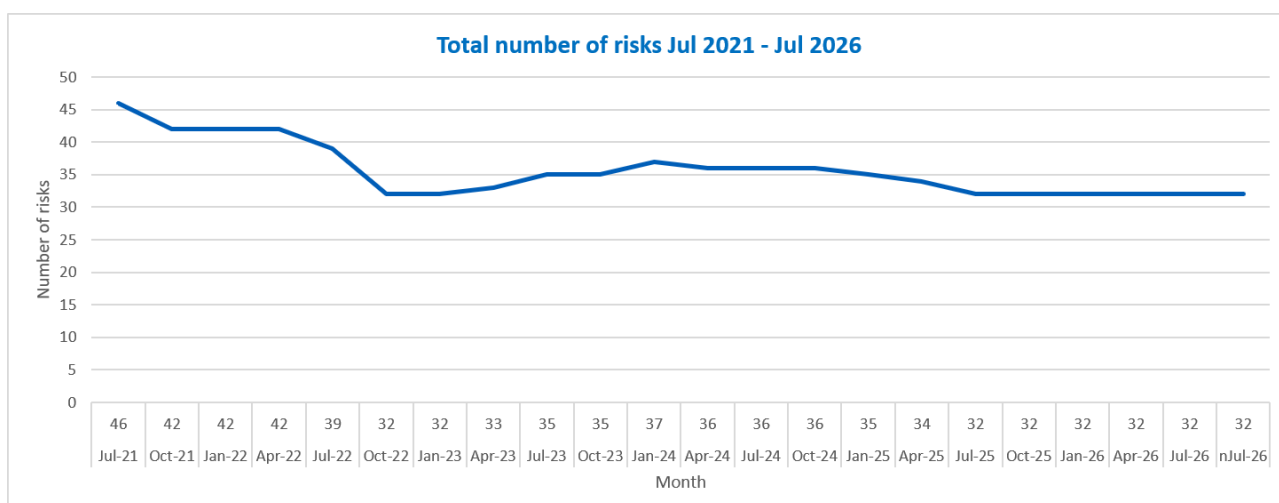
Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
	use of these areas is prolonged as a result of current levels of demand.			National improvement programme for patient flow completed. Joint improvement QI project in place with NHSE										

Appendix 1

**Trust Board
28 July 2026
Organisational Risk Register (ORR)
Quarter 1 analysis, July 2021 – July 2026**

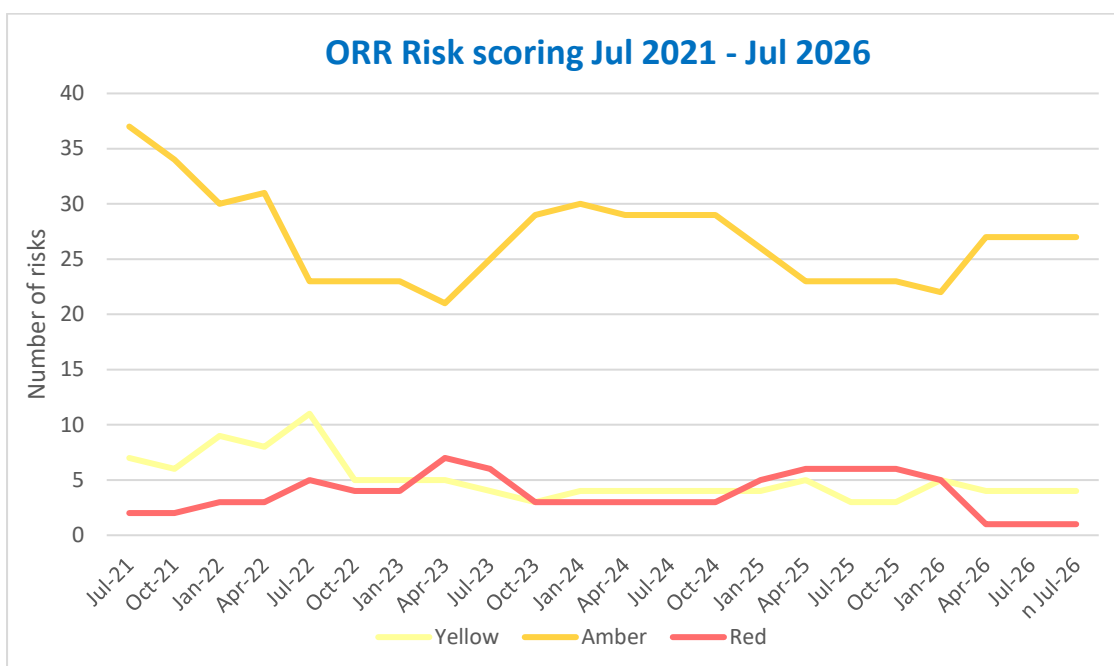
This heat map includes figures from the current Organisational Risk Register from July 2021 to July 2026 to show a longer-term trend. The charts show the current position as well as the projection if the proposals are accepted by Trust Board.

Total number of risks from July 2021 to July 2026



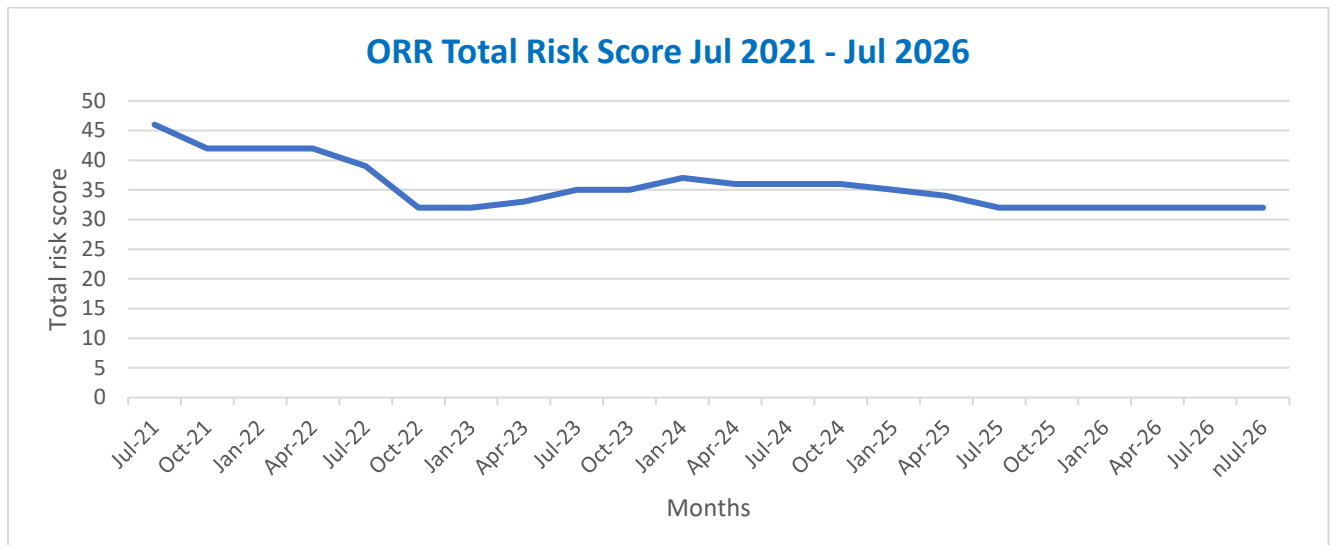
Proposed changes = n July 2026, the total number of risks will remain at 32 risks.

Total risk by grading from July 2021 – July 2026

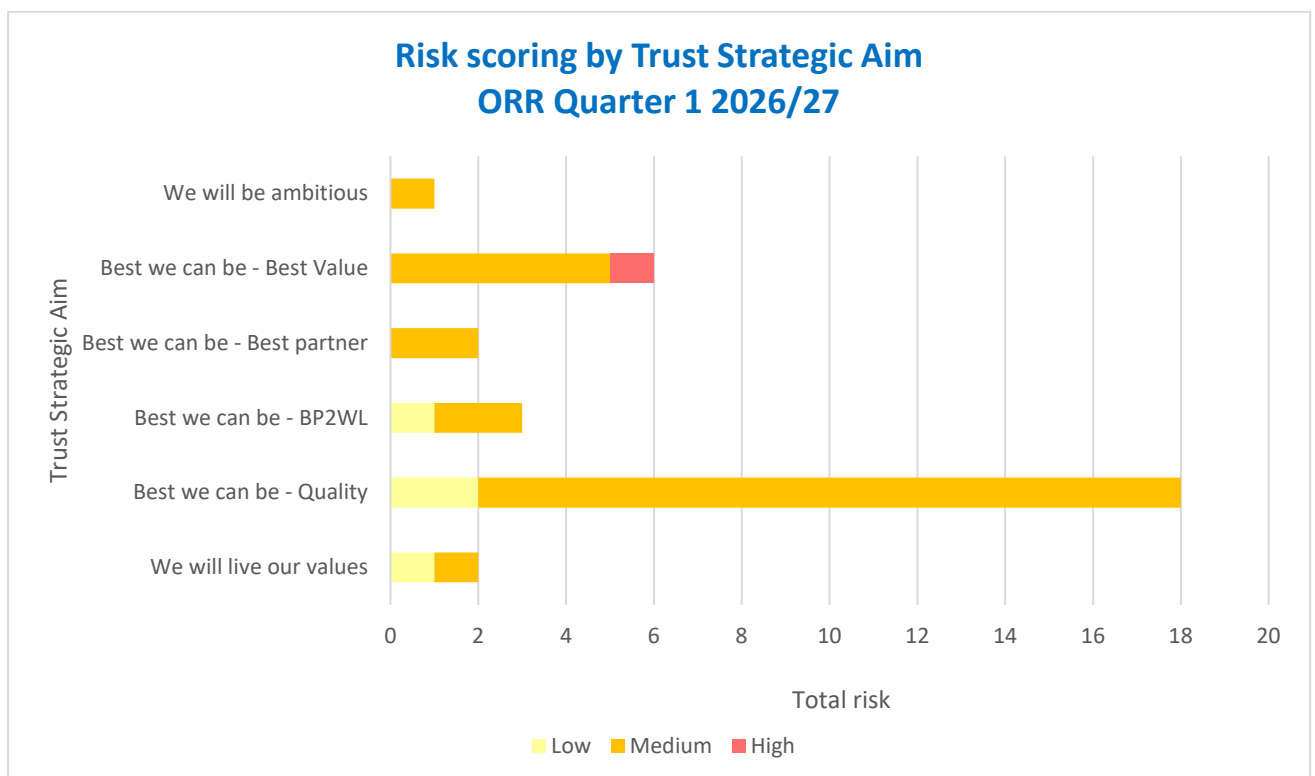


Proposed changes = n Jul 2026.

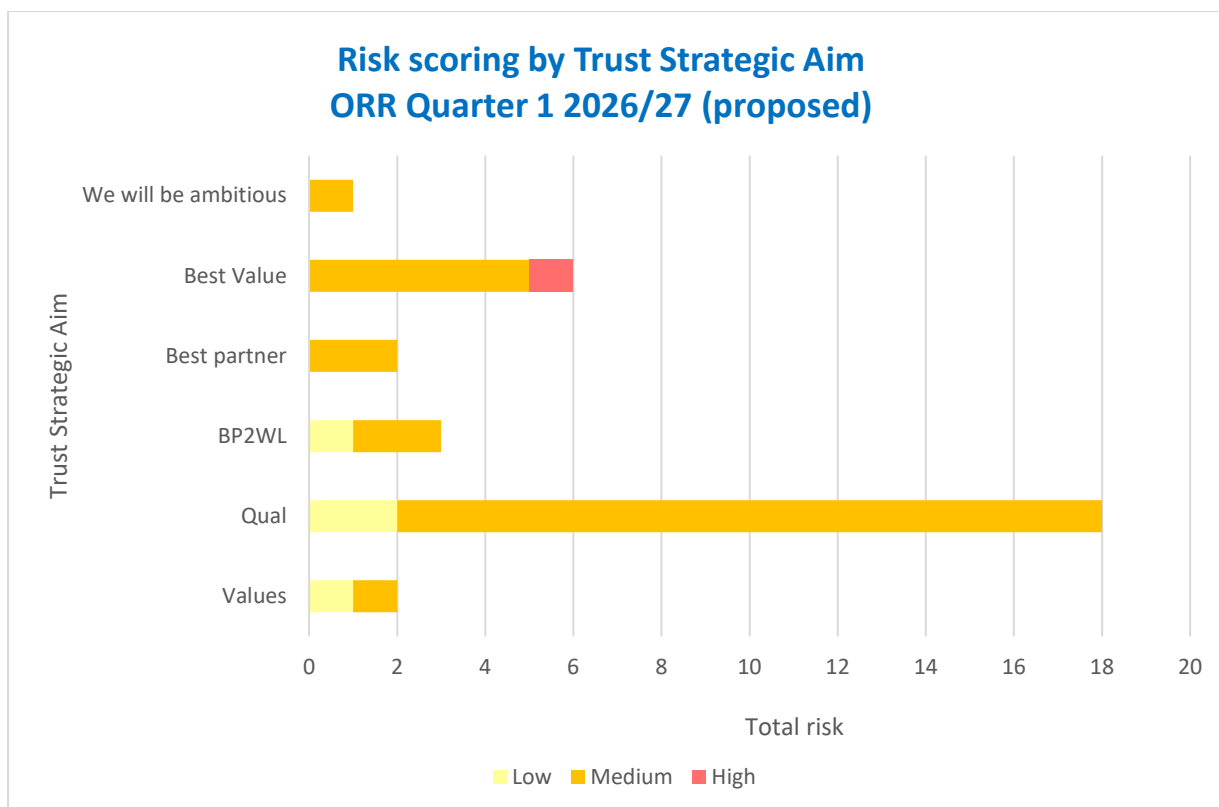
The current accumulative risk score is 309 and this remain at 309 if the proposals are accepted.



A current breakdown of Trust strategic aims ORR Quarter 1 2026/27



If the proposed changes are accepted:



If the proposals are accepted by Trust Board, low (yellow) risks remain at 4. Medium (amber) risks remain at 27 risks and high (red) risks remain at 1 risk.

Total number of risks by Trust objectives ORR Quarter 1 2026/27 (current):



Total number of risks by Trust objectives ORR Quarter 1 2026/27 (proposed)



If the proposed changes are accepted by Trust Board, risk alignment to the Trust strategic aims will remain the same for this quarter.

**Trust Board
28 July 2026
Agenda item 10.3**

Private/Public paper:	Public		
Title:	Equality Diversity and Inclusion (EDI) Annual Report 2025/2026		
Lead Director:	Dawn Lawson, Deputy Chief Executive/Director of Strategy, Inclusion and Change		
Purpose/values:	Equality Diversity and Inclusion (EDI) is woven through our purpose as an organisation and is an integral part to all of the Trust values.		
Purpose:	This paper is our first annual report following the approval of the new EDI strategy. It provides a summary of the work and progress against the six strategic objectives in the strategy for the period April 25 until March 26 as well as setting out our plans for 2026/7. This is in line with our Public Sector Equality Duties (PSED).		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	1.1 Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience. 1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience. 2.1 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. 4.3 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		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The Trust connects into EDI discussions and work at South and West Yorkshire. We have strong connections into EDI mechanisms in all four places.		

Any background papers / previously considered by:	The EDI annual report was previously presented into the Equality, Involvement and Inclusion Committee (EIIC). This report has been considered by: • The EDI Operational Group • Executive Management Team • People and Remuneration Committee on 14 July
Executive summary:	Our refreshed EDI strategy is the key driver of our EDI agenda across the Trust. It sets out how we will ensure that EVERYONE is helped to live well in their community. It describes how we will work to actively understand our communities and colleagues so that all of us reach our potential, identity does not predict outcome, and this is the best place to work and learn for all. The strategy contains six strategic aims, we will: One: strengthen our approach and weave EDI through everything that we do so it is easier to do the right thing. Two: consistently address health inequalities across our services, ensuring we are inclusive and working to minimise the impact of deprivation and the wider determinants of health. Three: actively address equality for the people we serve and our colleagues. Four: ensure we recognise and value diversity through the systematic collection and analysis of data (both numbers and voice) according to protected characteristics. We will use this to develop understanding and as the basis for our decisions. Five: ensure inclusive practices with #allofusinmind so that our colleagues feel they belong, are proud to work here and want to stay Six: truly listen to all our communities and demonstrate the difference we make to those we serve. The report describes progress against each of our strategic aims in terms of the actions we have taken and includes a section on the impact we have had. It includes a section on key themes from our involvement activity which provides information about our impact. A clear, unified operational plan, positioned to use our quality improvement methodology, data intelligence and Involvement approach during 2026/7 is shared.
Recommendation:	Trust Board members are asked to: • RECEIVE and APPROVE the EDI Annual Report for 2025/26 for publication on the Trust website. • RECEIVE and NOTE the integrated EDI single operational plan for 2026/27.

Equality Diversity and Inclusion (EDI)

Annual Report for Trust Board 2025/2026

1. Background and introduction

At South West Yorkshire Partnership Teaching NHS Foundation Trust (SWYPTFT), equality, diversity, inclusion and health inequalities are not standalone programmes; they are embedded within the way we lead, plan, deliver and improve services.

On 1st October 2024, the Trust Board formally agreed the new trust strategy to take the organisation up to 2030. Reducing inequalities and addressing EDI is a key component in achieving our strategy.

We have refreshed our EDI strategy, and this was approved by Trust Board at the meeting on the 25th March 2025. This is our first annual report following the approval of the new EDI strategy and it therefore provides a report on the first year of the delivery of the strategy and covers the period April 25 until March 26. It is a summary of the work that has been undertaken over this time period, further details on all items can be provided if requested.

The delivery of our EDI strategy is based within our Trust Values which provide the foundation for our EDI Strategy, shaping decision-making, leadership behaviours and service improvement across the organisation. These commitments are translated into action through our annual planning processes, organisational priorities and strategic programmes, ensuring that inclusion remains central to both workforce and patient care outcomes.

The leadership and accountability for delivery of our EDI strategy is demonstrated through executive sponsorship and Senior Responsible Owners (SROs) for key programmes aligned to our strategic priorities. Progress is monitored through metrics within each of our Priority Programmes but also on a Trust level with our Integrated Performance Reporting (IPR) framework, which includes equality, diversity, inclusion and health inequalities measures that are routinely reviewed at Board level. This provides robust oversight of delivery, performance and impact, ensuring that inclusion is considered alongside quality, safety and performance across the Trust.

2. Public Sector Equality Duty (PSED)

We are committed to the EDI agenda and to publishing our work on EDI in line with our Trust mission, strategy and values. In addition the public sector equality duty (PSED) requires us to:

- Publish one or more equality objectives at least every 4 years. **These are set out in our EDI strategy.**
- Publish information on general duty compliance with regard to people affected by our policies and practices every year. **This report, along with the other reports referenced within it, covers this for the period of 2025/26.**

- Publish information on general duty compliance with regard to our employees every year. **This report, along with the other reports referenced within it, covers this for the period of 2025/26.**
- Publish gender pay gap data by 31.03 every year. This is a separate process led by the Chief People Officer and reported to the Trust Board. **We can confirm this has been done for 2025/26.**

3. Our EDI strategy

3.1. Purpose

Our refreshed EDI strategy is the key driver of our EDI agenda across the Trust. It sets out how we will ensure that EVERYONE is helped to live well in their community. It describes how we will work to actively understand our communities and colleagues so that all of us reach our potential, identity does not predict outcome, and this is the best place to work and learn for all. Explicitly, the strategy sets out our EDI approach and plans for our community of colleagues (our colleagues) and also the communities we serve (our public). An important part of the communities we serve are our service users, patients and carers.



Figure one: graphic of EDI strategy

3.2. Strategic aims

Our EDI strategy consists of six strategic aims with underpinning work plans and visions for 'what will be different if we get this right.' This is set out in the table below:

Table one: Strategic aims of EDI strategy

Strategic aims	
Strengthen our approach to EDI	One: We will strengthen our approach and weave EDI through everything that we do so it is easier to do the right thing.
Embrace Equality	Two: Consistently address health inequalities across our services, ensuring we are inclusive and working to minimise the impact of deprivation and the wider determinants of health.
	Three: We will actively address equality for the people we serve and our colleagues.
Recognise Diversity	Four: We will ensure we recognise and value diversity through the systematic collection and analysis of data (both numbers and voice) according to protected characteristics. We will use this to develop understanding and as the basis for our decisions.
Deliver inclusivity	Five: We will ensure inclusive practices with #allofusinmind so that our colleagues feel they belong, are proud to work here and want to stay.
	Six: We will truly listen to all our communities and demonstrate the difference we make to those we serve.

3.3. What we will see if we are getting this right

In the development of our strategy document we used the evidence from our engagement and analysis to set out, under each strategic aim, what we will see if we are getting this right. This report uses these outcomes as a guide as we continue to build our measurement systems to more easily demonstrate the impact that we are having.

4. Our progress in 2025/26

This progress report covers the period April 2025 to March 2026.

4.1. Our approach

In the development of the strategy and the subsequent engagement we have always been clear that we must measure the EDI strategy by the impact it has to the people we serve. This includes our service users, patients, carers and communities as well as our colleagues. We need to understand whether we are moving forward on the EDI agenda and making the difference we set out to make for all people and specifically those from marginalised and minoritised groups.

However we are aware that:

- This impact is often not immediately evident in data, even when we consider both the numbers and voice.

- We are on a journey to develop detailed understanding of the data to interpret it fully and therefore coproduce meaningful measures of impact.
- We are only at the end of the first year in the delivery of our five-year strategy.

Consequently in this report we have considered progress against our strategic aims in terms of the actions we have taken and included a section on the impact we have had which we will continue to develop over the next 12 months.

Actions and achievements: Consideration of the areas we identified in the strategy and what we have done over the 12-month period. This is set out with the structure of the strategy as the framework.

Impact: Consideration of the areas we identified in the strategy and how we use data (numbers and voice) to measure our progress. This work is under development and we have set out our progress so far.

Table two Measuring impact

Area	Rationale
EDI Data (numbers) in relation to the areas identified	How have our key metrics changed over time and what is this telling us about our impact?
EDI Data (voice)	What are the key themes from our involvement activity and what is this telling us about our impact?
Triangulation	If we look at both data and voice together, what is this telling us about our impact?

4.2. Actions and achievements

4.2.1. Strategic aim one

One: We will strengthen our approach and weave EDI through everything that we do so it is easier to do the right thing.

In 2025/26 we have:

- Established new governance and architecture from Board to operational level to ensure we deliver the EDI strategy which includes:
 - Refocused Board level governance for EDI to be a responsibility of all Board level committees with clear objectives, rather than the focus of a standalone committee to ensure at Board level that the EDI agenda is business as usual.
 - A new 'allofusinmind insight group' whose purpose is to develop our active understanding of different elements of the EDI agenda and therefore deliver our EDI strategy and, most importantly, have a demonstrable and positive impact for our communities and colleagues. This means that Board committees can directly hear voice on issues relevant to their committee.
 - A new EDI operational group whose purpose is to drive activity which makes the EDI strategy real, ensures we deliver it and importantly achieves the impact we want. This group provides a connection between the EDI agenda for service users, carers and community with the EDI agenda for our colleagues. It is jointly chaired by the Director of Strategy, Inclusion and Change/Deputy Chief Executive and the Chief People Officer.

- Established monthly reporting into EMT on the EDI agenda to provide regular reports into the executive team on progress and issues and enable the regular frequent discussion of EDI alongside other items of Trust business.
- Ensured that EDI and inequalities have been central to discussions throughout our Annual Planning process and therefore as an integral part of our published plan. This was achieved by:
 - ensuring that all directorates had a clear and consistent focus on how plans for 2026/27 will contribute to reducing health inequalities, improving equitable access, and ensuring that services are both inclusive and responsive to the needs of underserved groups. Each stage of the planning cycle included explicit consideration of how proposed priorities, workforce decisions, quality improvements, and financial allocations will support the Trust's EDI ambitions and our overarching strategic aim to reduce inequalities. Examples of work include sessions on the Health Inequalities Toolkit; bespoke Care Group specific meetings and checklists designed to aid reflection within the process.
 - Developing a Trust Equality Impact Assessment (EIA) to inform the final annual plan.
- Considered EDI and health inequalities in the finalisation of the Trust priorities and improvement areas of focus for 2026/7.
- Agreed the terms of reference for an internal audit into the processes that we have in place to deliver on our Public Sector Equality Duties (PSED).
- Developed a single operational plan for 2026/27 which sets out the key activities we will undertake in line with the EDI strategy and which covers elements in relation to our workforce as well as those in relation to our communities.
- Woven our work on Culture of Care into everyday practice. The Culture of Care is an NHS England Quality Transformation Programme developed to transform inpatient wards into safe, therapeutic, and equitable environments for everyone. It centres on 12 core commitments and three cross-cutting equity principles: anti-racism, trauma-informed care, and autism-informed practice. As a Trust we aligned these national standards into our existing six-step Quality Improvement (QI) methodology across four pilot wards. Our approach emphasised strong ward-to-Board governance, ensuring lived experience insights directly informed decision-making and changes on the ward system. Our alignment successfully connected Culture of Care principles into Trust priorities, including the Patient Carer Race Equality Framework (PCREF) and Inpatient Improvement Priority Programme. Key achievements include co-producing Care Plan Approaches processes within Ward setting with patients, implementing sensory-safe environments through the Neurodiverse Connections SPACE (Sensory; Processing; Acceptance; Communication; Empathy) concept, and strengthening staff support through reflective practice. The National programme ended on 31st March 2026 but we have committed to continuing our approach to embed a Culture of Care.
- Improved quality and consistency of Equality Impact Assessments (EIAs) through the further embedding of our EIA processes across policy and service change activity, with a continued focus on quality, assurance and meaningful consideration of impact on people experiencing inequality. All policy EIAs have maintained as compliant, with increased emphasis on translating identified impacts into actions and mitigations. A review of the whole EIA process has started in January 2026 to continue through 2026/2027 with the aim of robustly streamlining core aspects, building in proportionality and creating a culture of engagement with the process.

4.2.2. Embrace Equality

Two: Consistently address health inequalities across our services, ensuring we are inclusive and working to minimise the impact of deprivation and the wider determinants of health.

During 2025/26, the Trust continued to strengthen its approach to reducing health inequalities by embedding equity, inclusion and community engagement across a range of programmes and improvement initiatives. Our work has focused on understanding where inequalities exist, listening to the experiences of underserved communities, and taking action to improve access, experience and outcomes. Our Board Integrated Performance Report has dedicated health inequalities metrics which are considered as part of the Performance review alongside quality, safety and performance.

We have developed the foundations for a dedicated health inequalities approach with tools such as the Health Inequalities Toolkit and a clear alignment of the approach to our already established Quality Improvement Methodology within the Trust. We have supported directorates to explicitly consider health inequalities, deprivation and inclusion within service planning, improvement priorities and resource allocation so for example the development of the Case Management tool has deprivation indicators built into its architecture. This has helped ensure that reducing inequalities is woven into mainstream decision-making rather than being a standalone activity.

We have several outstanding examples of services that have addressed Health Inequalities as a core approach such as the work undertaken within our PATHS (Maternal Mental Health) service in West Yorkshire and our Health Inclusion Team in Barnsley.

Key to this has been our EDS 2022 submission to NHSE. The Trust achieved an overall rating of Developing. A breakdown of the domain outcomes shows:

- Domain 1 (Commissioned/Provided Services): Rated Developing overall. While services (such as Inpatient Learning Disability and Early Intervention in Psychosis) actively accommodate diverse patient characteristics, improvements are targeted for data tracking and access.
- Domain 2 (Workforce Health & Well-being): Mixed outcomes, ranging from Developing (for managing long-term health conditions, tackling abuse, and staff recommendations) to Achieving for providing staff with independent support and advice.
- Domain 3 (Inclusive Leadership): Rated Achieving for Board-level commitment to health inequalities and tracking risks in official papers. It was rated Developing regarding the robust performance-monitoring levers used by leaders.

Three: We will actively address equality for the people we serve and our colleagues.

In 2025/26 we have:

- Continued the introduction and embedding of the Patient and Carer Race Equality Framework (PCREF) as a Trust wide programme. Our work has focused creating connectivity into the Priority Programmes and supporting colleagues to understand their roles within the PCREF commitments. We have initiated the development of an

external PCREF Advisory Group in close collaboration with ten diverse community groups across the Trust footprint. This group models true co-production as we sit side by side with individuals discussing work within the Trust and shaping how we respond to the voices within our communities. It ensures we maintain a highly reflective, culturally sensitive community voice while working alongside place-based partnerships to eliminate local inequalities.

- Reviewed and developed our Accessible Information Standards (AIS) Approach through a Quality Improvement methodology centred on lived experience. Key achievements include:
 - A comprehensive AIS Policy update (February 2026).
 - The successful remediation of website accessibility standards.
 - Technical integration progresses with a clear workstream on implementing the Reasonable Adjustment Digital Flag (RADF).
 - Targeted workstreams to improve inclusivity for Deaf, blind, and neurodivergent service users, supported by new staff resources and "Deaf Champion" roles.
 - Production of an Easy Read Intranet suite of resources to allow accessibility of language and information.
 - A review of the Interpreter contract we hold with Word 360.
- Strengthened place based and community led approaches to tackling health inequalities. We have built on previous investment, to continue to support grassroots and voluntary sector initiatives that address isolation, inequality and exclusion, particularly around the utilisation of our carers fund, which has allocated small grants to carers, but with a massive impact on the support our carers receive.
- Provided continued assurance against the NHS Equality Delivery System (EDS2022). The Trust has moved to an EDS 2022 developing rating, but with clear actions supported by improved triangulation of workforce, patient experience and involvement data.
- Undertaken work to improve outcomes for patients and reduce detentions under the Mental Health Act. This involved targeted engagement to explore the lived experiences of Black, Asian and Mixed Ethnic men, alongside carers, families, and community leaders to inform opportunities for improvement. The clinical focus areas were:
 - Males with a Black, Asian and Mixed ethnic background.
 - Aged between 18 – 65.
 - Based in the following postcode areas – HD1/HD2, HX1 and WF13.
 - Have, or experience of, a serious mental illness.

Questions/insight were codeveloped with a clinical reference group and with the Patient carer race equality community advisory group members. The engagement included focus groups, questionnaires and individual/targeted conversations, using a mix of guided questions and appreciative enquiry in conversation. From the information gather we are developing a work programme within the Trust to support shaping systemic opportunities to improve patient outcomes and safely reduce detentions under the Mental Health Act.

4.2.3. Recognise Diversity

Four: We will ensure we recognise and value diversity through the systematic collection and analysis of data (both numbers and voice) according to protected characteristics. We will use this to develop understanding and as the basis for our decisions.

In 2025/26 we have:

- Had a focus on building a strong foundation for insight led action, focusing on understanding the current position, establishing baselines, building capability, and creating the foundations for change.
- Commenced the work for this foundation work to be included in the Integrated Performance Report for 2026/27.
- Collected, analysed and submitted our workforce race equality data and our workforce disability equality data.
- From our analysis we have developed an improvement plan which includes actions on:
 - Inclusive recruitment and career progression
 - Tackling harassment and discrimination
 - Staff engagement and wellbeing
 - Representation and visibility in senior roles
 - Governance and accountability
- Refreshed our previous Insight Report and introduced the *Nothing About Me Without Me – Involving People Report* to strengthen the connection between community voice, governance and action. While the former approach successfully captured feedback from service users, carers, staff, partners and communities, it was less effective at ensuring that themes and experiences consistently informed decision-making, service improvement and organisational priorities. The revision has taken place through 2026 and reporting which will go LIVE in October 2026 is designed to move beyond collecting feedback to demonstrating how experiences influence change. It provides a structured framework for identifying themes, escalating priorities, and embedding learning within annual planning, governance and improvement processes. Recognising that “insight” encompasses clinical, performance and qualitative information, the new report focuses specifically on lived experience and community voice gathered through Trust involvement activity. Aligned to the Trust’s revised Involvement Approach and underpinned by the Involvement Ladder, the report ensures that involvement is purposeful, meaningful and action-oriented—supporting the principle that people should be actively involved in shaping the services they use, rather than simply being consulted about them.

4.2.4. Deliver inclusivity

Five: We will ensure inclusive practices with #allofusinmind so that our colleagues feel they belong, are proud to work here and want to stay.

Six: We will truly listen to all our communities and demonstrate the difference we make to those we serve.

In 2025/26 we have:

- Ensured that meaningful engagement and co-production are central to our approach. Internally we have four established staff networks, REACH, Carers, Disability and LGBTQ+, which are supported centrally by our People Directorate and provide invaluable insight, challenge and lived experience perspectives. Following a recent review, all networks have refreshed their leadership arrangements, with new Chairs and members appointed to strengthen representation, increase engagement and support the continued development of an inclusive organisational culture.
- Used a quality improvement methodology to refresh and improve our involvement approach. This approach has been co-designed with Lived Experience and a range of Colleagues, taking learning from other Trusts to shape an approach that understands the importance of Involvement, and provides opportunities embed this within Quality Improvement Methodology. Sitting within this there are numerous ways in which we involve people from ward-based community panels through to an external mental health panel and an external advisory group of community members.
- Adopted an EMT approved Ladder of Involvement, a conceptual tool that sits as central to our Involvement Approach demonstrating that participation ranges from sharing information to full co-production. By utilising this model, we are actively shifting our practice from "doing to" people to "doing with" them in reciprocal partnerships.
- Developed a new involvement guide which has been co-designed with a number of stakeholders (internal and external to the Trust) in line with our agreed Involvement Approach . We have called the guide "Nothing about me without me," it sets out the Trust's commitment to meaningful involvement of people with lived experience in shaping, delivering, and reviewing services. It promotes partnership, co production, and equity, while providing colleagues with the practical tools, guidance, and reflective prompts needed to involve people well, ethically, and consistently, so services are truly person centred rather than organisation led.
- Continued to develop our support for carers, including our accreditation for this work under triangle of care. We have made significant progress towards achieving Triangle of Care Star 2 accreditation by July 2026. We have noted strong developments in carer inclusive practice and positive momentum in areas such as forensic services, carer awareness training, young carer pathway development and the refresh of the Carer Champion Network.
- We have recognised the increasing organisational and National recognition of the need to be neurodivergence aware in both our clinical practice and the way we support our workforce. Neurodivergent people often experience disproportionate barriers when accessing services, navigating environments, or communicating their needs, and it is essential that our approach reflects this. We have used learning from a critical incident as a catalyst to identify specific actions to strengthen staff capability, improve reasonable adjustments, and ensure care is delivered in ways that are responsive to sensory, communication and processing differences.

We have also:

- Delivered a Neuroaffirming Language Session, aimed at helping staff understand the importance of identity affirming, strengths based and non pathologising language when working with neurodivergent people. These sessions have been positively received and are contributing to a broader cultural shift, helping staff feel more confident in using

language that respects lived experience and promotes psychological safety.

- Aligned this work into the Culture of Care programme – Developing an Autistic Approach equity principle.
- Continued to develop our Connecting people programme as a core delivery mechanism for inclusion and involvement. This programme helps the Trust move from isolated examples of engagement toward meaningful involvement and serves as the vital engine for this culture shift. We have successfully trained over 138 Connectors across partner organisations, our internal workforce, and third-sector communities. These Connectors are embedded across the Trust's geography, bridging the gap between NHS providers and diverse local communities. This model leverages community assets and supports the robust social networks that heavily influence long-term health and wellbeing. Alongside this we have maintained our connection with external service user groups and Mental Health Alliances structures in place to make sure voice comes not from those just in our services but also those who may be facing the biggest challenges and barriers to access.

4.3. Impact

4.3.1 Increased understanding

Our focus during 2025/6 has been to develop a deeper understanding of our data and to increasingly ensure that we consider our EDI data alongside other measures in a meaningful way. We have aligned our data to improvement methodology so it helps us to format it in a way that helps to guide insight and action. It allows us to [identify](#) where inequalities exist, [understand](#) who is affected, [plan and generate](#) ideas to target resources effectively, and measure whether our actions are making a difference and support better outcomes for our communities.

Year one of the EDI strategy and this annual report aligns closely with the Trust data culture and intelligence work that we are undertaking within the organisation so we increasingly use our data and information to inform all that we do. Building a strong foundation for insight led action has been the priority throughout 25/26 and has helped us to focus on understanding the current position, establishing baselines, building capability, and creating the foundations for change. This foundation work is now visible in our IPR and therefore presented on a quarterly basis into key Trust meetings and the Trust Board. Examples of the dashboards are shared below.



Figure two: examples of information in the IPR

This work has helped us to have a better understanding of:

- Who makes up our workforce, service users, and communities?
- Where are the inequalities?
- Which groups have poorer experiences or outcomes?
- What data do we currently collect?
- What data gaps exist?

We are creating a robust baseline against which progress can be measured. The new reporting framework collaboratively configured for our IPR, helps us to provide and strengthen the action required to make a difference. Our focus in 26/27 will be to embed this methodology across all the work we do.

4.3.2 Identifying priority inequalities in 26/27

Strengthening the data culture and intelligence across the organisation leads us into 26/27 in an improved position to accurately identify:

- The greatest disparities
- Highest-risk groups
- Areas where intervention is likely to have the most impact

This ensures our EDI priorities are evidence-led rather than assumption-led and means we can develop the insight needed to target action, measure progress, and hold ourselves accountable for reducing inequalities.

4.3.3 What do we hear from people?

Key Themes from Our Involvement Activity & What It Tells Us About Our Impact.

We have undertaken analysis from our involvement activities so that we can understand how our practices directly impact on service user/patient experience. This thematic analysis includes consideration of feedback from ward community meetings, targeted health inclusion initiatives, and service user life stories.

The overarching message from Service Users is clear. We want you to move from simply "managing" individuals to truly "understanding" them, making sure we not only see the person in the room but understand in a truly trauma informed approach why we are seeking your support. By making these improvements we believe we will create further momentum for recovery, build increased trust, and reduce distress.

We have undertaken detailed analysis and identified themes from our involvement activity which are set out below, along with the approach we have taken to respond to these:

Theme 1: Environmental Adaptations and Sensory Vulnerabilities

- **The Feedback:** Clinical and ward environments can inadvertently trigger severe distress if they fail to account for neurodiversity, trauma, or physical health conditions. For instance, loud noises and busy ward settings have historically led to autism-related meltdowns being misidentified as acute psychiatric panic or psychosis. Similarly, standard clinical environments can feel unwelcoming or unsafe for trauma survivors and migrant communities.
- **Our Action:** We understand that when we make targeted environmental adjustments (such as introducing neuro-affirming supports or creating trauma-informed clinical spaces), we significantly reduce patient anxiety and lower appointment "Did Not Attend" (DNA) rates.

We have therefore commenced work to:

- Test out change ideas through the Culture of Care methodology following from the learning in our Sandal Ward environment.
- Use the findings from our Culture of Care programme to inform the work we are doing to improve our Women's Pathway.
- Develop a specific programme reviewing the feedback from people who have been detained under the MH Act based upon the findings from the Empowering Partnerships in Communities (EPIC).

Theme 2: Communication, Clarity, and Relational Consistency

- **The Feedback:** Service users report extreme vulnerability when communication is broken or inconsistent. Non English speaking service users have historically experienced gaps in care, such as being given medication without explanation or consent due to inconsistent interpreter provision. Furthermore, standard administrative communication (such as official brown envelopes or complex language in letters) can trigger intense anxiety or fear for asylum seekers and refugees.
- **Our action:** We have
 - implemented tools like "About Me" flags on SystmOne to redefine how we respond to Reasonable Adjustments and will continue to embed this through 2026.
 - utilised consistent communication methods through a review of our interpretation services contract, and co-designed simplified, accessible information materials.
 - Reviewed our Accessible Information Standards Policy (AIS) in February 2026.

Theme 3: Patient Care vs. Operational Pressures

- **The feedback:** Service users consistently praise the care, kindness, and therapeutic relationships built with ward staff and Occupational Therapy (OT) teams. However, staffing shortages and use of Agency or Bank heavily impact this, with patients noticing that staff are often "always running around and really busy," which directly limits access to therapeutic activities and outdoor time. The lack of consistency gained from non-directly employed staff is also noted as a concern within feedback.

- **Our action:** The Trust has significantly reduced our use of agency staff. The reduction in the use of Bank staff is currently a key priority within the Trust alongside a key commitment to recruitment into fixed roles throughout 2026/ 2027.

Theme 4: Food Quality as a Clinical Intervention for Recovery

- **The Feedback:** Patient feedback strongly demonstrates that poor food quality in previous healthcare settings directly causes clinically significant, unintentional weight loss and reliance on oral nutritional supplements.
- **Our Action:** We have improved the quality and variety of meals and seen a subsequent impact on individual patients who have been able to completely discontinue prescribed supplements, progress to eating full portions, and resolve long-standing dietetic complications.

Theme 5: Culturally Inappropriate Models vs. Culturally Informed Support

- **The Feedback:** Our service users report that sometimes traditional clinical structures do not accommodate different cultural paradigms of mental wellness. This can mean we have systemic biases, make unconscious assumptions, and have an over-reliance on coercive practices or involuntary detentions under the Mental Health Act.
- **Our Action:** We are actively involving individuals in alternatives to detention and designing culturally appropriate care models. We have a Trust focus on personalised care, which we measure through Co-produced care plans which at date is at 95%. Our investment in our Community Connector model is helping to bridge the gap between services and community voice. Our work into 2026/2027 will further drive forward our approach aligned to our PCREF commitments as an organisation.

5. Our plans for delivery of the strategy in 2026/7

We have developed an integrated EDI plan for 2026/7 which is driving our work and discussions within the EDI Operational Group. A copy of this plan is included at Appendix A for reference.

Alongside this the embedding of our Involvement Approach, and our review of integral processes such as our EIA approach, and Insight Approach will be key to further embedding our EDI approach into all that we do and maintaining a clear identification and focus on our impact for those we serve.

6. Conclusion and recommendations

This report sets out the headline achievements on our EDI agenda in 2025/6 and an outline of our plans for 2026/7 capturing the first year of delivery under our refreshed 2025–2030 Equality, Diversity, and Inclusion (EDI) Strategy.

Over the past 12 months, the Trust has made significant progress from viewing EDI as a standalone initiative to weaving it directly into our leadership, governance, and annual planning architecture. We will continue this work into 2026 as it is a key strategic aim of our strategy.

We highlight the following key achievements for this year:

- **Strengthened Governance:** The establishment of the allofusinmind insight group and the EDI operational group has bridged workforce and community agendas under executive oversight. We are already seeing the advantages of this more integrated way of working.

- **Tangible Service Improvements:** Responding directly to patient "voice" has driven meaningful changes, including reducing agency staff usage, launching the reflection on sensory-safe ward environments, updating Accessible Information Standards (AIS), and achieving a 95% completion rate for co-produced care plans.
- **Data Culture Foundation:** We have established robust data baselines within our Integrated Performance Reporting (IPR) framework to better understand disparities across protected characteristics. This enables us to further develop the measures to demonstrate our impact.

While year one focused heavily on establishing these baselines, building capability, and embedding foundational tools like the Health Inequalities Toolkit, the Trust recognises that true equity is a journey.

We enter 2026/27 with a clear, unified operational plan, positioned to use our quality improvement methodology, data intelligence and Involvement approach to move from assumption-led practices to targeted, evidence-led interventions that actively reduce health inequalities. This work is fundamental to ensuring that we are the Best we Can Be for our patients, service users, carers and colleagues.

6.1. Recommendations

The Trust Board is asked to:

- Receive and approve the EDI Annual Report for 2025/26 for formal publication, noting compliance with our Public Sector Equality Duties (PSED).
- Note the integrated EDI single operational plan for 2026/27 (detailed in Appendix A) to drive accountability across both workforce and clinical directorates.
- Support the continued embedment of the EDI and health inequalities metrics within the monthly Integrated Performance Reporting (IPR) framework to track ongoing systemic impact.
- Support the embedding of strategic priority frameworks, specifically the Patient Carer Race Equality Framework (PCREF) commitments; Our Triangle of Care Standards and the legacy elements of the Culture of Care programme.



Shared EDI operational plan

EMT

23rd April 26



Introduction



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Partnership Teaching
NHS Foundation Trust

We have now established the EDI operational group under shared leadership of the Executive Director of strategy, inclusion and Change and the Interim Chief People Officer

The purpose of the group is to make the strategy real, ensure we deliver it and achieve the impact we want

The group has developed a **shared EDI operational plan** to set out the key priorities for 2026/7



With **all of us** in mind.

Agreed principles



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- Do it well, do it once with one plan
- Triangulation of data (numbers) and also data (voice)
- Clear focus on areas to maximise impact on the things we were told needed to change and which are therefore explicit in our EDI strategy
- Being brave to maintain focus and to clearly and confidently explain why. Help stop incentivitis
- Work together on the things that make sense to do so, work separately where this makes sense but always connect to share learning and language. Think of the work as having different lenses, rather than being in separate boxes. Actively looking at connections and sharing of learning
- Keeping things as simple as possible and having a simple way of describing the work on EDI with a shared language that we can all use
- Operational oversight, delivery and demonstrable impact are the key functions of the operational group.
- Shared plan to keep focus on key priorities with updates on
 - Progress against milestones
 - Impact (including the use of storytelling)
 - Any risks/barriers to delivery
- Receives information from the #allofusinmind insight group where the listening to data and voice has taken place. Takes this information and operationalises a response
- Enables co-ordination of EDI work to enable co-ordinated reporting into EMT

With **all of us** in mind.

Shared plan

- **Pulls together existing plans into one place**
- **To avoid replication we have signposted**



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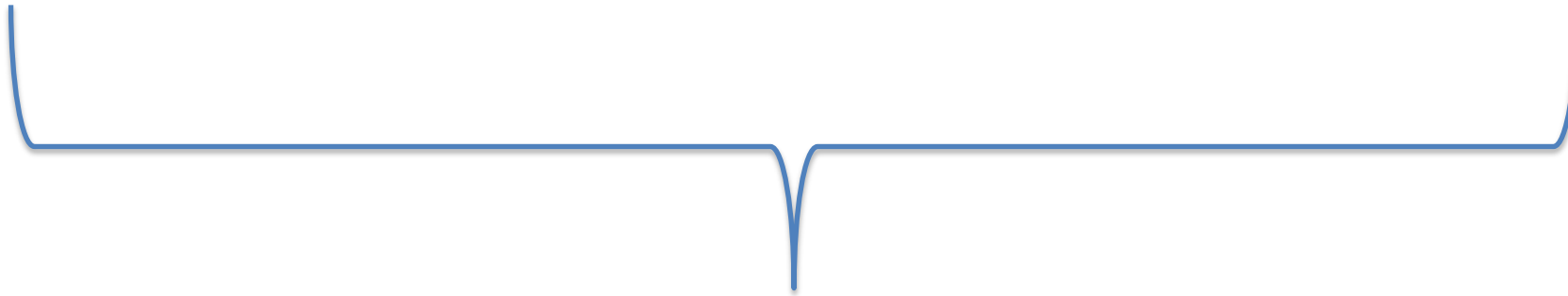
**Education, learning
and Organisational
Development Plan
(ELOD)**



**EDI improvement
plan
(EDli)**



**Areas of EDI priority
focus for 2025/6
agreed June 2025
(EDIp)**



One shared plan

**Used abbreviations in brackets above
to signpost and reduce duplication**



With all of us in mind.

Our strategic aims for EDI

Used these as the basis for the plan structure

Note – plan is high level



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Strategic aims	
Area	Strategic aim
Strengthen our approach to EDI	One: We will strengthen our approach and weave EDI through everything that we do so it is easier to do the right thing
Embrace Equality	Two: Consistently address health inequalities across our services, ensuring we are inclusive and working to minimise the impact of deprivation and the wider determinants of health*
	Three: We will actively address equality for the people we serve and our colleagues
Recognise Diversity	Four: We will ensure we recognise and value diversity through the systematic collection and analysis of data (both numbers and voice) according to protected characteristics. We will use this to develop understanding and as the basis for our decisions
Deliver inclusivity	Five: We will ensure inclusive practices with #allofusinmind so that our colleagues feel they belong, are proud to work here and want to stay*
	Six: We will truly listen to all our communities and demonstrate the difference we make to those we serve

Strengthen our approach to EDI

The weaving

PSED

Publish one or more equality objectives at least every 4 years	Publish information on general duty compliance with regard to people affected by your policies and practices every year	Publish information on general duty compliance with regard to your employees every year	Publish gender pay gap data by 31 March every year

1) Align to priorities in our annual plan (EDIp)	1.1 Ensure that EDI is included, as appropriate in the delivery planning for all priorities in 26/7
2) Improve EDI compliance and monitoring (EDIp)	2.1 Meet requirements of Public sector equality duty (PSED) • Equality objectives • Annual report • Report on compliance to duty to employees • Pay gap reporting (ELOD) 2.2 Undertake EIA review and implement findings 2.3 Develop a shared understanding of the ‘must do’s’ and monitor our delivery of them
3) Review and amend the supporting architecture (EDIp)	3.1 Review and develop architecture for delivery of strategy ensuring governance and accountability are clarified 3.2 Launch #withallofusinmind insight group and develop systems to ensure that the insight gained is used to actively influence the Trust 3.3 Develop robust KPIs for regular monitoring, reporting and driving improvement
Governance and accountability(EDli)	

Embrace Equality

4) Review and improve Accessibility Information Standards delivery compliance and related policies. (EDIp)	4.1 Review and improve Accessibility Information Standards delivery compliance and related policies.
5) Continue our journey as an actively anti-racist organisation (EDIp) (ELOD)	5.1 Develop and deliver a plan in line with our stance that we are an actively anti-racist organisation. To include • Active bystander (ELOD) • United against campaigns
6) PCREF implementation (ELOD)	6.1 Deliver the PCREF implementation plan
7) EDS2022 (ELOD)	7.1 Deliver the EDS 2022 requirements (all three domains)
8) Improve our understanding of the communities we serve and the health inequalities of our population (EDIp)	8.1 Develop and deliver our health inequalities plan for 26/7

Recognise Diversity

9) WRES and WDES reporting (ELOD)	9.1 Deliver the EDI improvement plan 9.2 Submit the data in line with requirements for WRES and WDES 9.3 Develop a new improvement plan based on findings (October 2026)
10) WRES / WDES representation and visibility in senior roles (EDli)	10.1 Understand the data in relation to representation in senior roles and develop specific actions to test in relation to areas of improvement

Deliver inclusivity

11) Build an inclusive workforce reflective of our population(EDIp) Inclusive recruitment and career progression(EDli)

- 11.1 Understand the data in relation to inclusivity in the workforce and identify particular areas to target
- 11.2 Develop and deliver an improvement plan
- 11.3 clarify expectations of Line Managers (ELOD) as part of work on values into behaviours

12) Tackling harassment and discrimination (EDli)

- 12.1 Tackle harassment and discrimination in line with plans already in place
 - Guardian and equality roles
 - Race forward – task and finish

13) Deliver an improved involvement approach (EDIp)

- 13.1 Undertake benefit realisation exercise to identify impact of recent/current stakeholder engagement activity. (EDIp)
- 13.2 Establish the involvement approach and budget

14) Staff engagement and wellbeing(EDli)

- 14.1 Deliver staff engagement and wellbeing plans already in place. Including
 - Coproduce how we support and develop staff networks

Next steps



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- We are currently aligning the monthly reporting into EMT around these 14 priority areas. This will include scheduling updates at key times
- We have developed an action tracker which we are testing
- We are developing the agenda to cover these areas in a proportionate way



With **all of us** in mind.

**Public Trust Board
28 July 2026
Agenda Item 10.4**

Private/Public paper:	Public		
Title:	Infection prevention and control (IPC) Board Assurance Framework (BAF)		
Lead Director:	Caroline Johnson, Chief Nurse, director quality and professions		
Mission/values:	Our values We put the person first and, in the centre We know that families and carers matter We are respectful, honest, open and transparent We improve and aim to be outstanding We are relevant today and ready for tomorrow		
Purpose:	The purpose of the IPC Board assurance framework enables the Trust to self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA). The document identifies any risks associated with infection prevention and control including, infectious agents and outline a corresponding systematic framework of mitigation measures. The outcomes can be used to provide evidence to support improvement and patient safety.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at	As a provider organisation within both Integrated Care Systems, the Trust is expected to maintain robust IPC governance arrangements, of which the IPC BAF self-assessment is a core component, providing assurance on compliance, risk management and continuous improvement.		

national regional or local level.	
Any background papers / previously considered by:	The IPC BAF: • Is presented to Quality and Safety Committee and Trust Board on a 6 monthly basis. • Was last presented and approved at Quality and Safety committee in July 2026. • Presented and reviewed at the Trust IPC TAG meeting, where monitoring, action and governance is applied.
Executive summary:	This report provides assurance on the Trust's Infection Prevention and Control (IPC) arrangements through the IPC Board Assurance Framework (BAF), which is aligned to the <i>Health and Social Care Act 2008: Code of Practice on the prevention and control of infections</i>. The BAF supports systematic oversight of IPC compliance, risks, and improvement activity across the organisation. As of June 2026, the Trust is compliant with 9 of the 10 IPC Code of Practice criteria, with one area of partial compliance relating to Criterion 6.5 (FFP3 fit testing). Good progress has been made, including improved recording of competencies, implementation of a structured fit testing programme, and a risk-based prioritisation approach focusing on ward and inpatient environments where there is potential for aerosol-generating procedures (AGPs) to be undertaken. However, full compliance has not yet been achieved due to capacity constraints and data assurance challenges. Robust controls are in place, including a structured fit testing programme, monitoring through governance groups (IPC TAG and Safety and Resilience TAG), and reporting via the IPC BAF. Despite this, key challenges remain, including limited fit testing capacity, predominantly in-hours service provision, and gaps in ESR (electronic staff record) data completeness and alignment with local records. This report also provides the Trust's response to NHS England requirements issued in June 2026 following the Covid-19 Inquiry (Module 3), which require improved ESR recording, strengthened fit testing capacity, and enhanced workforce resilience by November 2026. The Trust's response includes actions to: • Validate and cleanse ESR data • Align ESR records with local and IPC datasets • Strengthen care group accountability for data quality • Review and expand the fit testing workforce and delivery model • Progress investment in respirator hoods Overall, the Trust demonstrates strong IPC performance, with clear and focused actions in place to address the remaining gap and strengthen preparedness for future health emergencies.
Recommendation:	Trust Board members are asked to • RECEIVE the Report for assurance on the current position and actions being taken in response to the NHSE letter by the November deadline.

Infection Prevention and Control Board Assurance Framework

1. Introduction

The Trust is committed to maintaining robust, effective systems and processes to prevent and control infection, protect patients, staff, and visitors, and ensure compliance with statutory and regulatory requirements.

The IPC Board Assurance Framework (BAF) provides a structured mechanism to support this, enabling systematic oversight of IPC risks, controls, and assurance. It supports the Trust in identifying areas of compliance, highlighting gaps, and driving continuous improvement in infection prevention and control practice across all services and settings.

The IPC BAF is aligned to the ten criteria set out in the *Health and Social Care Act 2008: Code of Practice on the prevention and control of infections*, alongside relevant disease-specific IPC guidance. It enables:

- The recording of evidence of compliance
- Identification of risks and control gaps
- Monitoring of mitigating actions
- Continuous oversight through established governance arrangements

Each criterion is assessed using a RAG rating (not applicable, non-compliant, partially compliant, or compliant), providing a clear and transparent view of the Trust's position.

In addition, this report provides a formal response to NHS England correspondence issued on 18 June 2026 following the publication of the UK Covid-19 Inquiry (Module 3). This correspondence highlights the need for NHS organisations to strengthen preparedness for future pandemics, with particular focus on:

- The recording and assurance of FFP3 fit testing in ESR
- Workforce resilience and safety
- Organisational capacity to deliver fit testing at scale

This response forms part of the Trust's wider commitment to learning from the Covid-19 pandemic and ensuring a robust and sustainable approach to IPC and workforce protection.

2. Current IPC BAF Position (June 2026)

The June 2026 IPC BAF assessment demonstrates a strong level of compliance across the organisation and reflects the maturity of the Trust's infection prevention and control arrangements.

The Trust is currently compliant with nine of the ten IPC Code of Practice criteria. One criterion remains partially compliant.

This position provides assurance that the Trust has effective systems, processes and governance arrangements in place to meet most statutory IPC requirements and that areas requiring improvement are understood, actively managed and subject to ongoing monitoring.

2.1 Area of Partial Compliance

Criterion 6 – Requirement 6.5 (FFP3 Fit Testing)

This requirement relates to ensuring that all relevant members of staff have access to appropriate respiratory protective equipment and have successfully completed fit testing where this is required.

Significant progress has been made during the reporting period, including:

- Improved recording and reporting of fit testing competencies.
- Implementation of a structured fit testing programme aligned to operational need.
- Enhanced oversight and monitoring through established governance arrangements.
- Completion of risk stratification to identify priority staff groups and clinical areas.

Recognising the finite capacity available within the current fit testing service, the Trust has adopted a proportionate risk-based approach to prioritisation. Fit testing activity has been focused on staff working within clinical environments where there is the greatest likelihood of aerosol-generating procedures being undertaken or where respiratory protective equipment may be required at short notice. Emphasis has therefore been placed on ward-based and inpatient services, ensuring available resources are directed toward areas of highest operational risk.

Whilst progress continues, full compliance has not yet been achieved due to capacity constraints and the need to further strengthen data assurance processes.

3. Controls and Sources of Assurance

The Trust has a range of established controls in place to support compliance with IPC requirements and to provide assurance regarding the effectiveness of risk management arrangements.

These include:

- A structured and planned fit testing programme.
- Local monitoring of workforce fit testing coverage and service capacity.
- Availability of respiratory protective equipment from multiple manufacturers to maximise successful fit outcomes.
- Defined governance and reporting arrangements.
- Routine monitoring through the IPC Board Assurance Framework.
- Compliance with Health and Safety Executive requirements and national guidance.

Oversight is provided through the Infection Prevention and Control Trust Action Group (IPC TAG), with escalation through Clinical Governance Group and EMT where appropriate. These arrangements ensure that risks, performance indicators and improvement actions are routinely reviewed and that emerging issues are identified and addressed in a timely manner.

Collectively, these controls provide a robust framework for monitoring compliance, supporting continuous improvement and maintaining organisational oversight of IPC risks.

4. Key Risks and Challenges

Whilst substantial progress has been made, several challenges continue to impact achievement of full compliance with Criterion 6.5.

The principal challenge relates to the capacity available to deliver fit testing at the scale required to achieve and sustain full workforce compliance. Delivery of the programme continues to rely on a finite number of trained fit testers, creating constraints on the pace at which remaining staff can be assessed and recorded.

A further challenge relates to the quality, completeness and alignment of data held within the electronic staff record (ESR). Whilst fit testing data is recorded and reported, additional work is required to ensure full reconciliation between corporate records, local service records and IPC datasets. Until this work is complete, there remains a residual risk that compliance reporting may not fully reflect the current position.

The Trust has also considered the proportionality of achieving and maintaining fit testing compliance across the entire workforce within a mental health and community services setting, where aerosol-generating procedures are undertaken infrequently and where the operational experience of the Covid-19 pandemic demonstrated limited routine requirement for respiratory protective equipment across most staff groups. Whilst national requirements and organisational preparedness expectations must be met, there remains a need to ensure that workforce training, fit testing capacity and assurance processes are aligned to assessed risk and operational need. Consequently, the Trust has adopted a risk-based approach, prioritising staff working in ward and inpatient environments and other areas where respiratory protective equipment may be required at short notice.

Although these challenges do not represent an immediate risk to patient or staff safety, they impact the Trust's ability to provide complete assurance regarding compliance and organisational readiness in the event of future infectious disease outbreaks or pandemic-related surge demand.

5. NHS England Requirements Following the Covid-19 Inquiry (June 2026)

In correspondence issued on 18 June 2026, NHS England set out clear expectations for NHS organisations in response to lessons identified through Module 3 of the UK Covid-19 Inquiry.

These expectations require organisations to:

- Improve the recording of fit testing status within ESR.
- Ensure workforce records are complete, accurate and auditable.
- Assess and report organisational fit testing capacity.
- Strengthen preparedness for future health emergencies.
- Demonstrate effective governance arrangements supporting workforce safety.

Trusts are expected to demonstrate progress against these requirements by November 2026, supported by regional and national oversight arrangements.

6. Trust Response to NHS England Requirements

The Trust has undertaken a review of its current position against the NHS England requirements and has established a programme of work to address the remaining gaps.

Current arrangements provide a strong foundation from which to deliver these requirements. Fit testing information is recorded within ESR, performance is

monitored through governance structures and the IPC Board Assurance Framework, and established local processes are in place to support workforce compliance.

However, further work is required to strengthen assurance and improve resilience. The Trust's improvement programme will focus on:

- Validation and cleansing of ESR records.
- Alignment of ESR data with local fit testing records and IPC datasets.
- Strengthening accountability for workforce compliance data within care groups and services.
- Reviewing current fit testing capacity and delivery arrangements.
- Identifying opportunities to increase organisational resilience and flexibility.
- Continuing to monitor compliance through existing governance structures.

Progress against these actions will be routinely monitored through IPC governance arrangements and reported via the IPC Board Assurance Framework.

7. Governance and Oversight

The Trust maintains clear governance arrangements for infection prevention and control.

Operational oversight is provided through the Infection Prevention and Control Trust Action Group, with escalation through the Safety and Resilience Trust Action Group where required. Strategic assurance is provided through the IPC Board Assurance Framework, with regular reporting into the Executive Management Team, Quality and Safety Committee and the Board.

These arrangements ensure that:

- Risks are formally identified and monitored.
- Mitigating actions are implemented and reviewed.
- Areas of non-compliance receive appropriate scrutiny.
- Progress against NHS England requirements is monitored.
- The Board receives timely assurance regarding IPC performance and organisational preparedness.

8. Recommendations

The Trust Board is asked to:

- **Receive assurance** regarding the Trust's current IPC Board Assurance Framework position, noting compliance with nine of the ten Code of Practice criteria and the remaining area of partial compliance relating to Criterion 6.5 (FFP3 fit testing).

- **Note the programme of work underway** to address the requirements set out by NHS England following the Covid-19 Inquiry, including actions to strengthen fit testing assurance, workforce resilience and data quality.

**Trust Board
28 July 2026
Agenda item 10.5**

Private/Public paper:	Public		
Title:	Safer Staffing - Assurance from Establishment Reviews		
Lead Director:	Caroline Johnson, Chief Nurse / Director of Quality and Professions		
Mission/values:	➤ We are respectful, honest, open and transparent ➤ We put the person first and, in the centre ➤ We are always improving		
Purpose:	The purpose of this report is to provide the Trust Board with assurance regarding safer staffing across the Trust. It updates on progress against the establishment review programme, emerging findings from completed reviews, current workforce transformation initiatives, and the mitigations in place to ensure safe staffing pending completion of the confirm-and-challenge process and agreement of final recommendations through Executive Management Team (EMT).		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience. 2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents. 3.1 Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The Trust works collaboratively with partners across the Integrated Care System (ICS), Integrated Care Board (ICB), Place-based Partnerships and NHS England to support the delivery of safe, effective and sustainable services. Safer staffing is a shared system priority, and this report provides assurance that workforce planning is informed by evidence-based tools, professional judgement and patient need. Learning and good practice continue to be shared with local, regional and national partners to support workforce sustainability, patient safety and service quality.		

Any background papers / previously considered by:	Quality and Safety Committee review the bi-annual Safer Staffing reviews and receive a monthly AAA safer staffing report.
Executive summary:	This report provides the Trust Board with assurance regarding safer staffing across the Trust and progress against the 2025/26 establishment review programme. The Trust continues to maintain robust safer staffing governance arrangements, with staffing deployment monitored through monthly safer staffing reviews and triangulated against workforce, quality, patient safety and patient experience indicators. Trust-wide fill rates and clinically required fill rates have remained above 90%, supported by substantive and temporary workforce deployment and daily operational oversight. During 2025/26, the Trust completed its first full cycle of bi-annual inpatient establishment reviews. Mental Health Optimal Staffing Tool (MHOST) data collection has now been completed across all mental health inpatient wards and has been triangulated with professional judgement, workforce metrics and quality outcomes. Initial findings identified variation between current establishments and assessed staffing requirements across some services. A programme of confirm-and-challenge meetings is currently being undertaken with Care Groups to review the findings in detail and validate workforce requirements. Emerging themes indicate that some roster templates do not fully reflect current models of care, workforce deployment arrangements and service developments. Consequently, further validation work is being undertaken before final establishment recommendations are developed. Alongside the review programme, the Trust is implementing a number of workforce transformation initiatives, including Enhanced Therapeutic Observations of Care (ETOC), the Women's Model of Care, expanded Allied Health Professional provision, Psychology Assistant roles, rotational reducing restrictive practice posts and the introduction of a dedicated peripatetic workforce resource. These initiatives are expected to strengthen the therapeutic milieu, improve patient outcomes and influence future workforce requirements. The establishment review process has not identified any immediate patient safety concerns requiring urgent establishment changes. Appropriate mitigations remain in place, including daily operational oversight, temporary staffing deployment, substantive recruitment and executive oversight of staffing risks. At this stage, no further establishment changes are proposed. A detailed safer staffing and establishment review report, including final ward-level recommendations, will be presented to the next Quality and Safety Committee following completion of the confirm-and-challenge process and agreement of proposals through Executive Management Team (EMT). Key Assurance Messages • MHOST reviews have been completed across all mental health inpatient wards. • Trust-wide clinically required fill rates remain above 90%.

	• No immediate patient safety concerns requiring urgent establishment changes have been identified. • Controls and mitigations remain in place to maintain safe staffing levels. • Workforce transformation initiatives are underway and will inform future staffing requirements. • A detailed establishment review report will be presented to the next Quality and Safety Committee in September following completion of the confirm-and-challenge process and EMT approval
Recommendation:	Trust Board members are asked to: • RECEIVE the report.

Safer Staffing - Assurance from Establishment Reviews

1. Background

In 2013, the National Quality Board (NQB) set out ten expectations and a framework to guide organisations in making staffing decisions that place patient needs at the forefront. To further support the NHS Five Year Forward View, the NQB issued additional guidance in 2016: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing.

This guidance requires NHS Boards to ensure that staffing capacity and capability are sufficient and sustainable to deliver safe, effective care across all settings. A Trust Board safer staffing checklist is available. Boards must also undertake an Annual Strategic Staffing Review, using a triangulated approach that considers all healthcare professional groups and aligns with financial plans. A six-month interim review is also mandated.

This report provides the Trust Board with an update on the Trust's safer staffing position and the progress of the establishment reviews completed in 2025/26. It outlines the governance arrangements, workforce metrics and evidence-based review processes used to provide assurance regarding safe staffing across the Trust. The report also summarises the emerging themes from establishment reviews completed to date and the actions being taken to validate findings, review staffing models and support future workforce planning. Final ward-level recommendations will be presented in a subsequent report following completion of the confirm-and-challenge process and approval through Executive Management Team (EMT).

The report content aligns with the expectations set out in the NQB (2016) guidance, which requires organisations to ensure they have the right staff, with the right skills, in the right place, at the right time. (Figure 1).

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback - - Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	Right Skills 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	Right Place and Time 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Figure1: NQB guidance

2. Safer Staffing: Oversight, Governance and Reporting

Safer staffing activity is led by the specialist advisor for safer staffing, with strategic oversight from the assistant director of nursing, quality and professions, who is also an NHS England Chief Nursing Officer Safer Staffing Fellow. Bi-annual safer staffing reports are presented to Committee and Trust Board, while monthly performance is monitored through the Integrated Performance Report (IPR) and a 'Triple A' report.

These reports are informed by the detailed monthly safer staffing review conducted at the Safer Staffing Meeting, where workforce deployment is triangulated with patient and staff outcome measures using a monthly dashboard/scorecard. An example is provided in Appendix 2.

Oversight of safe staffing performance is maintained through three core components:

- Benchmarking fill rates against baseline establishments and clinically required levels based on acuity.
- Comparing Care Hours Per Patient Day (CHPPD) with baseline establishments and peer organisations.
- Ensuring minimum staffing levels are set through robust establishment review processes, using evidence-based tools where available, and triangulated with quality metrics and professional judgement.

Measure and improve

3.1 Regulatory compliance

Regulation 18 'Staffing' Breaches

Following the CQC's unannounced inspections in 2023, all actions relating to the breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 have now been completed and closed, with sign-off from the Chief Nurse/Director of Quality and Professions, pending final approval by Executive Management Team (EMT).

3.2 Fill rates

The Trust is required to report planned versus actual staffing fill rates through NHS Benchmarking, and these figures must also be published on the Trust website. Table 1 overleaf provides a ward-level breakdown of fill rates over the past 12 months.

Unit	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Barnsley Physical Health	102.9%	106.5%	107.9%	91.2%	82.4%	97.0%	97.6%	101.6%	93.6%	94.6%	93.8%	96.4%
Neuro Rehab Unit	116.9%	119.2%	117.8%	102.0%	83.1%	108.0%	107.6%	120.2%	103.4%	106.1%	102.6%	100.4%
Stroke Rehab Unit	92.2%	96.8%	100.3%	83.1%	81.8%	88.6%	90.1%	87.3%	85.6%	85.6%	86.7%	93.1%
Cheswold Park Hospital	118.4%	117.0%	115.7%	120.0%	117.9%	122.8%	128.6%	127.5%	119.0%	108.7%	106.8%	105.4%
Aire	110.8%	96.2%	91.9%	88.8%	89.6%	85.8%	101.6%	105.9%	109.9%	92.7%	92.4%	99.4%
Calder	99.2%	107.1%	106.4%	92.2%	98.8%	94.6%	103.1%	101.0%	91.3%	92.8%	91.0%	96.1%
Don	128.9%	132.6%	122.8%	132.0%	133.1%	139.3%	136.4%	124.9%	101.1%	112.0%	107.9%	102.0%
Esk	114.5%	116.8%	108.5%	99.6%	104.3%	113.7%	112.4%	114.4%	99.6%	102.6%	105.4%	99.0%
Foss	105.2%	102.2%	113.5%	101.8%	105.9%	107.4%	103.4%	96.5%	92.6%	92.9%	112.1%	125.3%
Skipton	102.9%	108.2%	105.1%	163.5%	159.4%	179.0%	202.1%	202.3%	201.9%	179.4%	123.6%	99.7%
Wentbridge	155.7%	150.7%	149.9%	151.1%	133.2%	139.1%	139.0%	143.1%	131.3%	96.4%	107.4%	112.9%
Forensic - Low Secure	121.9%	114.0%	120.4%	132.8%	121.5%	122.7%	117.8%	120.9%	119.0%	106.4%	107.3%	113.6%
Newhaven	124.9%	124.0%	132.2%	138.2%	143.4%	141.5%	117.4%	125.0%	131.1%	125.6%	120.4%	113.0%
Ryburn	98.4%	97.7%	97.6%	99.2%	97.4%	100.0%	97.5%	99.2%	97.5%	99.1%	100.3%	96.3%
Sandal	126.9%	110.9%	125.9%	154.0%	116.3%	119.9%	129.0%	130.7%	127.0%	98.9%	107.0%	138.1%
Thornhill	122.6%	113.7%	110.7%	115.3%	113.8%	115.1%	113.2%	113.8%	106.1%	99.0%	98.2%	95.7%
Forensic - Medium Secure	107.5%	113.2%	110.5%	117.4%	115.9%	113.4%	119.7%	114.8%	112.1%	111.7%	110.1%	112.0%
Appleton	128.6%	125.7%	126.0%	136.2%	138.0%	122.0%	128.7%	133.7%	137.2%	146.3%	143.7%	134.8%
Bronte	95.9%	97.7%	94.1%	94.5%	98.5%	111.1%	98.6%	99.2%	126.4%	106.0%	103.6%	98.2%
Chippendale	102.7%	118.8%	103.6%	141.4%	111.4%	116.0%	132.1%	126.2%	95.9%	94.0%	96.0%	99.0%
Hepworth	92.8%	89.8%	91.5%	94.9%	108.3%	95.4%	94.6%	91.3%	92.1%	96.8%	97.4%	99.2%
Johnson	118.0%	113.0%	119.6%	118.8%	120.0%	117.9%	150.3%	135.2%	121.4%	132.5%	124.6%	131.0%
Priestley	92.0%	93.0%	86.5%	92.9%	94.6%	94.4%	93.2%	89.0%	91.2%	93.7%	95.1%	107.8%
Waterton	124.2%	163.1%	156.3%	151.9%	143.5%	141.1%	137.9%	129.0%	118.8%	105.2%	106.2%	107.9%
Learning Disabilities	138.5%	104.5%	115.4%	118.9%	111.9%	104.0%	127.2%	133.3%	123.4%	122.1%	121.5%	133.7%
Horizon	138.5%	104.5%	115.4%	118.9%	111.9%	104.0%	127.2%	133.3%	123.4%	122.1%	121.5%	133.7%
Mental Health Rehab	105.7%	98.8%	101.4%	97.1%	99.0%	97.2%	94.0%	97.2%	97.0%	99.2%	97.6%	100.1%
Enfield Down	100.6%	96.0%	104.3%	97.0%	99.7%	98.0%	96.2%	97.2%	98.2%	97.1%	97.5%	99.1%
Lyndhurst	113.4%	102.9%	97.1%	97.3%	98.2%	96.1%	91.0%	97.1%	95.2%	102.2%	97.9%	101.6%
Older Adults Acute	142.9%	139.8%	141.1%	141.9%	130.5%	135.3%	134.1%	142.6%	141.8%	152.2%	152.6%	148.9%
Beechdale	122.7%	113.1%	136.0%	134.4%	125.3%	134.2%	131.6%	159.8%	152.2%	151.1%	134.5%	144.3%
Crofton	186.1%	168.7%	169.0%	175.8%	167.7%	163.8%	157.9%	157.9%	161.7%	174.0%	178.7%	169.8%
Poplars	223.5%	225.6%	191.6%	178.5%	186.7%	189.6%	185.8%	183.8%	195.7%	205.8%	200.5%	207.7%
Ward 19 - Female	94.7%	96.2%	107.9%	112.9%	94.5%	113.0%	106.7%	108.8%	120.2%	127.1%	133.5%	119.6%
Ward 19 - Male	99.6%	111.3%	123.3%	115.1%	101.1%	97.8%	100.9%	120.0%	101.4%	119.0%	145.4%	129.0%
Willow Ward	127.7%	119.9%	113.6%	125.9%	96.9%	104.8%	114.1%	116.1%	115.5%	127.8%	112.7%	112.9%
Psychiatric Intensive Care Units	143.1%	131.6%	144.3%	135.9%	140.4%	149.7%	137.6%	139.0%	130.0%	114.2%	109.5%	118.9%
Melton Suite PICU	123.3%	138.5%	176.0%	153.8%	147.1%	170.0%	144.9%	135.8%	120.2%	108.5%	104.1%	111.2%
Walton PICU	155.7%	127.5%	126.2%	125.5%	136.6%	138.2%	133.4%	140.8%	136.1%	118.1%	113.2%	124.0%
Working Age Adult Acute	120.3%	120.0%	112.6%	105.2%	107.0%	109.8%	113.7%	110.6%	106.8%	108.3%	106.3%	108.6%
Ashdale	127.9%	115.7%	107.0%	100.0%	101.8%	100.5%	105.2%	97.8%	99.4%	98.9%	101.8%	123.1%
Beamshaw	125.3%	139.1%	122.4%	136.2%	120.3%	112.9%	104.6%	112.0%	112.0%	112.9%	108.1%	108.3%
Clark	109.9%	135.5%	119.8%	103.5%	105.0%	115.6%	146.7%	124.8%	98.0%	106.4%	103.7%	110.9%
Elmdale	114.0%	102.6%	105.3%	99.0%	107.2%	112.7%	105.5%	119.3%	114.1%	112.6%	110.2%	99.3%
Nostell	133.7%	134.7%	120.4%	97.4%	92.6%	106.0%	124.6%	114.4%	94.5%	111.2%	113.1%	104.8%
Stanley	136.7%	117.5%	113.6%	107.5%	115.7%	109.7%	110.6%	113.8%	126.8%	115.6%	105.5%	100.0%
Ward 18	97.4%	105.3%	104.9%	102.0%	110.1%	114.4%	106.7%	97.1%	101.4%	101.2%	101.4%	114.4%
Overall Shift Fill Rate	121.6%	118.9%	118.7%	118.3%	115.6%	118.5%	120.6%	120.9%	116.4%	113.7%	112.2%	114.2%

Table 1: Ward level breakdown over 12-months

Overall, fill rates remained above 90%, with exceptions clinically justified by service leads due to low acuity or occupancy. A notable number of wards exceeded 120% fill rates, indicating that baseline establishments require review. While high fill rates demonstrate a commitment to maintaining patient safety, they also reflect significant reliance on temporary staffing, which carries financial implications and may affect continuity of care.

3.3 Clinically required Fill rates

In 2025, the Trust introduced clinically required fill rate monitoring, recognising that fill rates against establishment alone do not always provide assurance of safe staffing. A ward may exceed 100% of its establishment yet still be insufficiently staffed to meet patient needs.

The clinically required fill rates for the past six months are shown in table 2 below. Although Trust-wide clinically required fill rates have generally remained above 90%, it is essential that ward-level data continues to be reviewed monthly through safer staffing reporting.

Month	Clinically required fill rate total	Clinically required fill rate RN days	Clinically required fill rate RN nights
October 2025	89.8%	91.6%	93.6%
November 2025	90.5%	92.5%	98.0%
December 2025	91.4%	90.8%	99.1%
January 2026	90.6%	93.2%	97.6%
February 2026	91.6%	93.4%	98.4%
March 2026	91.7%	91.8%	94.8%

Table 2: Clinically required fill rates

3.4 Care Hours Per Patient Day (CHPPD)

CHPPD reflects the total time staff spend on direct and indirect patient care, including medication preparation, record-keeping and communication with other teams. It includes both permanent and temporary staff. CHPPD alone does not indicate whether care is safe or effective and must therefore be considered alongside other quality and safety measures (NHSE).

CHPPD benchmarking data

Model Health System data (December 2025) shows that the Trust's overall CHPPD and healthcare support worker (HCSW) CHPPD are higher than both peer and national medians, providing assurance that staffing is being deployed to meet clinical need, albeit with significant use of temporary staff as shown in table 4 below.

However, the Trust's registered nurse skill mix is lower than peer and national medians. Skill mix is a key determinant of quality and safety. Evidence-based tools provide analysis of required skill mix based on patient acuity and dependency, and these findings inform establishment review recommendations.

It is important to note that the Trust does not include ward manager hours in CHPPD unless they are recorded as working clinically. This practice varies nationally and may influence comparative CHPPD figures.

Monthly monitoring of CHPPD at ward level against baseline establishments is undertaken through the safer staffing report and meeting. Figures 2-4, highlight the Trust CHPPD data, compared nationally, and to peer groups.

	CHPPD Overall	CHPPD Total Registered Nurses	CHPPD- Support Workers
Trust Value	11.2	3.7	7.5
Peer Median	10.8	4.1	5.9
National Median	9.0	4.9	3.5

Table 3: CHPPD for Registered Nurses and Support Workers

Figure 2: Care Hours per Patient Day – Total Nursing and Midwifery staff

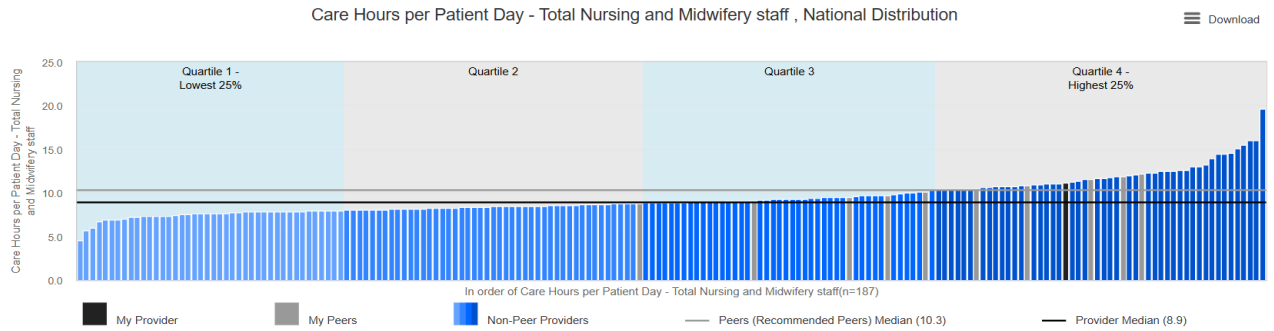


Figure 3: Registered Nurses and Midwives

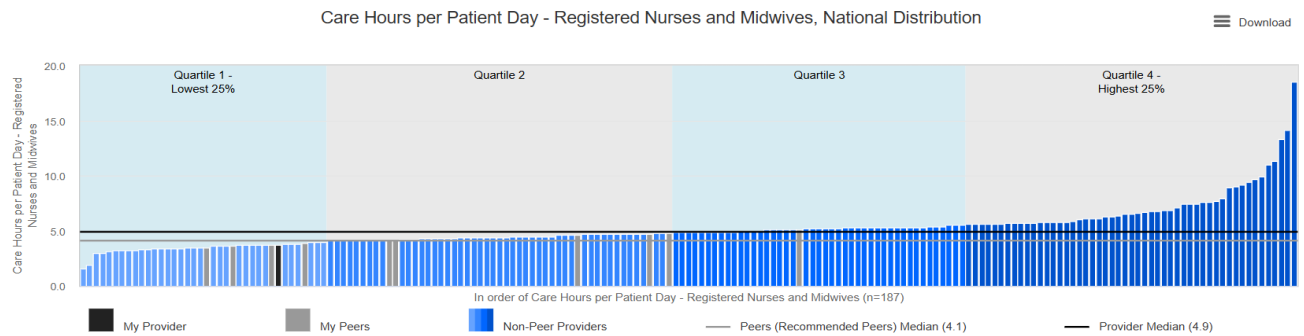
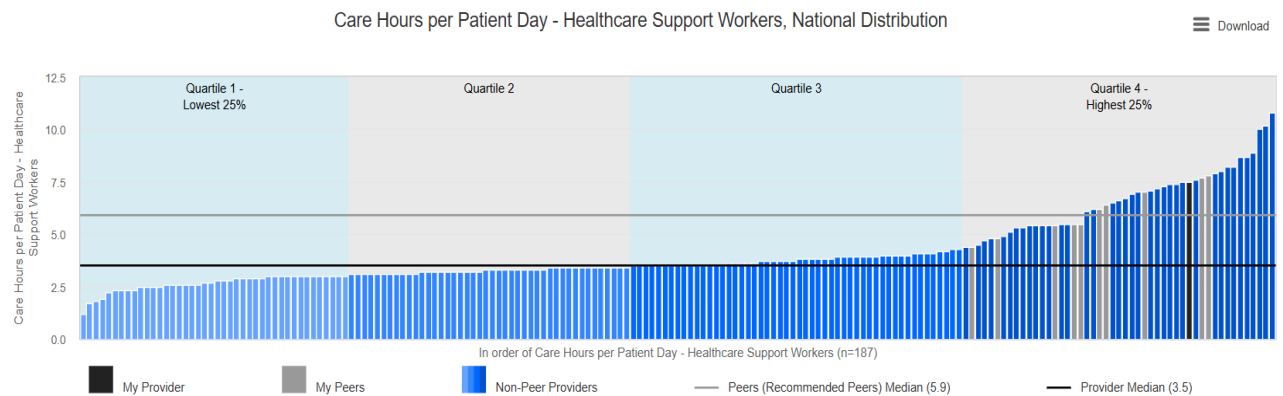


Figure 4: Care Hours per Patient Day Healthcare Support Workers



Right staff

4.1 Workforce Planning Methodology

National policy requires organisations to adopt a triangulated approach to safer staffing when undertaking workforce planning, as shown in Figure 5. This ensures that staffing decisions are informed by evidence-based tools, workforce data, professional judgement and outcome measures.



Figure 5: Triangulated approach to safer staffing

4.2 Evidence-Based Tools and Data

The Trust has three licensed evidence-based inpatient staffing tools to support establishment setting:

Mental Health Optimal Staffing Tool (MHOST):

Used across mental health inpatient services, including forensic wards. Patient dependency data is collected over a 20–30-day period and entered into the Trust’s bespoke MHOST template before being uploaded into the national tool to generate recommended staffing levels.

Safer Nursing Care Tool (SNCT):

Used within physical health inpatient units. Training for Stroke and Neuro-rehabilitation wards is currently being arranged with NHS England to support future implementation.

Community Nursing Safer Staffing Tool (CNSST):

Used within community physical health services. Training has been undertaken with service leads, and the initial data collection is due to take place imminently.

4.3 Outcomes and Quality Indicators

A broad range of quality and workforce indicators are reviewed monthly and triangulated with staffing data, including CHPPD and deployment of staffing resources. Indicators include:

- Sickness
- Vacancies
- Turnover

- Supervision and appraisal compliance
- Mandatory training
- Cancelled breaks
- Unplanned lone registered nurse working
- Complaints and FFT feedback
- Cancelled Section 17 leave
- Delayed medications
- Datix incidents
- Safer staffing incidents

This triangulation ensures that staffing decisions are informed by both quantitative and qualitative evidence.

4.4 Professional Judgement

Professional judgement remains a critical component of both daily staffing decisions and establishment setting. The Trust applies the Professional Judgement model (Saville et al., 2023) within all establishment reviews. This approach is particularly important in services without a recognised evidence-based tool, such as the Horizon learning disability assessment and treatment unit.

The Trust has completed the first full cycle of bi-annual inpatient establishment reviews, supported by the Mental Health Optimal Staffing Tool (MHOST), professional judgement and quality outcome measures. MHOST data collection has now been completed across all mental health inpatient wards, with two data collection periods undertaken during 2025 to provide a robust assessment of patient acuity, dependency and staffing requirements. Following completion of the MHOST reviews, a programme of confirm-and-challenge meetings is being undertaken with Care Groups to review findings in more detail and ensure that recommendations accurately reflect operational realities, patient need and service delivery models.

Whilst the MHOST reviews identified variation between current establishments and staffing required to meet assessed patient need, Care Groups have consistently highlighted that the current position may not be fully reflected within the data due to historical roster templates not always being updated in line with changes to clinical practice, workforce deployment and service delivery models. As a result, further validation work is being undertaken with operational teams, e-Rostering and Finance colleagues before any permanent establishment changes are proposed.

5. Service-Level Themes

5.1 Forensic Services

The MHOST reviews confirmed that forensic wards continue to manage high levels of patient acuity and complexity, with staffing levels frequently supplemented through temporary staffing arrangements. Confirm-and-challenge discussions have highlighted opportunities to improve workforce deployment, reduce reliance on temporary staffing and review how staffing resources are utilised to support observations, escorts and patient leave. It is a strongly held view of the Care Group that the development of a peripatetic team across Medium and Low secure will enable the additional daily staffing requirements to be met. A proposal for these is being developed for approval by EMT.

Whilst MHOST has not yet been implemented within Cheswold Park Hospital, professional judgement reviews have identified pressures associated with observations, vacancies and fixed working patterns. Further work is underway to ensure establishments and roster

templates accurately reflect current operational requirements. The MHOST is being implemented in the next review over the summer period.

5.2 Working Age Adult Services and PICUs

MHOST reviews identified that a significant proportion of staffing time is currently utilised supporting enhanced observations, escorted leave and the management of patients with high levels of acuity. Workforce redesign initiatives currently underway are expected to influence future staffing requirements in these areas and are outlined in the next section.

5.3 Older People's Services

MHOST reviews demonstrated that staffing demand continues to be influenced by increasing levels of complexity, physical healthcare need and observation requirements. Services continue to maintain safety through the deployment of temporary staffing whilst wider transformation work progresses.

5.4 Learning Disability

Establishment reviews have been completed using a professional-judgement approach, as no evidence-based staffing tool currently exists for learning disability services. Workforce data has been triangulated with patient and staff outcome measures and reviewed alongside current temporary staffing use to inform the recommendations. No changes are proposed to the current establishment; however, it is recommended that the existing Healthroster template is reduced. Although temporary staffing use remains high, reducing the roster template will prevent staff being allocated to duties that are not required and will support staffing to be planned more accurately around patient need, which may help reduce temporary staffing demand. This will result in higher fill rates against the baseline establishment, but these will be exception-reported to demonstrate that resources are being deployed in line with clinical need.

5.5 Barnsley Physical Health Inpatient Services

Until 2025, there had been no recent review of inpatient establishments. Previous reviews relied solely on professional judgement, as there was no evidence-based tool in use to assess acuity and dependency. NHS England has since confirmed that the Safer Nursing Care Tool (SNCT) should be used for establishment reviews for both the Neuro Rehabilitation Unit (NRU) and the Stroke Rehabilitation Unit (SRU). The Trust has now secured the required licence, and training for service leads is being arranged.

5.5 Rehabilitation Services

A full MHOST review has now also been completed within mental health rehabilitation services and will continue to inform future workforce planning. No immediate establishment changes are proposed. Reviews have identified opportunities to improve roster efficiency and align staffing deployment more closely to patient need while maintaining safe care delivery.

6. Workforce Transformation and Therapeutic Care Initiatives

Alongside the establishment review programme, several service improvements are being implemented that are expected to influence future staffing requirements and support an

improvement in safety, experience of care, reduction in restrictive practices, observation demand and overall temporary staffing utilisation.

These include:

- Expanding seven-day Allied Health Professional (AHP) provision in Wakefield working age adult wards, building on successful pilot work in Calderdale and Kirklees.
- Introducing MDT "take-over" sessions on inpatient wards, enabling nursing staff to participate in supervision, restorative and reflective practice, and professional development. This is an expansion of a successful project at the Dales.
- Recruiting Psychology Assistants to female working age adult wards to strengthen therapeutic interventions and support the development of psychologically informed ward environments.
- Developing rotational Band 3 posts linked to the Reducing Restrictive Practice (RRP) programme. A number of support workers from wards with higher rates of restrictive practice will be trained in RRP approaches and undertake dedicated rotational periods delivering restrictive practice training before returning to their clinical teams with enhanced skills and expertise to model best practice.
- Implementing the Enhanced Therapeutic Observations of Care (ETOC) programme, which is expected to improve the quality and therapeutic value of observations and reduce reliance on enhanced staffing arrangements over time.
- Delivering the Women's Model of Care, including workforce development and upskilling initiatives designed to better meet the needs of women accessing inpatient services and further reduce reliance on restrictive interventions and associated temporary staffing requirements.

Collectively, these initiatives are intended to strengthen the therapeutic milieu across inpatient services by increasing multidisciplinary input, improving staff capability and creating more opportunities for therapeutic engagement. The impact of these developments will be considered alongside MHOST findings before future establishment recommendations are finalised.

7. Interim Staffing Arrangements and Next Steps

Confirm and challenge meetings are in the process of being held jointly with the Chief Nurse and Chief Operating Officer to review the MHOST findings, overlay professional judgement and explore skill mix opportunities and innovative ways to fulfil requirements for additional staff for observations and escorts etc. In the interim, the Trust continues to maintain safe staffing through substantive recruitment, robust daily operational oversight and the deployment of temporary staffing resources where required.

To improve continuity and reduce reliance on ad hoc temporary staffing to support enhanced observations, agreement has been reached to block-book a dedicated peripatetic workforce resource. This model will be evaluated and, if successful, consideration will be given to incorporating a permanent peripatetic resource into future staffing establishments.

Consequently, whilst the MHOST review process has now been completed, the Trust is not proposing any further establishment changes at this stage. The focus remains on:

- Completing the confirm-and-challenge process.
- Validating roster templates and workforce data.
- Continuing substantive recruitment.
- Developing and implementing the Women's Model of Care.
- Implementing Enhanced Therapeutic Observations of Care.
- Expanding multidisciplinary workforce models.
-

- Evaluating the impact of psychology support, RRPI rotational roles and AHP-led initiatives.
- Reviewing the effectiveness of the peripatetic staffing model.

7.1 Risk and Mitigation

The principal risk identified through the establishment review process is that current roster templates, workforce models and funded establishments may not fully reflect current patient acuity, dependency and service delivery requirements. This may contribute to continued reliance on temporary staffing, reduced continuity of care, increased financial pressure and challenges in maintaining clinically required staffing levels over the longer term.

The Trust has several controls and mitigations in place whilst the review process is completed, including:

- Daily operational oversight of staffing levels and patient acuity through established escalation processes.
- Monthly safer staffing reviews incorporating clinically required fill rates, CHPPD, workforce metrics and quality indicators.
- Deployment of temporary staffing resources where required to maintain safe staffing levels.
- Introduction of a block-booked peripatetic workforce resource to improve continuity of care and support enhanced observation requirements.
- Ongoing substantive recruitment activity, including consideration of targeted recruitment to Band 5 registered nurse posts.
- Completion of confirm-and-challenge meetings to validate MHOST findings, roster templates and workforce assumptions.
- Implementation of workforce transformation initiatives, including Enhanced Therapeutic Observations of Care (ETOC), the Women's Model of Care, expanded Allied Health Professional provision, Psychology Assistant roles and RRPI workforce development programmes.
- Executive oversight through EMT, with routine reporting to the Quality and Safety Committee and Trust Board.

The establishment review process has not identified any immediate patient safety concerns requiring urgent establishment changes. Trust-wide clinically required fill rates have remained above 90%, and existing controls provide assurance that staffing risks are being effectively managed whilst the review process is completed and final recommendations are developed.

7. Conclusion

Whilst the Mental Health Optimal Staffing Tool (MHOST) reviews have now been completed across all mental health and forensic inpatient wards, the Trust is not proposing any further establishment changes at this stage. This reflects the need to complete the confirm-and-challenge process with Care Groups, validate roster templates and staffing assumptions, and evaluate the impact of the workforce redesign and model-of-care developments currently being implemented.

A detailed safer staffing and establishment review paper will be presented to the next Quality and Safety Committee in September following completion of the confirm-and-challenge meetings and once final ward-level proposals have been reviewed and agreed through Executive Management Team (EMT). This will enable the Committee to consider fully validated recommendations that reflect MHOST findings, professional judgement, quality

and safety indicators, workforce transformation initiatives and the agreed future models of care.

In the interim, the Trust will continue to maintain safe staffing through substantive recruitment, deployment of temporary staffing resources where required, daily operational oversight, and implementation of the workforce and service transformation initiatives outlined within this report.

8. Recommendation

The Trust Board is asked to:

1. **Receive and note** this interim update on the Trust's safer staffing establishment review programme.
2. **Take assurance** that MHOST reviews have been completed across all mental health inpatient wards and that confirm-and-challenge meetings are underway to validate findings and inform future recommendations.
3. **Take assurance** that appropriate mitigations remain in place to maintain safe staffing levels through substantive and temporary workforce deployment.
4. **Note** that no further establishment changes are proposed at this stage pending completion of the confirm-and-challenge process, implementation of workforce redesign initiatives and EMT review.

**Trust Board
28 July 2026
Agenda item: 10.6**

Private/Public paper:	Public		
Title:	NHS Staff Standards		
Lead Director:	Christine Brereton, Chief People Officer		
Mission/values:	Our workforce is our greatest asset and ensuring that we have the right workforce in place to deliver safe and quality services is critical. As well as being our greatest asset, our workforce is our greatest financial investment, with workforce spend accounting for 80% of our total budgeted expenditure		
Purpose:	To present to EMT the introduction of the National Staff Standards, highlight the expectations and next steps		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	To be determined Implementation of the staff standards is a national requirement.		
Any background papers / previously considered by:	EMT – 9 July 2026 PRC – overview – 14 July 2026 TPF – 21 July 2026		
Executive summary:	NHS England has introduced six mandatory NHS Staff Standards for all secondary care providers, placing workforce experience alongside finance, quality, and operational performance as a core organisational priority. While the standards consolidate existing frameworks and expectations, they introduce significantly greater accountability through the NHS Oversight Framework (NOF). Performance against the standards will directly influence organisational oversight and segmentation, making board-level ownership, governance, staff engagement, and delivery planning essential.		

	The six key standards are: 1. Line Management 2. Health and Wellbeing 3. Violence Prevention and Reduction 4. Championing Sexual Safety 5. Tackling Racism 6. Promoting Flexible Working The six key standards are outlined in section 2 of the report. A more detailed overall statement and expectations for Trusts are outlined in Appendix 1. Appendix 2 is a Q&A on the staff standards for information. NHSE has set out clear expectations about what is required in year 1 (section 4 of the report). This includes undertaking a baseline assessment against the six standards and identifying any gaps for future focus. Work on this assessment has already commenced. The Trust is in a strong position as it embeds the staff standards with the recent launch of the People Strategy in early 2026 which focusses on staff experience and wellbeing. Further, the Trust achieved good staff survey results in 2025 and has already identified two annual people priorities for 2026/2027 on safe and healthy and compassionate and inclusive, both directly linked to the staff standards. However, it is acknowledged that work on staff experience and wellbeing is always work in progress and there will be further areas of focus and improvement identified once the assessment has been completed. During 2026/27, NHS England's expectation is not full compliance but evidence of visible leadership, robust plans, staff and trade union engagement, and demonstrable action to address priority areas. An overview of the standards was provided to Executives on 9 July and at PRC on 14 July The Staff Standards was also discussed with Trade Union colleagues via the Trust Partnership Forum on Tuesday 21 July and will continue to be embedded into partnership priorities during 26/27. It is proposed that the implementation of the staff standards is overseen by EMT and then assurance oversight through PRC so that it is fully aligned with other people priorities and the People Strategy. However, to ensure full board oversight a progress report will be brought back to the Board in December 2026.
Recommendations:	Trust Board members are asked to: • NOTE the publication of the NHS Staff Standards on 6 July 2026 • APPROVE the proposal for assurance oversight through People and Remuneration Committee • NOTE a progress report will be brought to Board in December 2026.

STAFF STANDARDS

1.0 **Background**

1.1 As expected, NHS England has now published a new set of mandatory NHS Staff Standards for all secondary care providers, including mental health trusts. The standards establish a national baseline for staff experience and place workforce experience alongside finance, operational performance, and quality of care as a core organisational priority.

1.2 The 10 year plan, specifically states that:

“A positive experience of work and the workplace should not be a ‘nice to have’. We will work with the Social Partnership Forum to develop a new set of staff standards, which will for the first time outline minimum standards for modern employment. They will underpin the NHS Oversight Framework, and poor performance on staff-related outcomes will act as an early warning signal for CQC.”

Fit for the Future: The 10 Year Health Plan for England, Pg 105, July 2025

1.3 The standards do not replace existing frameworks such as the People Promise, Flexible Working Framework, Violence Prevention and Reduction (VPR) Standard or Leadership and Management Framework. Instead, they bring together existing expectations into a single mandatory framework with enhanced accountability.

1.4 The overall objectives of the staff standards are to:

- Improve staff experience
- Reduction of turnover and increased retention
- Positive impact on service delivery

2.0 **Staff Standards**

2.1 There are six Staff Standards as follows:

1. Line Management
2. Health and Wellbeing
3. Violence Prevention and Reduction
4. Championing Sexual Safety
5. Tackling Racism
6. Promoting Flexible Working

2.2 Below is a summary of each of the standards. Attached at appendix 1 is a copy of the six standards plus the criteria which outlines expectations for NHS Trusts and measures:

Line Management:

Staff can expect supportive, fair, developmental, and compassionate line management, enabled by employer support for line managers to help staff to perform well, feel valued and fulfil their potential.

Health and Wellbeing:

Staff can expect their organisation to protect their health, safety, and wellbeing at work. Employers are responsible for supporting staff wellbeing, preventing ill-health associated with work and helping staff to feel safe, cared for and able to perform well.

Violence Prevention and Reduction:

Staff have a right to feel safe and supported at work, in an environment that takes meaningful action to prevent and reduce violence, aggression, intimidation or abuse in any form. Staff should have access to simple, safe, and supportive channels for reporting violence in the workplace; timely, compassionate support after any violent or harmful incident; and the right training to equip them with the confidence and knowledge to keep themselves and others safe.

Championing Sexual Safety

Staff have a right to feel safe and supported at work, in an environment that is free from sexual harassment, abuse and unwanted or inappropriate sexual behaviours. Staff can expect: their organisations to take clear, consistent action to prevent sexual misconduct and harassment; promote a culture of transparency and openness that ensures incidents are reported and acted upon promptly and appropriately; training to be provided on how to recognise and report inappropriate behaviours; an approach that centres on the victim, with support provided to those affected; and that lessons are learned to reduce the risk of future incidents.

Tackling Racism

Staff should feel safe and supported at work, in an environment where their organisation takes sustained and meaningful action to prevent all instances of racism and discrimination in the workplace.

Promoting Flexible Working

NHS staff can expect flexible working (flexibility in how, where and when they work) to be openly encouraged and supported, fairly and equitably considered, and embedded into everyday practice, creating a 'flexible first' culture rather than treated as an exception. Requests must be considered objectively and not unreasonably refused, and where they cannot be agreed, alternatives will be explored.

3.0 Implications for Boards and Executives

3.1 NHS England is explicit that responsibility for delivery of the staff standards rests with boards and executive teams. It has been clear that staff experience should receive the same level of leadership attention as finance, quality, and operational performance.

3.2 Key board responsibilities include:

- Understanding current performance against the six standards.
- Establishing governance and executive ownership.
- Engaging trade unions and staff-side representatives.
- Developing a prioritised implementation plan.
- Monitoring performance and risks routinely.
- Ensuring staff voice informs improvement activity

4.0 2026/2027 Expectations

- 4.1 NHS England has deliberately set realistic expectations for the first year. Good performance in 2026/27 will be demonstrated where organisations can show:

Board leadership and accountability

- The Board has discussed the NHS Staff Standards and agreed how they align with existing staff experience priorities.
- Required Board-level roles and ownership are in place, with regular visibility and assurance on progress.
- In year one, good delivery means organisations have focus, grip and a clear direction of travel. Not everything will be fully embedded.

Understanding current position

- Organisations have established a clear baseline across the six standards, drawing on existing data, staff feedback and NHS Staff Survey results and understand where minimum expectations are already being met and where gaps remain

Credible, prioritised action

- A proportionate year-one action plan is in place, focused on meeting minimum expectations and reducing the most significant risks to staff experience.
- Actions are clearly owned, time-bound and integrated with existing workforce and people plans.

Listening to staff and working in partnership

- Staff and trade union representatives have been engaged through local partnership arrangements.
- Staff voice is shaping priorities and there is transparency about what will change.

Fit for purpose assurance

- The organisation understands how delivery will be assessed through the NHS Oversight Framework.
- Leaders can explain their Staff Standards position, what is driving it, and how they are responding.

- 4.2 Boards are not expected to achieve full compliance immediately but must show visible leadership and credible plans.

5.0 NHS Oversight Framework (NOF)

- 5.1 A significant development is the introduction of a new NHS Staff Standards score within the NHS Oversight Framework from 2026/27. Key points include:

- Performance contributes to overall NHS Oversight Framework segmentation.
- Performance also contributes to the People and Workforce domain assessment.

- The score is constructed using NHS Staff Survey measures aligned to each staff standard.
- Quarter 1–3 scores in 2026/27 will use 2025 Staff Survey data.
- Quarter 4 will use results from the 2026 Staff Survey.

5.2 Work is underway nationally, regionally and locally about how the specific measures will operate in practice.

6.0 **Local Action to date**

6.1 The Trust is in a strong position as it has already developed and launched the People Strategy which focusses on health and wellbeing, staff experience, and staff safety. Further, through our annual people priorities for 26/27, we have already identified our two organisational people priorities for: We are Safe and Healthy and Compassionate and Inclusive and embedded these into leadership (at all levels) objectives for 2026/27 through our new appraisal process. These specifically focus on staff experience and well-being.

6.2 We have commenced work on the self-assessment to understand our baseline position and engagement with key stakeholders such as trade unions representatives has begun. To support staff engagement, we have already undertaken a number of engagement sessions with staff on things that matter to them and this will continue throughout 26/27. This will be evidence for our self-assessment.

6.3 Further our staff survey results for 2025: staff engagement and morale remain steady which is a good base. Specific questions against the standards which link directly to the staff survey have been identified and as outlined in 5.1 data from 2025 will be used. These are shown below. The questions have shown in two areas: a) RAG: red represents the range of scores achieved by the lowest scoring 20% of organisations within the sector, the amber segment represents the middle 60% and the green segment represents the top 20%. b) Comparator data from other similar organisations is shown.

Standard	NSS Questions	Score 2025	Comparator
Line Management	Q7a,h Q9d,f,i; Q23a,c,d; Q24d,e		
	7a - The team I work in has a set of shared objectives.	78.7%	77.2%
	7h - I feel valued by my team.	75.6%	74.6%
	9d – My line manager takes a positive interest in my health and well-being.	79.5%	79.0%
	9f – My line manager works together with me to come to an understanding of problems	78.2%	76.9%
	9i – My line manager takes effective action to help me with any problems I face	76.2%	74.3%
	23a - In the last 12 months, have you had an appraisal, annual review or development review (Y/N)	88.5%	88.0%

	23c – Where yes. It helped me agree clear objectives for my work.	36.5%	36.6%
	23d - It left me feeling that my work is valued by my organisation	36.9%	34.6%
	24d - I feel supported to develop my potential	59.9%	59.5%
	24e- I am able to access the right learning and development opportunities when I need to	60.3%	61.3%
Health and wellbeing	<i>Q11a,c Q12b</i>		
	11a - My organisation takes positive action on health and well-being	65.3%	62.0%
	11c - During the last 12 months have you felt unwell as a result of work related stress?	37.4%	40.8%
	12b - How often, if at all, do you feel burnt out because of your work?	22.7%	26.7%
Violence and aggression	<i>Q13a,b,c; Q13d</i>		
	13a - In the last 12 months how many times have you personally experienced physical violence at work from Patients / service users, their relatives or other members of the public	14.1%	13.5%
	13b - In the last 12 months how many times have you personally experienced physical violence at work from managers	0.2%	0.5%
	13c - In the last 12 months how many times have you personally experienced physical violence at work from other colleagues	1.2%	1.1%
	13d - The last time you experienced physical violence at work, did you or a colleague report it?	92.1%	89.6%
Championing sexual safety	<i>Q17b</i>		
	17b - In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault (from staff or colleagues)	3.0%	2.8%
Tackling Racism	<i>Q14a,b,c; Q15; Q16a,b</i>		
	14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work From patients	23.2%	23.7%
	14b In the last 12 months how many times have you personally experienced	4.9%	7.6%

	harassment, bullying or abuse at work from managers		
	14c - In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues	12.6%	13.8%
	15 - Does your organisation act fairly with regard to career progression / promotion, regardless of e.g. age, disability, ethnic background, gender reassignment, religion, sex or sexual orientation?	60.6%	56.7%
	16a - In the last 12 months have you personally experienced discrimination at work from: patients / service users, their relatives or other members of the public	7.5%	8.3%
	16b In the last 12 months have you personally experienced discrimination at work from: Manager / team leader or other colleagues	6.1%	7.3%
Promoting Flexible Working	<i>Q4d, Q6b,d</i>		
	4d - The opportunities for flexible working patterns.	68.1%	66.4%
	6b - My organisation is committed to helping me balance my work and home life.	61.5%	58.4%
	6d - I can approach my immediate manager to talk openly about flexible working.	79.5%	79.1%

7.0 Next Steps

7.1 To meet the year 1 requirements further work will be needed now to cross reference work that is already underway against the staff standards requirements (as outlined in section 4). As outlined, work has commenced to undertake a self-assessment (baseline position) of how we measure up. We will also look at the specific year 1 requirements and put plans in place to address.

7.2 Further assessments will then be undertaken to identify how the introduction of the staff standards align with our local priorities and plans.

8.0 Governance and Oversight

8.1 To meet the requirements of NHSE about executive and board oversight it is important that this work aligns with current priorities. To ensure that this is achieved it is proposed that:

- The CPO will be the Executive lead on behalf of the Executive Team
- Regular updates are discussed through EMT (through both qualitative and quantitative data and employee voice) and as part of our people priorities
- This is a regular item of business at Trust Partnership Forum (TPF) to ensure full engagement with trade union representatives is embedded

- Oversight of delivery (including the initial assessment) will be through the People and Remuneration Committee (PRC)
- Full Board to receive bi-annual updates through an assurance framework against the requirements.

9.0 Conclusion

- 9.1 The NHS Staff Standards represent one of the most significant national workforce accountability developments since the introduction of the People Promise. The key change is not the content of the standards themselves—many requirements already exist—but the move to mandatory implementation with direct performance consequences through the NHS Oversight Framework and Provider Capability Assessment. The Board will therefore need clear oversight, assurance and improvement plans throughout 2026/27.

10.0 Recommendations

- 10.1 The Board is asked to:
- note the publication of the NHS Staff Standards on 6th July 2026
 - Approve the proposals for assurance and oversight, including through People and Remuneration Committee
 - Bring back a progress report to full Board in December 2026.

*Christine Brereton
Chief People Officer
June 2026*

NHS STAFF STANDARDS

Line Management

Health & Wellbeing

**Violence Reduction
& Prevention**

**Championing Sexual
Safety**

Tackling Racism

**Promoting Flexible
Working**

LINE MANAGEMENT

Standard: Staff can expect supportive, fair, developmental and compassionate line management, enabled by employer support managers, to help staff to perform well, feel valued and fulfil their potential

Criteria:

- Embed the NHS Leadership and Management Framework across strategies, policies, training, appraisal and recruitment, and require all managers to complete the self-assessment tool
- Ensure line managers have access to comprehensive line management training through the NHS Leadership and Management Framework (with a focus on first-time managers) and monitor and address line management quality
- Ensure job plans accurately allocate sufficient time for line management responsibilities
- Ensure all role descriptions have clear, accurate and up-to-date job descriptions and review role changes promptly through agreed processes when requested in accordance with the NHS Job Evaluation Scheme
- Ensure all line managers have appropriate supervision and mentoring for their own line managers and ensure that line management policies are accessible to enable timely and effective people management
- Ensure board-level oversight on how line managers are enabled by collecting and acting on feedback from line managers
- Work in partnership with trade unions through local arrangements to review workforce data, culture, health and safety risks and equality impacts

HEALTH AND WELLBEING

Standard: Staff can expect their organisation to protect their health, safety and wellbeing at work. Employers are responsible for supporting staff wellbeing, preventing ill-health associated with work and helping staff to feel safe, cared for, and able to perform well.

Criteria:

- Appoint a Health and Wellbeing Guardian at board level
- Use the NHS Health & Wellbeing Framework to produce a localised Health & Wellbeing Strategy that is built on workforce data and provides needs-driven health and wellbeing support
- Take steps to ensure that, where practicable, staff have access to safe, non-clinical environments to take their rest periods
- Ensure that all staff, regardless of work location or shift pattern, have reliable access to nutritious food and drink. Alternatively, employers should ensure that there are safe options available for staff to store and prepare their own food
- Ensure all managers are supported to complete mandated competencies on safety, health and wellbeing so that all staff can expect health & wellbeing conversations to be embedded into 1-1s and appraisals
- Ensure managers are trained on how to discuss reasonable adjustments with disabled staff and staff with alternative needs
- Ensure protection and provision for pregnant and breastfeeding staff and for those experiencing perimenopause and menopause
- Ensure all staff have access to Occupational Health and Wellbeing support and local services
- Work in partnership with trade unions through local arrangements to review data and monitor progress

VIOLENCE PREVENTION REDUCTION

Standard: Staff have a right to feel safe and supported at work, in an environment that takes meaningful action to prevent violence, aggression, intimidation or abuse in any form. Staff should have access to simple, safe and supportive channels for reporting violence in the workplace; timely, compassionate support after any violent or harmful incident; and the right training to equip them with the confidence and knowledge to keep themselves and others safe.

Criteria:

- Implement and embed the Violence Prevention Reduction (VPR) standard, as well as having a named Senior Responsible Officer for VPR
- with an annual VPR improvement plan
- Ensure that reporting systems are in place and actively promoted, so that all staff feel supported to report any incident of violence or abuse,
- irrespective of a patient's circumstances or condition
- Accurate and timely data should be recorded to inform strategies on tackling and preventing violence and feed into national VPR data collections
- Staff who are subject to violence or abuse should have access to high quality post incident psychological and welfare support. Managers
- As well as HR policies and procedures should provide the right support following incidents and during investigations
- Ensure that all staff receive training appropriate to their role
- Ensure the appropriate Health and Safety Committee/Forum is engaged in VPR planning and monitoring
- Work in partnership with trade unions through local arrangements, staff networks and local VPR groups to provide assurance on support for
- staff and to encourage staff to call out where organisations are failing. This should ensure that staff voice shapes local improvements

CHAMPIONING SEXUAL SAFETY

Standard: Staff have a right to feel safe and supported at work, in an environment that is free from sexual harassment, abuse and unwanted or inappropriate sexual behaviours. Staff can expect their organisation to take clear, consistent action to prevent sexual misconduct and harassment promote a culture of transparency and openness that ensures incidents are reported and acted upon promptly and appropriately; training to be provided on how to recognise and report inappropriate behaviours; and a victim centred approach, with support provided to those affected and lessons learned to reduce the risk of future incidents.

Criteria:

- Fully implement the actions set out in the sexual safety in healthcare organisational charter, assessing progress using the sexual safety charter assurance framework, ensuring board level ownership and accountability
- Ensure all staff to complete/ [Understanding sexual misconduct in the workplace e-learning](#)
- Ensure that investigators of sexual misconduct allegations receive specialist training
- Ensure they have robust staff policies and processes for dealing with sexual misconduct and that staff do not suffer detriment as a consequence of reporting, in line with victimisation legislation
- Share concerns about employees with future employers and host organisations
- Ensure all staff are familiar with the sexual misconduct people policy framework so that they understand how to recognise and report sexual misconduct, and what actions should be taken when sexual misconduct is reported and where staff are the perpetrators, including the other policies that might be used
- Work in partnership with trade unions and staff networks through local arrangements to provide assurance on support for staff, to shape local plans and to encourage staff to call out where organisations are failing

TACKLING RACISM

Standard: Staff should feel safe and supported at work, in an environment where their organisation takes sustained and meaningful action to prevent all instances of racism and discrimination in the workplace.

Criteria:

- Set consequential outcomes for misconduct at the individual level, from penalties for certain behaviours and/or repeated incidents to potential refusal of care for patients in non-emergency situations, and consequences for organisational performance and professional non-compliance
- Work with Trade Unions to ensure representation of the staff voice; ensuring policies are fair/proportionate; support staff to speak up; and support during formal procedures to ensure racism is taken seriously
- Ensure implementation and monitoring of the six High Level Impact Actions as part of the NHS EDI Improvement Plan
- Ensure every board member has a published Specific Measurable Achievable Relevant Time-bound objective on tackling racism
- Implement inclusive recruitment and talent management practices including recruitment and career progression plans for equity of opportunity
- Work to create inclusive cultures that encourage staff at all levels to report, and for employers to consistently work to root out racist behaviour
- Where appropriate evaluate and implement the recommendations of key leading bodies on good practice
- Update emergency protocols and responses to include adequate and appropriate responses that help to maintain safe working environments
- Update grievance, disciplinary and investigative processes so they are responsive to the experiences of racism and discrimination and are void of biased applications in their process. Ensure they encourage thorough and unbiased investigation, with careful examination of evidence
- Where appropriate, evaluate and implement the recommendations of key leading bodies on good practice

PROMOTING FLEXIBLE WORKING

Standard: NHS staff can expect flexible working (flexibility in how, where and when they work) to be openly encouraged and supported, fairly and equitably considered, and embedded into everyday practice, creating a “flexible first” culture, rather than treated as an exception. Requests must be considered objectively and not unreasonably refused, and where they cannot be agreed, alternatives will be explored.

Criteria:

- Appoint a board level flexible working champion who is responsible for promoting and leading improvements inflexible working
- Implement a Flexible Working Action Plan using organisational workforce data which is owned by the Board
- Implement preference-based team e-rostering for all frontline workers (where operationally appropriate)
- Collect data on the number of flexible working requests which are approved or rejected, the types of flexible working requests, and broken down by protected characteristic, staff groups / professions, bands and at department level
- Publish this data for staff and linked to the Flexible Working Action Plan set out what actions will be taken to improve areas of concern
- Work in partnership with Trade Unions through local partnership arrangements to assess progress
- Ensure that managers, leaders and staff members have training in line with their roles to ensure they are confident to lead flexible teams
- Include flexible working as an option in all job adverts, job interviews, pre-retirement conversation and line manager conversations such as appraisals or regular one to one discussion
- Ensure your organisation is following the guidance set out in [The National Flexible Working People Policy Framework](#) and reference this within the local flexible working policy

NHS Staff Standards Q&A

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Overview of the new standards

What is the aim of the new standards and why were they needed?

The 10 Year Health Plan committed to developing a new set of staff standards, outlining minimum standards for employment across a range of areas in order to improve staff experience. Whilst there has been considerable focus on improving staff experience in recent years, the impact has not been consistent across the NHS. Staff experience therefore remains a significant concern, with many staff reporting chronic stress, burnout, and declining morale. The [2025 NHS Staff Survey results](#) show that, while there has been progress in some areas, staff experience remains inconsistent and under pressure, underlining the need for a new set of NHS Staff Standards. The standards are about raising the profile of staff experience, putting it on a par with other key priorities like productivity and financial performance.

How were the NHS Staff Standards developed?

The NHS Staff Standards were shaped using a range of evidence and workforce data to focus on the areas that matter most to staff. They were developed through close engagement with the NHS Social Partnership Forum and other key stakeholders to ensure both staff and employer voices were represented and reflected in the content of the standards and that the standards would be deliverable.

How will the NHS Staff Standards be different?

Currently, there is an inconsistent focus on staff experience across the NHS, with variable implementation of initiatives. The NHS Staff Standards will be pivotal to driving consistency across the board and ensuring that all NHS employers prioritise improving staff experience. The standards are different because they will be mandatory for employers and will be measured using a range of metrics, including a new headline requirement in the NHS Oversight Framework. This means that an organisation's overall performance will be affected by how successfully they have delivered the standards.

How are the NHS Staff Standards different from existing guidance and initiatives?

The NHS Staff Standards do not replace existing guidance, policies or improvement programmes, such as the NHS People Promise – rather, they are complementary. They are also not intended to replace or cut across action already underway locally to drive improvements that are working well. Instead, they bring together and strengthen what is already in place, setting a clear national baseline for what all NHS employers are expected to deliver for staff and a clear framework to help boards prioritise their efforts.

Unlike many previous initiatives, delivery of the standards is mandatory, and performance will be measured through national oversight and assurance processes, including the NHS Oversight Framework.

Do the NHS Staff Standards replace other staff experience initiatives like the NHS People Promise?

The staff standards will not replace existing initiatives like the NHS People Promise or the NHS Constitution staff rights and pledges. Instead, they will complement them, providing a clear framework to help employers prioritise and focus efforts on staff experience and against which they will be measured. For example, the NHS People Promise can provide guidance and resources to support implementation of the standards and ensure continuous improvements in staff experience.

How should employers work with local partnerships to implement the NHS Staff Standards?

The standards set clear national expectations, but organisations have flexibility in how they are delivered locally, informed by staff feedback, workforce data and ongoing dialogue with staff and their representatives.

They set clear expectations for employers, but staff also have an important role to play and responsibility for creating a positive culture and workplace. Employers and trade union representatives should work together through their local partnership arrangements and through board-level engagement to implement the standards. This includes boards working with trade unions to provide assurance on delivery of the standards and to ensure that the staff voice shapes local improvements.

How can staff use the NHS Staff Standards?

The NHS Staff Standards set out a clear statement of what staff can expect from their employer regarding their experience at work.

Staff can use the standards to:

- understand the minimum national expectations for their experience at work
- inform conversations through staff networks, staff side representatives or trade unions
- support constructive discussions about improvement at team and organisational level
- understand how they can contribute to developing a positive local culture

The standards are intended to support open, ongoing dialogue between staff and employers, helping to create a shared understanding of what good looks like and where action may be needed to improve staff experience.

Staff also have an important role to play in creating a positive culture and workplace - local implementation should recognise this and deliver the standards through local partnership working arrangements.

What will the next phase of development of the NHS Staff Standards look like?

The NHS Staff Standards represent an important first step in setting clear, consistent national expectations for staff experience across the NHS.

Implementation in 2026/27 will be the initial phase with ongoing work to refine our approach, building on the standards and how they are measured over time. This will include reviewing how effectively they are driving improvement, considering new evidence and data (including sources that allow for quarterly updates), and identifying where expectations can be clearer, or more ambitious, in future iterations.

There will also be continued engagement with NHS staff and leaders and the Social Partnership Forum (SPF) as the standards are embedded, creating opportunities to further develop the standards, associated measures and supporting guidance based on learning from implementation.

Key questions for the boards and senior leaders of NHS organisations

Who is responsible for delivering the new standards?

The boards and executives of NHS organisations are accountable for delivery of the new standards. This will be driven through the NHS Oversight Framework (see questions below). Trade unions in the local staff side and staff networks will play a vital role in developing local plans for implementation and ensuring they are implemented. So, boards are expected to facilitate staff sharing their views to help inform delivery.

What will 'good' look like in year one?

Following launch of the new standards, it is expected that NHS organisations will take immediate steps to begin reviewing both the requirements set out and their existing staff experience programmes. A new score – which will inform segmentation – in the NHS Oversight Framework (see below) is in place from the beginning of 2026/27 to ensure accountability against the standards.

Good in year one means:

- organisations have clear ownership, an honest baseline and a prioritised plan, rather than full maturity

- boards understand their current position against the six standards, have agreed clear leadership and oversight, are engaging staff and trade unions, and have a credible action plan focused on meeting minimum expectations and managing key risks
- leaders can explain how delivery will be assessed and how they are responding

What do the standards mean for me as a senior leader?

The standards are about making staff experience a core priority for your organisation. Boards and executive teams are accountable for making sure the standards are understood, implemented and monitored, with the same level of focus and grip given to other organisational priorities such as finance, operational performance and quality of care.

Implementation should be done in partnership with staff, staff networks, and the recognised trade unions in local partnership arrangements. This partnership approach will be important for identifying what matters most locally, shaping practical actions, and providing assurance that the standards are being embedded in a way that reflects the needs of different staff groups and services.

However, it is ultimately up to senior leaders to have a visible role in setting expectations for respectful, inclusive and supportive workplaces; ensuring managers are equipped to lead well; and making sure staff can raise concerns, share feedback and see that action is being taken in response.

Who do the NHS Staff Standards apply to?

What organisations are covered by the standards?

The staff standards apply to secondary care, which includes acute, mental health, ambulance services, and community healthcare. Further work is needed to understand how we can roll out the standards in primary care, and other settings in the future.

Due to the nature of primary care, with numerous independent providers, it is not possible to mandate application of the standards yet, which is a key point of difference to ensure they have genuine impact on staff experience. However, we encourage all organisations delivering NHS services to embed these new standards as far as possible to ensure that they are protecting and valuing the experience of their workforce.

Is everyone working in secondary care covered by the standards?

The standards apply to all staff working in secondary care, however, we recognise that different contractual arrangements will impact how they are applied in practice. For example, as agency staff are not employed directly by the trust, certain elements of the standards, such as line management and flexible working, will look different.

Contractual arrangements should take precedence, but the essence of the standards should still be applied to all.

Individual standards

Line management

How will the Line Management standard improve staff experience in the NHS?

Effective line management is a strong driver of positive staff experience, and the [latest staff survey results](#) show that 73% of staff feel listened to by their line manager and 70% feel their manager works together with them to come to an understanding of problems. However, it's important to ensure that this is consistent across teams and organisations.

The Line Management standard sets out important steps employers should take to ensure that line managers feel supported and are able to fulfil their role effectively. It also sets a clear and consistent baseline for what good line management looks like, including regular, meaningful supervision, appraisal and development, and compassionate leadership behaviours. This helps ensure all staff feel supported, listened to and able to raise concerns.

The Line Management standard underpins all other staff standards, as a compassionate and capable line manager is often the main route through which staff will experience the standards in practice. Feeling able to raise issues with a trusted line manager, and having confidence that they understand, follow and will apply organisational procedures, is critical to ensuring concerns about racism, violence, sexual safety, health and wellbeing or flexible working are identified early and properly addressed.

What challenges do line managers in the NHS face?

We know that many line managers may not always have the time, capacity or tools to support their staff in the way they want to. Data from 2025 Pulse Surveys show that line managers are more likely to report stress than non-line managers, with stress increasing at a faster rate. The data also tells us that the line managers who are least engaged are the youngest cohort of 21–30-year-olds, suggesting early career line managers struggle the most. We understand that there are challenges with fulfilling a line management role alongside wider duties such as clinical roles. The standard therefore makes it explicit how employers should enable and empower line managers to prioritise the expectations set out in the standard, through appropriate resourcing, support and organisational leadership.

How does the standard support and enable line managers?

The standard makes clear what employers must do to enable and empower line managers to meet expectations. This includes providing sufficient time, capacity, training, and organisational support to prioritise high-quality line management.

It recognises that staff experience is shaped not only by formal processes, but by day-to-day relationships which influence whether staff feel safe to speak up, trust their manager, and receive support when issues arise. By strengthening both the practical and relational aspects of line management, the standard helps create more consistent, supportive and open working environments in which staff can thrive.

How does this interact with existing guidance or leadership programmes?

The Line Management standard does not replace existing leadership frameworks, training programmes or guidance, such as the new NHS Leadership and Management Framework. Instead, it complements the framework and includes it within the 'actions for employers' section, making aligning local organisational work with the NHS Leadership and Management Framework a requirement for organisations. These frameworks together move good, consistent line management from an aspiration to a requirement, helping to drive sustained and system-wide improvement.

Health and Wellbeing

How will this standard improve the health and wellbeing of the workforce?

The standard sets clear expectations across NHS employers of steps they should take to minimise the risk of work-related mental or physical harm amongst their employees. Employers will need to identify risks to staff wellbeing early, use workforce data and staff feedback, and take targeted, needs-based action before issues escalate, for example, into sickness absence.

By strengthening board-level accountability and making wellbeing part of everyday leadership and management, the standard helps create a culture where staff feel safe, cared for, and able to perform well at work.

What else is happening to improve health and wellbeing at work in the NHS?

The Health and Wellbeing Staff Standard is part of a wider programme of work across the NHS to improve staff experience, safety and wellbeing. This includes the NHS Growing Occupational Health and Wellbeing Strategy; the introduction of Staff Treatment Hubs; and targeted initiatives such as menopause support, guidance for line managers, and accessible resources for staff.

NHS England is also leading a reform of statutory and mandatory training, which aims to reduce unnecessary training burden, remove duplication, and make required training more effective and relevant for staff. This work is designed to improve staff experience and free up time for patient care, while still meeting legal and safety requirements.

There is also a broader shift away from relying on training alone to address health and wellbeing risks at work. The statutory and mandatory training review highlights the importance of combining training with wider system level action – such as better leadership, clearer standards, improved data, and stronger accountability – to prevent harm to staff in the first place.

What should organisations do if their data shows poor health and wellbeing outcomes?

The intention of this standard is to drive evidence-based improvements and each organisation's starting point will look different. Employers should use data to identify risk, work in partnership with trade unions, and develop targeted, needs-driven interventions. Boards are expected to have visibility and oversight of this data and to take action where staff experience indicates health and wellbeing is at risk.

How does the standard account for different operational settings and shift patterns?

The standard recognises that staff work in very different environments, including community, ambulance, remote and mobile settings. Employers are expected to ensure that health and wellbeing support is equitable and inclusive, even where traditional facilities are not available, and to consider practical alternatives where needed.

Violence Prevention and Reduction

How is the violence prevention and reduction staff standard different from previous work to prevent and reduce violence?

The standard builds on and reinforces many of the measures already in place to prevent and reduce violence against NHS staff. This includes the [Violence Prevention and Reduction \(VPR\) standard](#), which was developed in partnership with the Social Partnership Forum (SPF) and sets out clear actions that organisations must take to protect staff.

What else is in place to help organisations prevent and reduce violence?

In addition to the action being taken via the staff standards, there is significant work underway to support organisations to prevent and reduce violence.

The [Violence Prevention and Reduction \(VPR\) standard](#), which was developed in partnership with the Social Partnership Forum (SPF), supports employers to understand and manage risks around violence. This has been made mandatory as part of the 2026/27 NHS Standard Contract. The staff standard provides additional assurance that the VPR standard will be implemented and embedded by employers, whilst ensuring the necessary interventions are taken.

Additionally, work continues in partnership with employers and trade unions to implement the recommendations set out in the SPF VPR report, including improving security, ensuring cases are reported and investigated, providing better training for staff on de-escalating and dealing with incidents, and enhancing post-incident support for staff.

The SPF violence subgroup has commissioned several pieces of work which seek to improve organisational responses to staff violence including Safe Working Practice guidance, a VPR Data Reporting Framework to standardise how all NHS provider organisations record and report incidences of violence and aggression against staff, and a new communications campaign. Work on these continues and their publication will support organisations in their implementation of the violence prevention and reduction staff standard.

Championing Sexual Safety

How are you going to make organisations accountable for a zero-tolerance stance on sexual misconduct?

The sexual safety standard, alongside the other five standards, will be measured via a combined metric in the NHS Oversight Framework. Although this will produce a single score for all of the standards, organisations will be able to see how they have performed against the NHS Staff Survey questions that feed into the score. Taken together, this should allow organisations to understand how they are performing against the sexual safety standard. Through this process and wider assurance mechanisms, NHS England will then be able to step in to support those organisations who may not be doing so well.

How are these staff standards going to make a difference to what is already in place?

All standards, including the specific one on sexual safety, will be measured through the NHS Oversight Framework and other assurance processes to ensure clear consequences for a lack of action on tackling unwanted, inappropriate/or harmful sexual behaviours in the workplace.

The standard also sets out clear actions that organisations must be taking. This includes ensuring they have robust policies and processes in place for dealing with

sexual misconduct, ensuring all staff complete the necessary sexual misconduct training and fully implementing the actions set out in the [‘Sexual safety in healthcare’ organisational charter](#).

Tackling Racism

How will the standard on tackling racism make a difference to NHS staff experiencing racism?

Tackling racism is critical to improving the experience of all staff, but particularly ethnic minority staff, to ensure they feel safe working in the NHS. The key difference with the NHS Staff Standards is that performance against them – including the standard on tackling racism – will be measured through the NHS Oversight Framework, with real consequences for organisations who aren’t delivering.

The standard also sets out clear actions organisations must be taking to tackle racism, including reinforcing the role of board level seniors and requiring real visible consequences to be in place for racist behaviour.

How does the standard on tackling racism link to the Lord Mann Review?

The standard on tackling racism is separate to the Lord Mann review into antisemitism and racism, however, both pieces of work complement one another.

In October 2025 Lord Mann was commissioned to lead a rapid review into how healthcare regulators and the NHS tackle antisemitism and racism at every stage, from employment through to professional oversight. This review considered how regulatory processes, transparency in investigations and reporting mechanisms might be improved. His recommendations included the updating of mandatory training on antisemitism and anti-Muslim Hostility as well as clearer national guidance on uniforms. The Government [published and accepted the remainder of Lord Mann’s recommendations on 4th June 2026](#).

What else is being done to tackle racism?

NHS England’s [Equality, Diversity, and Inclusion \(EDI\) Improvement Plan](#), published in 2023, has been our pathway to date to create further progress through NHS systems – setting out six high impact actions to create an environment where staff feel they belong, can safely raise concerns, and are empowered to deliver the best care to our patients. There is intentional alignment within the data points in the EDI Plan and the staff standard on Tackling Racism to ensure the focus on improvement can continue based on the good work already underway.

Promoting Flexible Working

How is the staff standard on flexible working going to make a difference to what is already in place?

The standards set out clear actions that organisations must take to improve flexible working opportunities so that it is openly encouraged and supported, fairly and equitably considered, and embedded into everyday practice, creating a “flexible first” culture, rather than treated as an exception. Requests must be considered objectively and not unreasonably refused, and where they cannot be agreed, alternatives will be explored.

Organisation boards are expected to take clear responsibility for improving flexible working, including appointing a board level flexible working champion, owning and delivering a Flexible Working Action Plan, monitoring its effect through workforce data, and implementing preference-based team e-rostering for all frontline workers (where operationally appropriate).

This will ensure that flexible working opportunities are offered fairly and consistently to NHS staff regardless of organisation and role.

What does flexible working in the NHS mean in practice and how does the staff standard support this?

Flexible working in the NHS means flexibility in how, where and when staff work. Staff have a statutory right to make flexible working requests from day one and employers must handle requests in a reasonable manner and respond within required timescales. The [National Flexible Working People Policy Framework](#) sets out details on types of flexible working arrangements, how to make a request, and guidance for managers to support embedding flexible working practices and enable a “flexible first” culture within organisations.

The staff standard sets out the minimum national expectations for how all NHS organisations must create a positive, fair and transparent culture in which flexible working is normalised operational practice, proactively offered, openly discussed, and consistently applied.

Improving flexible working is not solely about training, but also about time, capacity, job planning and iterative data maturity. It is essential to recognise that providing staff with the necessary resources and support, such as adequate time allocation and thoughtful job design, can make a significant difference. Furthermore, continually refining data processes allows organisations to better understand needs and outcomes, ensuring that changes do not inadvertently create additional pressures for organisations and staff.

What else is in place to help organisations promote flexible working in the NHS?

The standard builds on existing rights within current legislation, NHS contractual provisions and national guidance, including the National Flexible Working People Policy Framework, national flexible working toolkits, e-rostering guidance, and NHS Staff Survey measures. Further work is underway with NHS Employers and trade unions through 2026/27 to strengthen data, oversight and shared learning on flexible working.

Supporting the NHS to embed the Staff Standards

How will NHS organisations be measured on delivery of the standards?

A new score has been introduced in the NHS Oversight Framework in 2026/27. This new score reflects performance across all six of the standards, contributing to an organisation's overall segmentation. You can find more [information on the NHS Oversight Framework at this link](#).

The NHS Oversight Framework score is based on the results of questions in the NHS Staff Survey (NSS) that relate to each of the 6 standards.

The Staff Standards will also be reflected in the upcoming update to the provider capability assessment process, alongside revisions to reflect the importance of staff engagement and experience. This will help ensure that boards are providing assurance that they are giving staff experience a high degree of priority.

Can I see my organisation's performance?

You can see your organisation's performance against the various scores in the NHS Oversight Framework by accessing the [NHS Oversight Framework Dashboards](#) – there are links to dashboards for acute trusts, ambulance trusts and mental health and community trusts. These enable you to see your organisation's score for the overall NHS Staff Standards score and compare them to the scores of similar organisations. The NHS Staff Standards NHS Oversight Framework score will be included in the dashboard from the quarter 1 update.

In addition, you can see your organisation's performance for each of the NSS questions that make up the overall NHS Oversight Framework score. This can be accessed via the [NHS Staff Survey dashboards](#). Further development is underway to ensure supplementary data can be published to show each organisation's score for the six individual standards – this will follow later in the year.

While only the overall score across the standards is included in the NHS Oversight Framework, you will also be able to see your organisation's performance against each of the six individual standards, alongside the overall score, on the [Model Health System's](#) NHS Staff Standards page. This supplementary data will be available shortly.

Are there any other ways that I can see how my organisation is performing against the NHS Staff Standards?

Ensuring the new standards are reflected in the NHS Oversight Framework is a key step to ensuring NHS organisations prioritise staff experience in the same way they do other key metrics.

To further support this, we will continue to develop additional data and resources to help organisations understand their performance and to help staff across the NHS to check progress. This may include additional data to ensure the full breath of the standards is being implemented and provide assurance that changes are helping staff.

There are also some other sources of data and information you may find helpful to understand an NHS organisation's performance on issues related to staff experience, these include:

- [National Quarterly Pulse Survey](#)
- [NHS Workforce Statistics](#)
- [National Education and Training Survey](#)

Each [Staff Standard](#) includes other data sources you could use to understand your own performance and highlights sources we will look to include in future iterations.

To further support organisations and individuals to assess progress against the standards, further data sources and quarterly data will be explored. This will draw on existing reporting as far as possible to ensure we have the benefits of greater insight into staff experience while avoiding the burden on organisations of additional data collection.

How was the NHS Oversight Framework score developed?

How has the new Staff Standards score for the NHS Oversight Framework been developed?

The new score has been introduced into the NHS Oversight Framework and the first scores will be included in the Quarter 1 2026/27 results. This new score impacts an organisation's segmentation score for both the overall NHS Oversight Framework segmentation and the People and Workforce Domain. Further details can be found here regarding how [NHS Oversight Framework scores impact performance assessment](#).

In 2026/27, the score is based upon questions from the NHS Staff Survey that align to each of the six standards. To ensure each of the standards carry equal weighting, a sub-score for each standard is developed and then these sub-scores are compounded together to create a single overall score for the NHS Oversight Framework. A detailed methodology is set out in the [NHS Staff Survey Technical Guidance](#) to ensure

transparency – the updated 2026/27 guidance is currently available on NHS Futures and will be available on the main NHSE website in due course.

The questions that are used to derive the single overall score included in the 2026/27 score for the NHS Staff Standards NHS Oversight Framework are:

Standard	Sub-Set of Standard	Question List
Line Management	Line management	<i>Question 9d</i> - My immediate manager... takes a positive interest in my health and well-being.
		<i>Question 9f</i> - My immediate manager... works together with me to come to an understanding of problems.
		<i>Question 9i</i> - My immediate manager... takes effective action to help me with any problems I face.
	Team Management	<i>Question 7a</i> - The team I work in has a set of shared objectives.
		<i>Question 7h</i> - I feel valued by my team.
	Appraisal	<i>Question 23a</i> - In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?
		<i>Question 23c</i> - It [appraisal] helped me agree clear objectives for my work.
		<i>Question 23d</i> - It [appraisal] left me feeling that my work is valued by my organisation
	Development	<i>Question 24d</i> - I feel supported to develop my potential.
		<i>Question 24e</i> - I am able to access the right learning and development opportunities when I need to.
Health and Wellbeing	N/A	<i>Question 11a</i> - My organisation takes positive action on health and well-being.
		<i>Question 11c</i> - During the last 12 months have you felt unwell as a result of work related stress?
		<i>Question 12b</i> - How often, if at all, do you feel burnt out because of your work?
Violence prevention and reduction	N/A	<i>Question 13a+b+c</i> - In the last 12 months how many times have you personally experienced physical violence at work from... (Patients or Public / Managers / Other Colleagues)"
		<i>Question 13d</i> - The last time you experienced physical violence at work, did you or a colleague report it?
Championing Sexual Safety	N/A	<i>Question 17b</i> : In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault - (From staff / colleagues)
Tackling racism	N/A	<i>BME responses to Question 15</i> - Does your organisation act fairly with regard to career progression / promotion, regardless of e.g. age, disability, ethnic background, gender reassignment, religion, sex or sexual orientation? (<i>WRES Indicator 7</i>)

		<i>BME responses to Question 14a</i> - In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from... Patients/service users, their relatives or other members of the public (<i>WRES Indicator 5</i>)
		<i>BME responses to Question 14 b & c</i> - In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from... Managers / Other colleagues (<i>WRES Indicator 6</i>)
		<i>BME responses to Question 16a</i> - In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?
		<i>BME responses to Question 16b</i> - In the last 12 months have you personally experienced discrimination at work from any of the following? (Manager / team leader or other colleagues) (<i>WRES indicator 8</i>)
Promoting Flexible working	N/A	<i>Question 4d</i> - How satisfied are you with... The opportunities for flexible working patterns
		<i>Question 6b</i> - My organisation is committed to helping me balance my work and home life.
		<i>Question 6d</i> - I can approach my immediate manager to talk openly about flexible working.

How can organisations improve their performance if the data is based on the 2025 NHS Staff Survey?

In line with other scores in the NHS Oversight Framework that use NHS Staff Survey data, the scores for quarters 1-3 in 2026/27 will be based on the 2025 NHS Staff Survey results. This will provide organisations with a benchmark for their current performance against the standards.

Quarter 4 2026/27 NHS Oversight Framework scores will be based on the 2026 NHS Staff Survey, which will run in October 2026. This will enable all organisations to improve their scores during 2026/27.

In future years, the quarterly reporting that is being developed will complement the NHS Oversight Framework score and support organisations to understand their performance across the standards in more detail and on a more regular basis.

Will the new score in the NHS Oversight Framework replace the existing Engagement Score?

No – the existing Staff Engagement score is a vital measure of staff experience and will remain in the NHS Oversight Framework. The new score for the staff standards has been introduced to assess delivery against the specific requirements the six standards set

out. We will use the results of the new score for the standards alongside the existing Staff Engagement score to facilitate a holistic understanding of staff experience.

How can we see the scores for the individual standards?

The new overall score for the NHS Oversight Framework is a compound score based on performance against all six standards. These are in turn based on selected NHS Staff Survey questions that align to the requirements set out in the Staff Standards.

The [NHS Oversight Framework dashboard](#) will only include the overall score. However, the sub-scores for each of the six standards will also be available shortly as supplementary data on the NHS Staff Standards [Model Health System](#) page.

Scores for each of the individual NHS Staff Survey questions that are used in the score (including the sub-scores) can also be accessed via the [NHS Staff Survey dashboard](#).

The full detail of the methodology used for developing the overall score in the NHS Oversight Framework is accessible in the [NHS Oversight Framework Technical Guidance](#).

Will the NHS Oversight Framework score change in future years?

We will continue to review the available data to ensure the Staff Standards NHS Oversight Framework score is able to effectively assess delivery across the full range of expectations set out in the standards. This may result in some update to the NHS Oversight Framework score for 2027/28 and beyond. However, we understand the importance of ensuring a consistent approach for both NHS organisations and those working in health services. We will therefore seek to ensure any changes are implemented at appropriate points so that both staff and employers are always aware of what is expected.

Staff standards in the provider capability assessment

What is the provider capability assessment?

NHS England's provider capability assessment sits alongside an organisation's NHS Oversight Framework segment and together the two measures guide our interaction with providers. While the NHS Oversight Framework segment is driven by relative performance against a range of validated metrics, the capability assessment is an evidence-based judgement of a management team's ability to run its organisation to deliver objectives for the NHS and patients. Further details can be found on the [NHS Provider Capability Assessment web pages](#).

How will the staff standards be included in the assessment

The new standards are a key new requirement that aim to ensure NHS organisations are reflecting the importance of staff experience. The assessment will include a requirement for organisations to reflect on how they are delivering improvements in staff experience and supporting staff to have a role in these developments. This will form part of the People and Culture domain. If either;

1. The trust's return is concerning - e.g. they admit they do not use or act on staff information to improve experience and wellbeing, or
2. External evidence of a significant lack of duty of care to staff contradicts the trust's own self-assessment – such as a poor Staff Standards score (e.g. bottom quartile) **or** the region is aware of, or suddenly learns of, serious staff issues e.g. through staff governors at foundation trusts, Freedom To Speak Up (FTSU) issues or concerns raised by CQC in their well-led reviews,

then regions may reflect this in the capability rating and can request follow-up action. Self-assessments are carried out once a year, but regions may revise capability ratings in-year in response to more up-to-date information.

**Trust Board
28 July 2026
Agenda item: 10.7**

Private/Public paper:	Public		
Title:	Leadership and Management Framework		
Lead Director:	Christine Brereton, Chief People Officer		
Mission/values:	Our workforce is our greatest asset and ensuring that we have the right workforce in place to deliver safe and quality services is critical. As well as being our greatest asset, our workforce is our greatest financial investment, with workforce spend accounting for 80% of our total budgeted expenditure		
Purpose:	To provide a strategic overview on internal and external people related issues for discussion, review and as appropriate escalation.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	To be determined. Implementation of the standards within the NHS Leadership and Management Framework is a national requirement.		
Any background papers / previously considered by:	Discussed at EMT on 9 July and PRC on 14 July.		
Executive summary:	On 6 July 2026, NHS England launched the NHS Leadership and Management Framework alongside the establishment of the new NHS College of Leadership and Management.		

	The framework responds directly to the recommendations of the Messenger and Kark reviews and aims to establish a consistent, professional approach to leadership and management development across the NHS. The framework introduces a single national architecture comprising: • A Leadership and Management Code, setting out the behaviours and values expected of all NHS leaders and managers. Appendix 1 provides an oversight • A national set of leadership and management standards, defining the competencies required at different levels of responsibility. • A national curriculum, to be introduced during 2026, providing a consistent development offer aligned to the standards. The new framework applies to both clinical and non-clinical leaders and managers and is designed to create greater consistency in leadership expectations, talent development, recruitment, appraisal, and succession planning across the NHS. The core principles of the code are: • Be accountable • Be collaborative • Be compassionate • Be curious • Be inclusive • Show Integrity They will be supported by a set of expectations for managers. Expectations: The expectation is that by the end of Q4, every leader and manager in all parts of the NHS should self-assess (against a self-assessment tool) against the relevant stage for their level, i.e., first time leader to board leader and then discuss the outcomes with their line manager, and agree a focused development plan to address any gaps/areas for improvement/ NHS organisations are also expected to begin embedding the framework during 2026/27 through existing people management processes, including recruitment, appraisal, leadership development, talent management, and succession planning. NHS England has emphasised that implementation should be proportionate and phased, allowing organisations to align the framework with existing local arrangements. Whilst we will need to ensure full implementation of the framework into our people processes, the Trust is well placed given the implementation of the People Strategy in early 2026 and the people priorities as part of the annual priorities. In development of our new People Manager Essentials training for our leaders and managers, all our workshops and resources have been mapped in anticipation of the launch of the new framework.

	We have already identified two appraisal objectives for leaders and manager for 26/7 around our people priorities of safe and healthy and compassion and inclusion and these will link directly to the framework. Whilst we identify an action plan around full implementation of the framework, we have promoted the framework through our intranet and leadership and management resources encouraging our managers to complete the assessment. A more formal communications plan and approach for completion will be developed. The Leadership and Management Framework will also be shared with Trade Union via the Trust Partnership Forum on Tuesday 21 July. It is proposed that the implementation of the framework is overseen by PRC and then a progress report back to the Board in early 2027 to monitor progress. Appendix 1 provides an overview of the standards.
Recommendation:	Trust Board members are asked to: • NOTE the publication of the NHS Leadership and Management Framework on 6 July 2026 • NOTE the initial work carried out to launch the standards • APPROVE the proposal to ensure that People and Remuneration Committee have oversight of the implementation of the standards • Bring back a future report to Board to evidence progress with implementation in early 2027.

LEADERSHIP AND MANAGEMENT FRAMEWORK

1. Introduction

- 1.1 NHS England launched the NHS Leadership and Management Framework on 6 July 2026 alongside the creation of the new NHS College of Leadership and Management.
- 1.2 The framework is a direct response to the recommendations of the Kark Review (2019) and the Messenger Review (2022), both of which called for a more consistent, professional approach to NHS leadership and management.
- 1.3 The framework has been developed in partnership with CMI and aligns closely with recognised management and leadership standards. Individuals who already hold qualifications such as Chartered Manager or Chartered Fellow are likely to find significant overlap with the NHS standards. The framework is also being aligned with relevant clinical, professional, and regulatory leadership requirements wherever possible.

2. What is the Framework?

- 2.1 The framework is intended to create a single, nationally consistent standard for leadership and management across the NHS, applying to both clinical and non-clinical leaders and managers.
- 2.2 It consists of three components:

1. Leadership and Management Code

This sets out the core principles and behaviours expected of all NHS leaders and managers. It aims to establish a common understanding of "what good leadership looks like" across health and care.

Be accountable

Take responsibility for your actions and decisions. Hold yourself and others to account for doing the job well, work together fairly and effectively and always looking for ways to improve.

Be collaborative

Build productive relationships based on respect and trust. Bring in different views and work across teams and organisations. Make sure everyone is included, heard, and supported – especially when things are changing.

Be compassionate

Lead with thought and consideration. Show care and understanding for others – and for yourself. Support people so they feel at home in teams and can thrive.

Be curious

Stay open and questioning. Use evidence, listen to diverse views, challenge old assumptions – and find better ways of doing things.

Be inclusive

Confront discrimination, bullying, harassment, and inequality. Ask who is missing, who isn't being heard, and why – and then act to address biases and unfairness.

Show Integrity

Stay true to your values, even under pressure. Be honest and open. Stick to the highest professional and ethical standards.

2. National Leadership and Management Standards

These define the competencies leaders and managers should demonstrate at different levels of responsibility. They create a common benchmark for recruitment, appraisal, development, and career progression.

The standards are based on responsibility rather than Agenda for Change banding or job title. This means a clinical leader, operational manager or corporate leader with similar responsibilities would be assessed against the same core standards.

3. National Curriculum (being developed and rolled out)

A national curriculum aligned to the standards will be available later in 2026 and will underpin all NHS-funded leadership and management development. Free online modular learning will be available to support each competency area.

Organisations may continue to design and deliver their own learning and development programmes, but these should align with the national standards and curriculum over time. A national development curriculum will be published later in 2026, providing structured learning and development linked directly to the standards. NHS England has also announced supporting tools including:

- Online modular learning
- A national 360-degree feedback tool
- Enhanced talent management processes
- Refreshed leadership development programmes

3. Expectations of local Trusts

- 3.1 The expectation is that Boards are made aware of the Leadership and Management Framework to ensure that by the end of Q4, every leader and manager in the Trust has self-assessed against the relevant stage for their level, discuss the outcomes with their line manager, and agree a focused development plan.
- 3.2 The framework is not being introduced as a new regulatory regime, but NHS organisations are expected to begin embedding it during 2026/27 and align it to key people processes such as recruitment and appraisal and leadership development. Work has already begun in this regard with the development of the new People Leaders Training.
- 3.3 The framework is intended primarily as a development tool rather than a performance management tool. Individuals will be encouraged to gather evidence of how they

demonstrate the standards through their work, development activities, projects, and achievements.

- 3.4 Over time, the framework is intended to support the entire employee lifecycle, including recruitment, appraisal, development, talent management, and career progression. NHS England will work with partners to explore how the standards can be reflected within job descriptions, person specifications and talent processes.
- 3.5 Data from the self-assessment and future 360° tool and modular development will be collected centrally and shared with organisations in anonymised and aggregated form. Organisations will not be required to submit separate returns.
- 3.6 Initially, reporting will focus on participation rates, with additional organisational reporting planned over time to support workforce planning and learning needs analysis. No personally identifiable information will be shared.
- 3.7 Equality, diversity and inclusion are fundamental principles of the framework and are embedded throughout the code, standards, and competencies. Inclusive leadership, compassionate management, open dialogue, and people-centred approaches are expected at every level. This commitment includes anti-racist practice and promoting equitable opportunities for all staff.

4. Next Steps

- 4.1 We have already promoted the Framework as part of our leadership resources and will embed this further into our newly developed programme for leadership – People Management Essentials.
- 4.2 We will develop a plan as part of our people priorities about ensuring full roll-out of the framework to ensure compliance as required.

5. Recommendations

- 5.1 The Board is asked to:
 - note the publication of the NHS Leadership and Management Framework on 6th July 2026
 - Note the initial work carried out to launch the standards
 - Approve the proposal to ensure that People and Remuneration Committee have oversight of the implementation of the standards
 - Bring back a future report to Board to evidence progress with implementation in early 2027.

LEADERSHIP AND MANAGEMENT FRAMEWORK

Be Accountable

Be Collaborative

Be Compassionate

Be Curious

Be Inclusive

Show Integrity

Be Accountable

As a leader or manager in health and social care, you must:

- take responsibility for your actions and decisions
- hold yourself and others to account for doing the job well, working together fairly and effectively and always looking for ways to improve

That means:

- following the relevant professional codes of conduct, including duty of candour where appropriate
- taking responsibility for your work, including tasks you delegate to others, making sure they are done well
- holding yourself, and those you are responsible for, to the highest professional and ethical standards
- if things go wrong, promptly applying all relevant processes
- admitting when you fall short
- showing humility and a commitment to improve
- setting fair and realistic expectations, balancing ambition with what is possible
- responding to serious incidents and inquiries with honesty and transparency
- taking appropriate steps to rectify issues, including with patients, people who draw on care, their families and communities neighbourhoods and wider communities
- being transparent about decisions and how they are made
- honouring promises and commitments
- recognising personal challenges without losing focus on the job

What do effective and ineffective practices look like?

Effective Practice

- ✓ Sets realistic goals with clear outcomes, explains what is needed to reach them and measure success.
- ✓ Promptly acknowledges mistakes, takes responsibility and works with others to stop them happening again.
- ✓ Identifies gaps in support, acts to address them and involves others in finding lasting solutions.
- ✓ Takes responsibility for unintended outcomes and works with others to improve results.
- ✓ Communicates honestly and sensitively with their teams and those they report to – explaining clearly why tasks have gone well or badly and making sure people take responsibility when they need to.

Ineffective Practice:

- ✗ Lets teams drift from reactive task to reactive task, without clear goals and ways to measure success.
- ✗ Avoids taking responsibility, shifts blame to others and fails to resolve issues effectively.
- ✗ Ignores feedback, blaming others for problems and allows issues to continue.
- ✗ Ignores what is happening and undermines trust by not acting.
- ✗ Avoids uncomfortable conversations and doesn't challenge poor practice.

Be Collaborative

As a leader or manager in health and social care, you must:

- build productive relationships based on respect and trust
- bring in different views and work across teams and organisations. Make sure everyone is included, heard and supported – especially when things are changing

This means:

- creating inclusive environments where people feel they can speak openly and where everyone's opinions are valued
- encouraging teamwork and cooperation by engaging external expertise and staff representatives and building relationships across departments, organisations and systems
- working with others towards shared goals that improve outcomes and experiences, involving people in decisions and helping teams work together across the organisation, communities and partners
- recognising and celebrating what others contribute, so success feels shared
- asking for and accepting feedback from team members, colleagues, patients, service users and partner organisations
- focusing on collective benefits, building trust and cohesion

What do effective and ineffective practices look like?

Effective Practice:

- ✓ Meets people from different groups, listens to everybody's perspectives, and uses open discussion to find shared solutions
- ✓ Gathers feedback and adjusts ways of working accordingly.
- ✓ Brings organisations together, supports shared learning, and helps teams work together more effectively.
- ✓ Actively works in partnership with recognised trade unions.
- ✓ Makes sure individuals and teams take responsibility for delivering agreed results.
- ✓ Listens to the concerns of others, recognising the limits they may face when working in partnership, and is realistic about what is possible in the short, medium and long term.

Ineffective Practice:

- ✗ Makes decisions without consulting others, including trade union representatives, ignoring their input and expertise.
- ✗ Imposes a rigid approach without consulting key teams.
- ✗ Avoids engaging partners in finding solutions and blames others for problems.
- ✗ Focuses solely on one aspect of care and ignores the goals and ways of working of partners.
- ✗ Fails to recognise that working in partnership means each team must take responsibility for delivering their part of the work.
- ✗ Ignores concerns of others and shows little understanding of the challenges they face when trying to collaborate.

Be Compassionate

As a leader or manager in health and social care, you must:

- lead with thought and consideration
- show care and understanding for others – and for yourself. Support people so they feel at home in teams and can thrive

This means:

- prioritising the mental, emotional, and physical wellbeing of colleagues, patients, people who draw on care, their families and communities, and yourself
- acting with empathy and care and considering the impact of your actions on others
- treating everyone with dignity and respect and tailoring your approach to suit each person
- creating space for honest conversations about concerns, errors, and performance
- creating open opportunities for people to learn together, build trusting relationships, and feel part of the team
- challenging inappropriate use of power or hierarchy, whilst ensuring appropriate accountability
- balancing understanding and empathy with the courage to have difficult conversations and managing performance effectively

What do effective and ineffective practices look like?

Effective Practice:

- ✓ Is empathetic and offers support when team members are having problems.
- ✓ Understands and recognises the effort people are putting in, and what motivates them. Makes sure they feel valued as members of the team.
- ✓ Acknowledges the limits of what team members can take on, reviews workloads and adjusts timelines when necessary.
- ✓ Listens to neighbourhood and community needs, uses resources to support inclusive services, and improves access to services.

Ineffective Practice:

- ✗ Focuses solely on outputs and ignores the challenges team members are facing.
- ✗ Manages tasks not relationships and isn't interested in individuals' wellbeing or the effort they are putting in.
- ✗ Ignores signs of burnout, fails to address workload issues and creates unnecessary stress around deadlines.
- ✗ Focuses solely on operational goals, overlooks disparities and ignores complaints.

Be Curious

As a leader or manager in health and social care, you must:

- stay open and questioning
- use evidence, listen to diverse views, challenge old assumptions – and find better ways of doing things

That means:

- reflecting on your behaviours, acknowledging biases and using what you learn to grow professionally
- asking open questions, listening carefully to different views, and trying to understand them
- checking assumptions and using data, evidence, and risk assessments to guide improvements
- encouraging feedback and ideas from colleagues and staff representatives, partners, patients and people who draw on care, their neighbourhoods – and working together to find new solutions
- encouraging a culture where it's normal to question how things are done and push for more effective approaches
- using research and the team's expertise to spot trends, improve results and support innovation
- embracing learning opportunities and using technology where it helps
- working across professional, organisational, and system boundaries to achieve lasting improvements

What do effective and ineffective practices look like?

Effective Practice:

- ✓ Uses open questions to help find inefficiencies and gets the whole team thinking creatively to address them.
- ✓ Fosters a culture of experimentation that encourages team members to be inquisitive, seek input from stakeholders and test new approaches.
- ✓ Works with teams and their representatives to understand staff feelings, views and ideas.
- ✓ Questions assumptions and seeks different perspectives.
- ✓ Keeps up with the latest developments and tries out new approaches.
- ✓ Works to give colleagues the time, resources and space to think, plan and carry out improvements.

Ineffective Practice:

- ✗ Dismisses inefficiencies as unavoidable, resists exploring new approaches, and fails to engage the team in problem-solving.
- ✗ Relies on outdated methods without investigating root causes, discourages innovation, and fails to address delays and inefficiencies.
- ✗ Assumes traditional methods are sufficient, avoids exploring new ideas, and fails to adapt, leading to disengagement and missed opportunities.
- ✗ Dismisses out of hand views from staff representatives as unrepresentative or unhelpful.
- ✗ Avoids engaging with new technologies and relies on outdated strategies, leaving the organisation ill-prepared for future demands.
- ✗ Asks for innovative ideas but does not help colleagues manage competing pressures to implement these changes.

Be Inclusive

Is a leader or manager in health and social care, you must:

- confront and remove discrimination, bullying, harassment and inequality
- ask who is missing, who isn't being heard, and why. Act to remove bias and unfairness

This means:

- creating an environment where everyone feels safe, valued, supported, and can be themselves
- tailoring support to each person's needs and recognising that everyone is different
- standing up for people who are treated unfairly – and helping people feel confident to do the same
- thinking about how conscious and unconscious biases affect decisions – and then addressing those biases
- listening to people who are marginalised or underrepresented – and valuing what they say
- making reasonable adjustments so that differences in background, identity, or ability don't unfairly limit participation or outcomes
- tackling the causes of injustices, rather than only reacting to the effects
- engaging in continuous learning about cultural humility, inclusivity, and intersectionality to enhance their leadership impact
- honouring other people's beliefs, customs and values
- understanding how diversity can make an organisation more effective – and helping others see this
- learning what inclusion really means – how people's different backgrounds and experiences shape their lives, and how to lead in ways that respect and include everyone

What do effective and ineffective practices look like?

Effective Practice:

- ✓ Consults with people and their representatives to understand their needs, implements inclusive practices, and educates people to create a supportive environment.
- ✓ Reviews hiring practices, addresses barriers to diversity, and implements inclusive strategies to attract and support underrepresented groups.
- ✓ Creates space for honest conversations, introduces bias training, and reviews policies to make sure they are fair and hold people to account.
- ✓ Puts fairness at the heart of strategy, directs resources to where they are most needed – particularly to underserved groups – and acknowledges the advantages they may have and how these may shape their perspectives.

Ineffective Practice:

- ✗ Overlooks people's difficulties, expects them to adapt without support, and accepts exclusion in the workplace.
- ✗ Dismisses a lack of diversity as unavoidable, fails to address systemic barriers and limits opportunities for marginalised groups.
- ✗ Dismisses concerns from staff and their representatives, assumes existing policies are fair, and fails to provide opportunities for change, reinforcing systemic inequities.
- ✗ Avoids tackling inequality, treats equity as irrelevant to day-to-day work, and fails to invest in real change.

Show Integrity

As a leader or manager in health and social care, you must:

- stay true to your values, even under pressure
- be honest and open – stick to the highest professional and ethical standards

That means:

- upholding the highest professional and ethical standards, especially when facing opposition or personal risk
- being honest and open and making sure your actions match your words
- keeping your promises and commitments
- acknowledging your faults and weaknesses, showing humility and willingness to learn
- giving and receiving honest feedback, encouraging openness and accountability
- facing challenges honestly and thinking about how your actions affect others
- being fair and treating people equally – and helping your team do so, too

What do effective and ineffective practices look like?

Effective Practice:

- ✓ Addresses issues privately and respectfully, checks the facts, and escalates when necessary to ensure transparency and fairness.
- ✓ Discloses conflicts of interest, removes themselves from decisions, and documents actions.
- ✓ Corrects errors promptly, informs all parties (including patients and those who access care and support, where involved) and puts steps in place to stop them happening again.
- ✓ Makes fair, open decisions and works with others, including staff representatives, to find balanced solutions that reflect the organisation's values.

Ineffective Practice:

- ✗ Ignores issues to avoid confrontation, compromising ethical standards and undermining trust within the team.
- ✗ Doesn't disclose conflicts of interest and prioritises personal interests over integrity.
- ✗ Conceals errors to avoid scrutiny, leaving issues unresolved and eroding trust and accountability.
- ✗ Implements changes without consultation, ignoring ethical concerns and damaging trust and morale.

**Trust Board
28 July 2026
Agenda item 10.8**

Private/Public paper:	Public		
Title:	Health and Safety Annual report		
Lead Director:	Adrian Snarr, Director of Finance, Estates and Resources		
Mission/values:	To aim to be outstanding and ensure we are relevant for today and ready for tomorrow To ensure the Trust makes best use of resources and provides improved quality in all that we do.		
Purpose:	This paper provides an annual report on health and safety to Trust Board.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓	
	Be ambitious		
BAF Risk(s):	5.2 Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	In order to be a full partner in the local systems it is important that SWYPFT has a comprehensive safety management system in place and fulfils its statutory duties in this area. These regular reports are part of assurance/reassurance process which is best practice and tested by the Health and Safety Executive a part of good practice checks.		
Any background papers / previously considered by:	The Health and Safety Annual Report was considered by Audit Committee on 14 July 2026. Prior to this, the report was received by: • Safety & Resilience Trust Action Group • Executive Management Team (EMT)		
Executive summary:	The annual report is presented to give an overall assessment of the Trust performance on safety services over the previous year. The following areas are topics covered in the report. • The Annual Plan • The Annual Safety Audit Overall, the following points are of particular note: • The introduction of Health, Safety and Welfare as a mandatory training requirement.		

	• Overall compliance from the annual Health and Safety monitoring survey at 91%, an increase from 89% in 2024/25. • Revised and enhanced guidance for lone workers introduced after the review of existing policies and guidance. • The Health & Safety Team continued to support Trust wide clinical Ligature Audits, including at Cheswold Park as part of their transition. • The programme to upgrade fire resilience by installing water mist fire suppression systems in identified existing wards has continued, and extension to the system in Newton Lodge is currently being commissioned. • Consultation with learning and development with regard to proposed changes in fire safety training in order to comply with revised national NHS requirements. • Consultation with police and partners are continuing in subject matters, such as prevent, redress, restorative justice, and to support prosecutions, where appropriate. Current partnership working and relationships with the Police are now in a very positive position across West and South Yorkshire. • Reporting of Hate Crime incidents procedure developed after collaboration with Race Forward Group and Reach Network. • The security team have been requested to attend 118 potentially vulnerable patients (PVP) appointments across the organisation during the financial year. • The Trust maintained effective command and control arrangements throughout multiple operational incidents and resilience exercises, supporting service continuity and patient safety despite significant staffing changes within the EPRR (emergency preparedness resilience and response) team. • Significant progress has been made in strengthening Business Continuity and EPRR compliance through the introduction of a new Business Continuity Management System, improved assurance processes, and increased staff training and preparedness activity. For the annual audit the pertinent points are: The Trust Annual Health and Safety Monitoring Programme continues to provide an important element in helping to assure the Trust Board of compliance and good, safe working practices within the Trust. The monitoring tool is designed as an invaluable aid memoire to managers when determining their services and teams' strengths and weaknesses, allowing an easy way to prepare effective annual action plans. It is recognised that this report is not used in isolation to review Trust Health and Safety performance but is an important element of the whole process in supporting HSG65, coupled with audits, inspections and visits by the Health and Safety team to verify claims by managers' submissions and/or concerns raised from members of the Safety & Resilience Task and Finish Group to manage and enhance the overall Health and Safety performance in the Trust. A targeted, direct email approach to identified managers during the 2025/26 audit provided a response of 219 returns. Some managers provided a combined survey for several of their teams, ensuring coverage of all services. All Care Groups achieved between 83% and 95% compliance, with a Trust wide compliance of 91% a slight increase from 89% in 2024/25.
Recommendation:	Trust Board members are asked to: • NOTE the content of the report

Annual Health and Safety Monitoring Audit Report 2025/2026

Trust wide results

Report commissioned by:
Aaron Luckarift
Health, Safety and Fire Advisor

Report produced by:
Victoria Hitchman and Claire Robson
Quality Governance Team
February 2026
Project reference: AA02

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Record of appreciation

The Health and Safety Team would like to place on record their appreciation to the Quality Governance Team (QGT), for their support.

The Health and Safety Team look forward to developing this project over the coming years.

Please note:

Percentages throughout this report may add up to +/- 100% due to rounding up/down.

EXECUTIVE SUMMARY

South West Yorkshire Partnership Teaching NHS Foundation Trust provides a variety of services to a diverse population across the geographical localities and is committed to achieving the Trust's 'Mission and Values'.

Our mission

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

Our values

- We put the person first and, in the centre,
- We know that families and carers matter
- We are respectful, honest, open, and transparent
- We improve and aim to be outstanding
- We are relevant today and ready for tomorrow

The Quality Governance Team (QGT) were commissioned by the Safety & Resilience Trust Action Group (TAG) to undertake the annual audit of general health and safety issues. The QGT provided support with the questionnaire design, analysis, and report. The aim of the audit was to provide a review of health and safety issues across the Trust.

The main conclusions are:

The Trust annual health and safety monitoring programme continues to provide an important element in helping to assure the Trust Board of compliance and good, safe working practices within the Trust. The monitoring tool is designed as an invaluable aid memoire to managers when determining their services and teams' strengths and weaknesses, allowing an easy way to prepare effective annual action plans.

It is recognised that this report is not used in isolation to review Trust Health and Safety performance but is an important element of the whole process in supporting HSG65, coupled with audits, inspections and visits by the Health and Safety team to verify claims by managers' submissions and/or concerns raised from members of the Safety & Resilience TAG to manage and enhance the overall Health and Safety performance in the Trust.

A targeted, direct email approach to identified managers during the 2025/26 audit provided a response of 219 returns. Some managers provided a combined survey for several of their teams, ensuring coverage of all services. 15 teams did not submit a response in the 2025/26 audit compared to 21 who did not submit a response in 2024/25.

All Care Groups achieved between 83% and 95% compliance, with a Trust wide compliance of 91% a slight increase from 89% in 2024/25.

The main recommendations are:

1. To share the report with Specialist Advisors and the Safety & Resilience Trust Action Group (TAG) in March 2026 to ensure areas of improvements can be identified.
2. Ensure the small number of teams and services that did not complete a return this year are subject to audit and inspection, and that these teams are identified to their respective senior managers. Failure to complete the survey has left the teams concerned at risk during any inspection by regulatory bodies, i.e., the Health and Safety Executive, Care Quality Commission (CQC), Fire and Rescue Authorities etc.
3. To continue to work with Quality Improvement and Governance Team colleagues to identify the most efficient way for managers and staff to complete the survey in 2026/27 and to rationalise further, the questionnaire and recognise the impact of new ways of working.
4. The 2026/27 Audit will be reviewed and reformatted ensuring that all departments who take part in the monitoring survey has their questions clear and consistent and relevant to areas such as inpatients and support services.
5. Specialist advisors will support the teams and services that requested additional help and support in areas where required identified through the monitoring survey.

1. INTRODUCTION

The Quality Governance Team (QGT) was commissioned by Aaron Luckarift, Health, Safety and Fire Advisor on behalf of the Safety & Reliance TAG to undertake the annual audit of the health and safety in all Trust premises across the geographical sites in Barnsley, Calderdale, Kirklees, Wakefield, Doncaster, and Cheswold Park Hospital.

1.1 Background

The National Health and Safety Executive (HSE) work to, and assess organisations based on HSG65, a Plan, Do, Study, Act approach to Health and Safety management system. The Trust annual health and safety audit is a fundamental element of HSG65.

1.2 Aim

The aim of the audit was to provide a comprehensive view of health and safety issues across the Trust with the following objectives:

- To monitor health and safety areas across the Trust
- To highlight areas of good practice and areas of concern
- To ensure that an action plan is provided for areas of concern that will feed recommendations into the Estates and Facilities annual estates programme

1.3 Methodology

The 2025/26 audit tool was reviewed and revised as appropriate by the project team. The tool was designed in Survey Monkey, a web-based survey programme. The link to the survey was circulated via a targeted email. Regular updates were placed in the weekly bulletin and on the intranet pages.

The weekly numbers of returns were monitored by the Health and Safety team. QGT completed the analyses and the production of this report, along with the compliance reports for each Care Group and Corporate and Support Services.

1.4 Project team

Aaron Luckarift	Health, Safety & Fire Advisor
Richard Chamberlain	Specialist Advisor Health & Safety
Meana Kane	Health & Safety and Helpdesk Co-ordinator
Victoria Hitchman	Project Manager
Claire Robson	Project Manager

1.5 Report structure

The Trust wide audit of health and safety took place during November 2025 – December 2025. The audit tool had several sections, and the results are presented within these sections. Each section provides the results for the survey as tables and the overall compliance level for the standard.

To assess the 'self-declared' level of compliance, the results are calculated on the actual 'yes' and 'no' responses. There are several 'not applicable' responses which are not included in the calculations however the numbers of 'not applicable' responses are shown. Missing data is also not included in the calculations.

The Trust has a standard measure of percentage compliance scores as described below. Each standard has been assessed against the compliance levels described below.

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

Appendix 1 shows the comparison between the 2022, 2023, 2024 and 2025 audits for each standard overall, which demonstrates improvements in 5 of the 11 standards.

Teams are expected to address gaps through means of local action plans that can be inspected during audits and inspections.

2. RESULTS

A total of 219 responses (covering 286 of 301 invited teams) were received in 2025/26 compared to 211 (covering 279 of 301 invited teams) in 2024/25, these were split as follows.

Care Group	n=	%
Barnsley physical health, and wellbeing care group	37	17%
Children, young people, and families care group	10	5%
Forensic care group	8	17%
Mental health care group	98	45%
Learning disability and adult ASD/ADHD care group	6	3%
Cheswold Park	7	3%
Linked charities	2	1%
People directorate	4	2%
Medical directorate	6	3%
Finance, estates, and resources	20	9%
Nursing, quality, and professions	8	4%
Provider development	0	0%
Strategy and change	4	2%

Colour coding:

Green – improvement in 2025's figures

Red – decline from 2025's figures

Blue – figures have remained the same

2.1 Fire

*Standard: All staff **must** be aware of the existence, location, and content of the Fire Safety Risk Assessment & specifically any 'Significant Findings' that may impact on their Fire Safety and/or the Trust Fire Policy & Procedures.*

Summary: 89% overall compliance achieved

Table 1: Fire safety

Fire Safety	Yes	No	Not applicable	Percentage compliance achieved 2025	Percentage compliance achieved 2024
Are ALL staff aware of the Fire Safety Risk Assessment that exists for the Ward/Department that they work in?	218	1	–	100%	97%
Have ALL staff been informed of the 'Significant Findings' of the respective Fire Safety Risk assessment?	207	12	–	95%	90%
Is a copy of the Fire Safety Risk Assessment displayed in a prominent position where it can be readily accessed by ALL staff i.e., adjacent to the relevant Fire Alarm Panel?	210	9	–	96%	94%
Is a copy of the fire safety risk assessment immediately available for inspection by any relevant outside authorities?	214	5	–	98%	95%
Are ALL staff fully aware of the fire procedures in case of a real fire situation and false fire alarm activation where there is a requirement to affirm/cancel the fire service attendance as soon as possible?	216	3	–	99%	99%
Have ALL 'new starters' (irrespective of length of service) been given a guided tour of their new workplace & made aware of ALL emergency escape routes & the location of their respective assembly point(s)?	217	2	–	99%	100%
Have ALL 'new starters' (irrespective of length of service) been given instruction on the importance of closing a kitchenette Fire Door prior to the commencement of any cooking taking place & to leave it closed for up to thirty minutes upon vacating the kitchenette?	205	14	–	94%	88%
Have ALL 'new starters' (irrespective of length of service) been given instruction on the use of Trust Approved "Dualit" Toasters including how they differ in operation to that of a common domestic automatic toaster?	172	47	–	79%	73%

Is there a simple procedure in place for your Ward/Department to monitor & prevent lithium batteries from being over charged & presenting a potential serious electrical fire?	166	53	–	76%	64%
Every Ward/Department should have a sufficient number of Fire Wardens. Have you appointed trained fire wardens for your team/department, and are they aware of their role and duties in the event of a fire/fire alarm?	169	13	37	93%	86%
Where your team / department is situated on the upper floor levels of a building it is likely that emergency evacuation chairs have been installed to aid the escape of disabled person(s) working or visiting the premises. If this applies, have you sufficiently trained staff in the use and operation of such specialised equipment?	67	9	143	88%	78%
Has at least one fire evacuation drill been undertaken in your work area within the last 12 months?	115	104	–	53%	69%
Does your building/ward have a fire log book?	191	28	–	87%	89%
89% overall compliance	2367	300	180	89%	87%

2.2 First aid

Standard: All staff should have access to a First Aider in accordance with the First Aid policy and your service / team's First Aid risk assessment. Contents of First Aid boxes must be checked against a list as per the First Aid policy. First Aid cover can be shared with another service. A First Aider is someone who has undergone additional training and holds a relevant First Aid certificate, suitable for the level of risk covered. Consider also different risk factors i.e., kitchen areas (burns / scalds), workshops (eyewash required?) etc.

Summary: 91% overall compliance achieved

Table 2: First aid

First Aid	Yes	No	Not applicable	Percentage compliance achieved 2025	Percentage compliance achieved 2024
Is there access to a First Aider at this level all the time, either within your department or neighbouring departments that you have agreement to access?	168	49	–	77%	71%
Does your department/area have a first aid box?	209	8	–	96%	94%
Is the location of the nearest first aid box and contact details of the first aider signposted?	198	19	–	91%	88%
Are the contents of the First Aid box sufficient and in date? Refer to -Appendix 4 of the First Aid Policy	206	11	–	95%	93%
Is access to the defibrillator available during operating hours?	180	9	28	95%	98%
91% overall compliance	961	96	28	91%	88%

2.3 Moving and handling

Standard: All staff are required to have level 1 e-learning training for the moving and handling of loads. All clinical staff who offer hands on support in patient/client handling in both the clinical and non-clinical environments require level 2 people handling, face to face training.

Summary: 92% overall compliance achieved

Table 3: Moving and handling

Moving and handling	Yes	No	Not applicable	Percentage compliance achieved 2025	Percentage compliance achieved 2024
Have all staff attended Moving and Handling training relevant to their job role as outlined in the Mandatory/Essential Training Brochure?	201	16	–	93%	93%
Have moving and handling risk assessments and action plans been completed for all load or person handling where a potential hazard has been identified?	84	8	125	91%	90%
Have staff been trained by a competent person in the use of moving and handling equipment and records kept in the department?	80	6	131	93%	87%
Have details of moving and handling equipment i.e., hoists been logged with the Facilities department for inclusion in the relevant service and maintenance contracts?	44	2	171	96%	98%
Have all staff that use a computer or laptop for more than an hour a day completed the '000 Display Screen Equipment Information and Training' mandatory online training for the use of this equipment?	206	4	7	98%	94%
Have all staff identified as regular users of computers or laptops completed a workstation risk assessment as outlined in the DSE Guidance document?	172	36	9	83%	79%
92 % overall compliance	787	72	443	92%	89%

2.4 Work systems, risk assessments and incident reporting

Standard: Managers should consider the risk in the work environment and that all staff should be aware of procedures for undertaking risk assessments, incident reporting, and subsequent incident reviews and action plans. Work systems include procedures for lone working or how staff alarms are issued / tested on entry to the ward. General risk assessments are needed for such activities as dealing with risk of violence, lone working, slips, trips, and falls, moving equipment, cleaning activities etc.

Summary: 77% overall compliance achieved

Table 4: Work systems, risk assessments and incident reporting

Work systems, risk assessments and incident reporting	Yes	No	Not applicable	Percentage compliance achieved 2025	Percentage compliance achieved 2024
Have you completed a Baseline Assessment for your service/team?	162	53	–	75%	72%
Do staff have access to workplace risk assessments covering the most obvious risks? i.e., violence and aggression, lone working, equipment being used, one off activities.	200	11	–	95%	94%
Have you reported any incidents in the last 12 months?	103	108	–	49%	52%
If yes, have you reviewed any of these incidents in the last 12 months? *	97	7	–	93%	95%
Have any risk assessments been reviewed or undertaken from accidents/incidents recorded and fed back to staff? *	77	7	20	92%	91%
Can staff gain access to Trust policies at all times, whether via the intranet or paper based where this may not be available?	104	0	–	100%	96%
77% overall compliance	569	172	20	77%	76%

* Not included in overall compliance rating

2.5 Lone Working

Standard: A Lone Worker is an individual who works by themselves without close or direct supervision at any point during working hours. They may be the only person working on the premises or working separately from others. This specifically covers work hours where their isolation is increased with no colleagues working nearby and covers a wide range of staff from Clinicians in the Community, Estates staff on call to Administration staff.

Summary: 85% overall compliance achieved

Table 5: Lone Working

Lone Working	Yes	No	Not applicable	Percentage compliance achieved 2025	Percentage compliance achieved 2024
Are all staff who have periods of working in isolation covered by adequate lone working procedures that keep them safe?	129	5	77	96%	95%
Does your team utilise lone worker devices?	84	51	–	62%	59%

If you have lone worker devices, are your escalation details up to date?	82	2	–	98%	93%
Do all the managers of teams have access to the lone worker portal?	69	15	–	82%	76%
Is your lone worker risk assessment up to date?	122	12	–	91%	82%
85% overall compliance	486	85	77	85%	80%

2.6 Security and safety

Staff need to be aware of local procedures for ensuring the safety and security of staff, patients and assets, and the training of individuals when using medical devices and ligature hook knives where supplied.

Summary: 92% overall compliance achieved

Table 6: Security and safety

Security and safety	Yes	No	Not applicable	Percentage compliance achieved 2025	Percentage compliance achieved 2024
Do staff know how to contact police/local security services in the event of adverse incidents?	208	3	–	99%	99%
Does your ward/unit area have an effective means of immediately informing visiting colleagues of any local risks for the duration of their visits?	197	14	–	93%	91%
Are all staff (including agency staff and students) made aware of the local alarm activation and response procedures (including testing, charging, and using devices) in line with Trust guidance during their local induction at the start of their employment?*	154	2	55	99%	99%
Are staff aware of alarm activation guidance for courtyards within ward environments?	57	1	153	98%	98%
Do staff know how to report any faults to local alarm systems i.e., pinpoint and quantec?*	105	3	103	97%	95%
Have lone working procedures been fully assessed, protocols agreed and implemented?	120	6	85	95%	90%
Are storage areas secure and appropriate for property and equipment?	207	4	–	98%	95%
Is the storage of patient property and money appropriate in your work area?	49	2	160	96%	94%
Is the storage of petty cash safe and secure in your work area and in line with the service user property policy (including money)?*	58	0	153	100%	100%
Do you offer support to staff who have been victims of violence and aggression?	199	12	–	94%	97%
Do staff, who are victims of violence and aggression know how to access support and which support is available?	195	0	16	100%	100%
Do you offer support to staff who are victims of hate crime and do they know which support is available?	186	0	25	100%	100%

Do you encourage staff to report serious incidents of violence and aggression and hate crime to the Police and internally onto DATIX?**	197	0	14	100%	100%
Do you support staff who are victims of violence and aggression and hate crimes and do you know and they know what other support is available?**	187	1	23	99%	100%
Have you or your team required security support at your team base within the last 12 months?	75	136	–	36%	32%
92% overall compliance	2194	184	787	92%	91%

** Please note the wording of these questions have changed since the previous audit

2.7 General issues

Standard: Staff need to be aware of local procedures for ensuring the security of assets, and the safety and training of individuals when using medical devices and ligature hook knives when supplied.

Summary: 95% overall compliance achieved

Table 7: General issues

General issues	Yes	No	Not applicable	Percentage compliance achieved 2025	Percentage compliance achieved 2024
Has the annual ligature assessment been undertaken within your area and is available for all staff to read and actions agreed?	85	1	125	99%	95%
Is there a ligature hook knife available in your area? (inpatient areas only)**	48	5	158	91%	81%
Have all staff been trained in the use and safe storage of the ligature hook knife? (inpatient areas only)**	39	2	7	95%	90%
Are fans in clinical areas covered by a robust risk assessment?	73	5	133	94%	94%
If you have anti-barricade doors, fitted with door top alarms, are staff trained in using/operating them?	48	1	162	98%	87%
Can you confirm robust procedures for all staff, including temporary staff for a local induction in your area/ward before starting shifts?	197	14	–	93%	91%
95% overall compliance	490	28	585	95%	90%

** Please note the wording of these questions have changed since the previous audit

2.8 Emergency planning

Standard: All teams / departments should have a Business Continuity Plan

Summary: 87% overall compliance achieved

Table 8: Emergency planning

Emergency planning	Yes	No	Not applicable	Percentage compliance achieved 2025	Percentage compliance achieved 2024
Is there a Business Continuity Plan (BCP) in place for your team /building?	198	13	0	94%	98%
Have all team members been informed about the BCP and where to find it?	194	6	–	97%	94%
Has the BCP been tested by way of a tabletop exercise in the past 12 months?	123	77	–	62%	81%
Has the BCP been updated in the past 12 months?	175	23	–	88%	88%
Have the updated BCP/Exercise notes been sent to emergency.resilience@swyt.nhs.uk for processing?	160	14	–	92%	91%
Do you need additional support in preparing/reviewing your BCP?*	12	198	–	94%	93%
Does your team receive local alerts for things such as weather warnings?	187	23	–	89%	87%
87% overall compliance	1037	156	0	87%	90%

* Not included in overall compliance rating

2.9 General environment

Standard: Managers need to ensure that all electrical equipment is 'PAT' tested; procedures are in place for checking water temperatures and appropriate signage is in place.

Summary: 95% overall compliance achieved

Table 9: General environment

General environment	Yes	No	Not applicable	Percentage compliance achieved 2025	Percentage compliance achieved 2024
Is electrical equipment within its PAT test date, including service users' own equipment?	204	6	–	97%	97%
Are all appropriate signs in place? (i.e., danger of scalding on hot water/drinking dispensers, up to date banned items lists)	185	3	22	98%	98%
Are work activities appropriate to your area of work? (i.e., is there enough room to do the task)	206	4	–	98%	95%
Are there any trailing cables or other slip and trip hazards in your workplace, including at workstations which could result in someone tripping over them and/or causing damage to equipment?	15	195	–	93%	90%
Is there sufficient security lighting, and lighting within car parks and surrounding areas suitable to your team's working hours?	190	20	–	90%	90%

Are window restrictors in working order, with 100mm maximum opening where service users/visitors have access above the ground floor?	109	1	100	99%	98%
In service user areas, to avoid scalds, do taps provide controlled hot water? (If in doubt, please contact your local Estates and Facilities department for advice)	86	3	121	97%	96%
In service user areas, are local procedures in place for checking bathing water temperature with a thermometer?	29	3	178	91%	97%
Is regular flushing taking place on all water outlets in your work area/ward?	132	0	78	100%	98%
Does everyone know where to look for waste information on the intranet and do they know who to contact?***	201	9	–	96%	–
Is everyone aware of the correct procedures for segregating waste?***	203	7	–	97%	–
Are new starters/temporary staff/agency staff/students made aware of waste procedures?***	201	9	–	96%	–
Do you need any additional support/training with segregating waste correctly?***	29	181	–	86%	–
95% overall compliance	2122	109	499	95%	95%

***Please note this standard included 4 new questions

2.10 COSHH and personal protective equipment

Standard: Managers need to ensure that inventories and COSHH (Control of Substances Hazardous to Health) assessments for hazardous substances are in place, (these are managed through internal Trust systems, predominately via accessing the Trust Data Base on the "K" Drive - K:\COSHH) along with appropriate Personal Protective Equipment (PPE) for their areas. This covers both clinical and office environments and is covered in the Trust's COSHH Policy.

Summary: 90% overall compliance achieved

Table 10: COSHH and personal protective equipment

COSHH and personal protective equipment	Yes	No	Not applicable	Percentage compliance achieved 2025	Percentage compliance achieved 2024
Do you have a COSHH inventory of all your relevant products?	160	50	–	76%	71%
Has the COSHH inventory of substances used in the work area been checked in the last 12 months to review if products are still relevant?	148	12	–	93%	92%
Do staff have access to the COSHH risk assessments, either electronically or paper based?	153	7	–	96%	93%
Is there suitable and sufficient Personal Protective Equipment available for all staff for the products you use?	151	2	57	99%	100%
If your staff are required to wear FFP3 for your duties, have they been fit tested?	46	4	160	92%	84%
90% overall compliance	658	75	217	90%	87%

2.11 Individual staff health and safety

Standard: All staff should complete appropriate Health and Safety training. Managers need to consider if their teams are being adversely affected by stress. Travel at work includes all staff in both clinical and office environments and managers are required to check staff vehicle documentation at least annually.

Summary: 95% overall compliance achieved

Table 11: Individual staff health and safety

Individual staff health and safety	Yes	No	Not applicable	Percentage compliance achieved 2025	Percentage compliance achieved 2024
Have all staff received appropriate safety related training specific to their job? (i.e., Health and Safety, Local Safe Working Practices, Lone working, First Aid, COSHH, Moving and Handling, and RRPI)	206	4	–	98%	94%
Are safety related training records available for inspection, either on the Trust's central database or from local records? (e.g. from team meetings)	208	2	–	99%	97%
As a result of stress at work, have steps been taken to resolve this for staff?	161	2	47	99%	99%
Have staff driving licences/business insurance been checked in the last 12 months for all people who either claim mileage or drive Trust vehicles?	184	4	22	98%	95%
Are all staff able to confirm that vehicles used for travel are roadworthy, legal, adequately insured, taxed, and have a current MOT, with any loads (from specimens, medical gases to wheelchairs and other heavy, bulky items) secured and transported legally?	190	1	19	99%	99%
Have risk assessments been completed for all staff who undertake travel at work?	122	25	63	83%	78%
Were risk assessments undertaken for any staff members who were pregnant in the last 12 months?***	98	7	105	93%	–
<i>The following questions now have a sub-heading of IPC and Medical Devices; to effectively report against last year's audit figures, they are still being assessed within the standard defined as Individual staff health and safety.</i>					
Are all relevant staff appropriately trained to use medical devices /care equipment used on patients in your area? (i.e. glucose meters, pressure care equipment, resuscitation equipment)**	107	1	–	99%	100%
Do you keep a record of training/competency assessments for medical devices / care equipment used for patients?***	86	22	–	80%	84%
Are all medical devices / care equipment used on patients in your area tested and in date (service, tested and calibrated etc)**	100	7	1	93%	99%
Do all medical devices / care equipment used on patients have an asset sticker in place?***	101	3	4	97%	99%

Do you and your team have access to hand sanitisers?***	200	10	–	95%	–
95% overall compliance	1763	88	262	95%	95%

*** Please note the wording of these questions have changed since the previous audit*

****Please note this standard included 2 new questions*

- Do you use medical devices in your area was one of the new questions for the 2024 audit but was unable to be included in the above table due to the nature of the question. 100 responses answered 'yes' medical devices were used in their area and 102 answered 'no'. 2025 108 yes 102 no

3. SUMMARY OF RESULTS

The following table compares the self-declared compliance results from each Care Group for the Health and Safety audit in 2025/2026. The key for the colour codes is shown below.

	91% - 100% compliance achieved
	81% - 90% compliance achieved
	Less than 81% compliance achieved

Table 12: Summary compliance achieved for each Care Group

(arrows indicate changes in % from 2024/25 results)

Health and Safety standards	Trust	Barnsley physical health, and wellbeing care group	Children, young people, and families care group	Forensic care group	Mental health care group	Learning disability and adult ASD/ADHD care group	Cheswold Park	Corporate Services
Fire	89%↑	86%↑	86%↑	97%↓	91%↑	94%↑	79%↑	85%↑
First Aid	91%↑	89%↑	90%↑	87%↓	93%↑	100%↑	83%↓	89%↑
Moving and Handling	92%↑	94%↑	79%↓	90%↓	93%↑	85%↑	54%↑	97%↑
Work Systems, Risk Assessment, and Incident Reporting	77%↑	70%↓	91%↑	80%↓	78%↓	82%↑	88%↑	74%↑
Lone Working	85% ↑	84%↑	79%↑	92%↑	88%↑	96%↔	24-25 (17%) 25-26 N/A	71%↑
Security and Safety	92% ↑	88%↓	86%↓	98%↔	94%↑	96%↑	94%↑	88%↑
General issues	95% ↑	96%↑	95%↑	99%↔	96%↑	100%↑	81%↓	80%↓
Emergency Planning	87% ↓	93%↓	60%↓	97%↑	97%↑	100%↑	47%↓	84%↔
General Environment	95%↔	95% ↑	92%↑	94%↓	95%↑	98%↑	94%↑	96%↑
COSHH and Personal Protective Equipment	90% ↑	89%↑	75%↑	99%↔	90%↑	91%↓	100%↑	83%↑
Individual Health and Safety	95%↔	94% ↓	94%↑	99%↔	93%↓	93%↔	82%↑	94%↓
Overall compliance	91%↑	90%↑	85%↔	95%↓	92%↑	95%↑	83%↑	88%↑

Overall, the Trust has achieved 91% compliance with all the Health and Safety standards which is slightly higher than the previous year (89% 2024/25). All the Care Groups have achieved between 83% and 95% compliance. Overall, the compliance results for the Trust standards were as follows and in general 5 results had improved from the 2024/25 results (see Appendix 1).

4. CONCLUSIONS AND RECOMMENDATIONS

4.1 Conclusions

The Trust Annual Health and Safety Monitoring Programme continues to provide an important element in helping to assure the Trust Board of compliance and good, safe working practices within the Trust. The monitoring tool is designed as an invaluable aid memoire to managers when determining their services and teams' strengths and weaknesses, allowing an easy way to prepare effective annual action plans.

It is recognised that this report is not used in isolation to review Trust Health and Safety performance but is an important element of the whole process in supporting HSG65, coupled with audits, inspections and visits by the Health and Safety team to verify claims by managers' submissions and/or concerns raised from members of the Safety & Resilience TAG to manage and enhance the overall Health and Safety performance in the Trust.

A targeted, direct email approach to identified managers during the 2025/26 audit provided a response of 219 returns. Some managers provided a combined survey for several of their teams, ensuring coverage of all services.

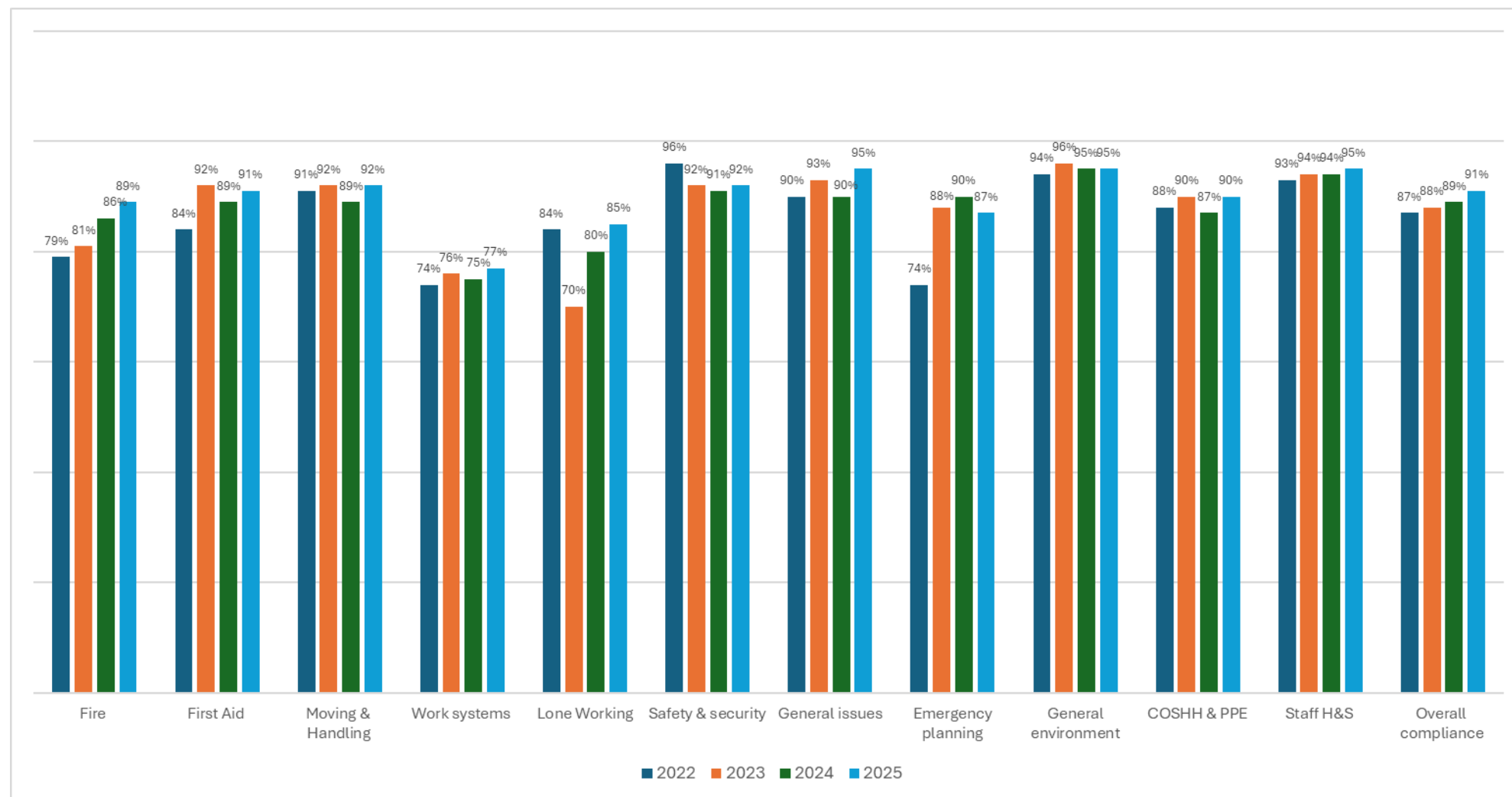
All Care Groups achieved between 83% and 95% compliance, with a Trust wide compliance of 91% a slight increase from 89% in 2024/25.

4.2 Recommendations

The main recommendations are:

1. To share the report with Specialist Advisors and the Safety & Resilience Trust Action Group (TAG) in March 2026 to ensure areas of improvements can be identified.
2. Ensure the small number of teams and services that did not complete a return this year are subject to audit and inspection, and that these teams are identified to their respective senior managers. Failure to complete the survey has left the teams concerned at risk during any inspection by regulatory bodies, i.e., the Health and Safety Executive, Care Quality Commission (CQC), Fire and Rescue Authorities etc.
3. To continue to work with Quality Improvement and Governance Team colleagues to identify the most efficient way for managers and staff to complete the survey in 2026/27 and to rationalise further, the questionnaire and recognise the impact of new ways of working.
4. The 2026/27 Audit will be reviewed and reformatted ensuring that all departments who take part in the monitoring survey has their questions clear and consistent and relevant to areas such as inpatients and support services.

APPENDIX 1: TRUST COMPARISONS 2022, 2023, 2024 & 2025





**South West Yorkshire
Partnership Teaching**
NHS Foundation Trust

Safety Services

Annual Report 2026

June 2026

Nick Phillips, Deputy Director, Estates & Facilities

Produced in conjunction with Specialist Safety Service Advisers

With **all of us** in mind.

Heading

Contents

1. Executive Summary
2. Introduction
3. Health & Safety
4. Fire Safety
5. Security
6. Emergency Preparedness, Resilience & Response

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1. Health & Safety Action Plan – 2026/2027
2. Fire Safety Action Plan – 2026/2027
3. Security Management Action Plan – 2026/2027
4. Emergency Preparedness, Resilience & Response Action Plan 2026/2027

1. Executive Summary

This report has been produced to provide an overview of the activity within the safety and security services in 2025/2026 and to provide assurance to the Board on activity in 2026/2027. Overall safety and security management has been in line with annual plans.

Overall, the following points are of particular note:

- The introduction of Health, Safety and Welfare as a mandatory training requirement.
- Overall compliance from the annual Health and Safety monitoring survey at 91%, an increase from 89% in 2024/25.
- Revised and enhanced guidance for lone workers introduced after the review of existing policies and guidance.
- The Health & Safety Team continued to support Trust wide clinical Ligature Audits, including at Cheswold Park as part of their transition.
- The programme to upgrade fire resilience by installing water mist fire suppression systems in identified existing wards has continued, and extension to the system in Newton Lodge is currently being commissioned.
- Consultation with Training and Development with regard to proposed changes in fire safety training in order to comply with revised national NHS requirements.
- Consultation with Police and partners is continuing in subject matters, such as the PREVENT program, redress, restorative justice, and to support prosecutions, where appropriate. Current partnership working and relationships with the Police are now in a very positive position across West and South Yorkshire.
- Reporting of Hate Crime incidents procedure developed after collaboration with Race Forward Group and Reach Network.
- The Security team have been requested to attend 118 Preventing Vulnerable People (PVP) appointments across the organisation during the financial year.
- The Trust maintained effective command and control arrangements throughout multiple operational incidents and resilience exercises, supporting service continuity and patient safety despite significant staffing changes within the EPRR (emergency preparedness resilience and response) team.
- Significant progress has been made in strengthening Business Continuity and EPRR compliance through the introduction of a new Business Continuity Management System, improved assurance processes, and increased staff training and preparedness activity.

2. Introduction

This report provides an overview of key achievements from all respective areas of health & safety, security, fire safety and emergency preparedness, during the financial year 2025/2026. Also included within this report are any identified areas of development within the financial year 2026/2027.

Any areas of development will be documented within respective action plans, located as appendices at the end of this report.

This report also provides assurance to the Trust Board that compliance with key legislative requirements has been maintained. Requirements include, but are not exhaustive to, the Health & Safety at Work etc. Act 1974, the Civil Contingencies Act (2004) and the Management of Health & Safety at Work Regulations 1999, the Regulatory Reform (Fire Safety) Order (RRO) 2005, Managing Violence and Aggression Standards, Security Industry Association, and the Emergency Preparedness, Resilience and Response (EPRR) Core Standards.

3. Health & Safety

2025/2026 proved to be a challenging and ultimately successful year for the Health & Safety Team.

The annual action plan provided a solid platform for the prioritisation of work from Quarter 1 onwards. The team ensured that traditional, existing risk issues were still addressed. This was accomplished by:

- Continued partnership working with third parties, i.e. Other regional NHS Trusts, Local Authorities, Health & Safety Executive (HSE) etc.
- Following and delivering the 2025/2026 Health & Safety Action Plan.
- Services being supported with their ongoing priorities, i.e. Ligature Audits in community and inpatient areas.
- Revision and implement of current policies and procedures relating to Health and Safety.
- Supporting the transition and taking on board the Trusts new inpatient site at Cheswold Park Hospital (Doncaster).

The emphasis was broad based, including policy development, incident management and onsite inspections.

Achievements

- Business was maintained in 2025/2026 including regular contact with other NHS Trusts across the Region to ensure a consistent provision of advice to Trust services.
- The Trust continued to work with the HSE to support any inspections/investigations and RIDDOR reporting.
- The Health & Safety Team also supported service led Trust wide Ligature Audits, covering in-patient areas and community settings.

- Health, Safety and Welfare was agreed as a new mandatory training requirement for all staff during 2025/26 is available as an e-learning package. This provides better assurance for the Trust and gives a better alignment to the wider NHS Core Skills Framework.
- Revised and enhanced guidance for lone workers introduced after the review of existing policies and guidance.

Annual Health and Safety Monitoring

The Trust wide audit of health and safety took place between November 2025 – December 2025. The audit tool was reviewed and revised as appropriate by the project team in conjunction with the relevant specialist advisers.

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

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

A targeted, direct email approach to identified managers during the 2025/26 audit provided a response of 219 returns. The survey was circulated on the 3rd November 2025, and various chase emails were sent to non-responders until such a time the survey was closed in December 2025.

Some managers provided a combined survey for several of their teams, ensuring coverage of all services. In total 279 of 301 invited teams responded to the survey.

Several teams did not complete the survey, which are noted below:

Adults and older people's mental health care group
• Priestley Unit, Kirklees Addiction Psychiatry Service
• Becks Court - North Kirklees Enhanced Team
• Perinatal Service
• Ground Floor - Senior Leadership and Management Team & Admin Team
• Specialised Therapies Team
• Wakefield Single Point of Access Adults
• SPA - Single Point of Access Team
• Early Intervention in Psychosis (EIT)
• CIC, ADHD and what will be LD
Support Services
• Trust Bank Team/E-rostering and International Recruitment
• Occupational Health
Cheswold Park Hospital
• OT and Clinical Service

All Care Groups achieved between 83% and 95% compliance, with a Trust wide compliance of 91% a slight increase from 89% in 2024/25.

A total of 219 responses were received in 2025/26 compared to 211 in 2024/25; these were split as follows.

Care Group	n=	%
Barnsley physical health, and wellbeing care group	37	17%
Children, young people, and families care group	10	5%
Forensic care group	8	17%
Mental health care group	98	45%
Learning disability and adult ASD/ADHD care group	6	3%
Cheswold Park	7	3%
Linked charities	2	1%
People directorate	4	2%
Medical directorate	6	3%
Finance, estates, and resources	20	9%
Nursing, quality, and professions	8	4%
Provider development	0	0%
Strategy and change	4	2%

- Performance was measured by the Trust standard measure of percentage compliance scores as described below.
- Teams are expected to address gaps through means of local action plans that can be inspected during audits and inspections.

The Trust has a standard measure of percentage compliance scores as described below. Each standard has been assessed against the compliance levels described below.

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

RIDDOR (Report of Injuries, Diseases and Dangerous Occurrences Regulations)

RIDDOR reports are monitored and scrutinised regularly by the health & safety team, with regular reports now included in the Trust Integrated Performance Report; this does not negate that RIDDOR reportable incidents have generally increased over the past three years although they remained the same in 2025/26 as they did in 2024/25.

It is a note that the Health & Safety Executive, have the power to inspect the Trust based on any reported figures/trends. In the event of inspection there is a Fee for Intervention (FFI) fee at a cost of £188 per hour, per inspector.

Analysis of figures over a 4-year period is noted below:

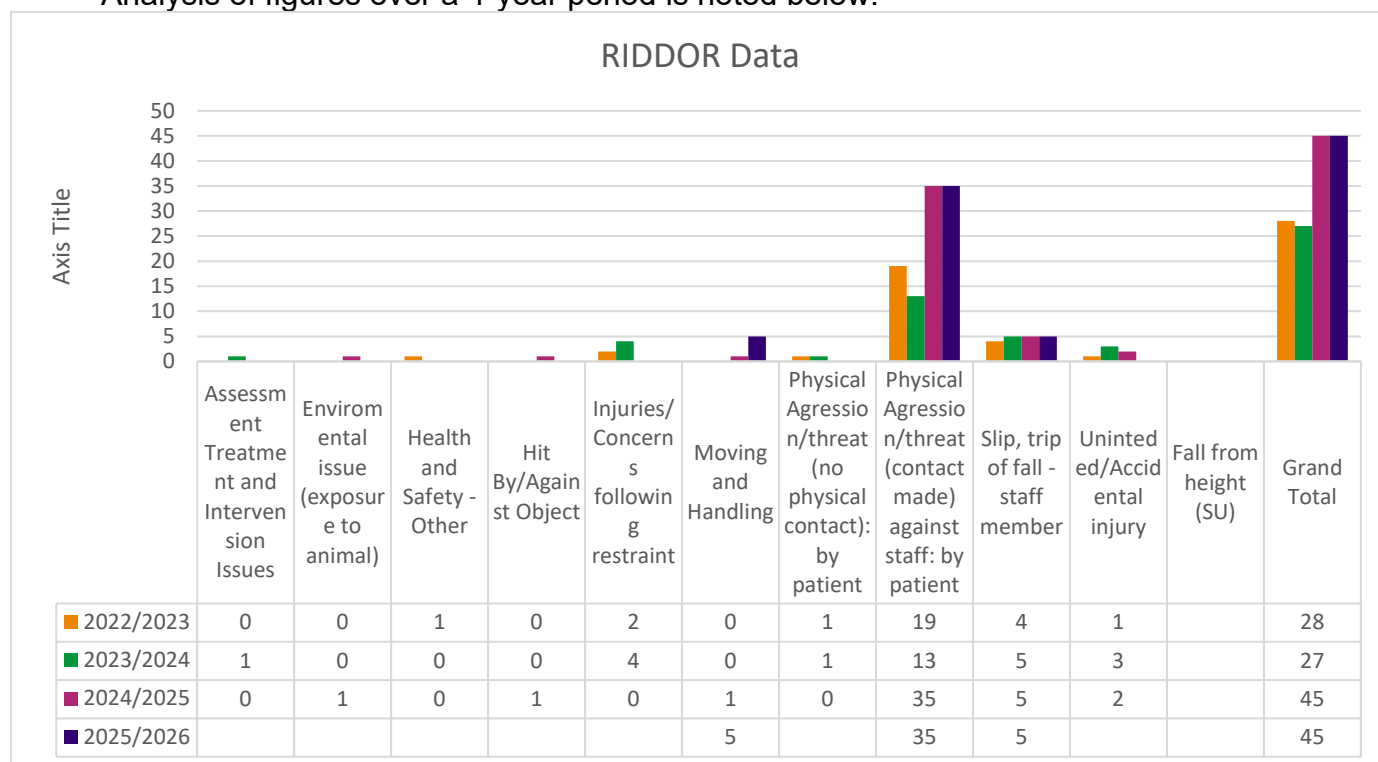


Figure 1. RIDDOR analysis over 4 years

A total of 117 RIDDOR incidents have been reported in the last 3 financial years, all of which were injuries resulting in over 7 days absence from work with key factors identified to aide in the processing of RIDDOR incidents, including:

- RIDDOR awareness for managers and staff to complete Datix and associated paperwork in a timely manner.
- Review of processing paperwork within Safety Services to implement a more streamlined method of works.
- Data review and scrutiny at OMG and the amount of RIDDORs reported and type of incident are accepted to be in scope.

Lone Worker device usage

Overall usage of lone worker devices usage has steadied during 2025/26 after a general increase overall over the last 18 months. There has been an increase in the number of yellow alerts being made so colleagues that are using devices are using them more appropriately in communicating with the monitoring centres. However, we still have around 25% of devices not being used during the year. In order to raise awareness and increase usage of the devices, the following has been implemented:

- Lone worker usage discussions at meetings across the Trust.
- Communications regarding device usage and the benefits of using the device, are regularly cascaded to all staff.
- Service Directors receiving regular reports and undertaking challenge and confirm on data received.
- Monitoring implemented at OMG to provide up to date position of usage and any hot spot areas.

- Refresher/online training provided to all lone worker device users on request.
- Establishment of working groups involving all Care Groups at Senior Management level to monitor and manage usage of lone worker devices.

The ongoing work with Care Groups has highlighted some anomalies with information available in the lone worker management portal. Work as part of future procurement processes will include working closely with the device providers to ensure that information is captured accurately. This will give us better assurance in terms of accuracy of information in reports. Internally we will also plan to have more proactive meetings with managers to discuss device allocations and usage, ensuring that devices are allocated appropriately.

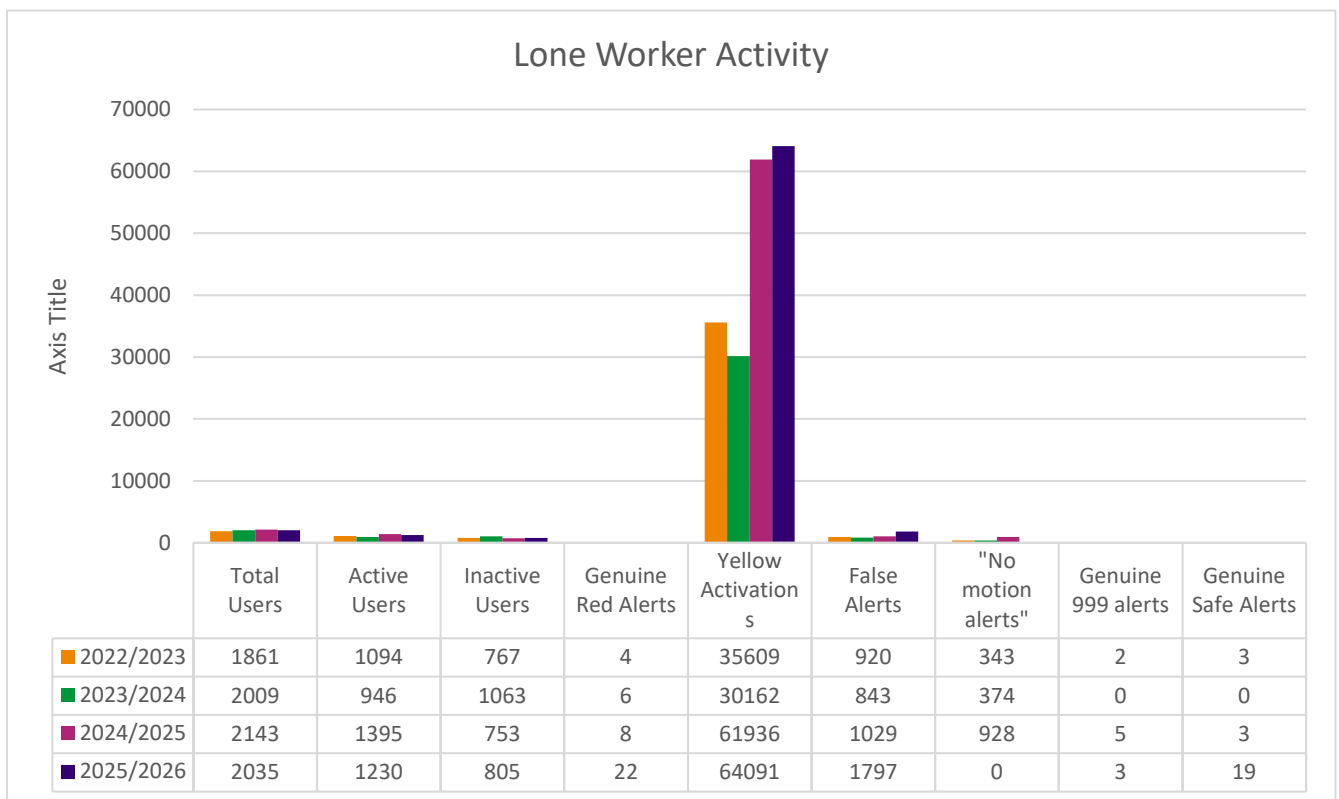


Figure 2 – Lone worker device usage over 4 years

Health & Safety Objectives 2026/2027

- Undertake audits and inspections, based on the outcomes of the 2025/2026 annual monitoring tool, providing support to teams where required.
- Review, update and implement the 2026/2027 Annual monitoring tool, working with wider specialist advisers and the Quality Governance Team.
- Support operational colleagues undertake the trust ligature programme for inpatient and community settings.
- Continue to support the transition of Cheswold Park Hospital to SWYPT policies and procedures, by way of delivering additional workshops and training.
- Monitor lone worker device usage and allocation, along with subgroups to improve usage.

- Prepare for the tender for the new lone worker contract, liaising with wider stakeholders and procurement colleagues.

4. Fire Safety

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

Achievements

- The programme to upgrade fire resilience by installing water mist fire suppression systems in identified existing wards has continued, and extension to the system in Newton Lodge (delayed because of building layout changes) is currently being commissioned.
- Maintaining effective consultation with the Estates and Capital Planning teams to ensure that appropriate fire safety precautions are included in all building projects (new construction or adaptations/alterations of existing premises), and that fire safety investment is included in the annual minor capital plan.
- Review and revision of fire safety procedures, fire risk assessments and fire plans for Cheswold Park Hospital to align with existing Trust Procedures.
- Consultation with Training and Development with regard to proposed changes in fire safety training in order to comply with revised national NHS requirements.
- Attendance at face-to-face fire training sessions has improved from the previous year although if staff does not meet the requirements of the fire policy with regard to ward based staff.

Fire safety information 2025/2026

- 157 Instructor lead fire training sessions (including classroom, Microsoft Teams remote training, and practical session in the fire demonstration training facilities) were provided.
- 1586 staff attended instructor lead sessions. Staff attendance has decreased from the previous year (166 sessions were provided with an attendance of 1622)
- 5089 staff completed e-learning level 1 fire safety refresher training.
- E-learning completions have increased from 1439 in the year. However, the high numbers of e-learners should have attended face to face training to comply with the requirements of the Trust Fire Policy and NHS Fire code.
- Trust wide fire training attendance was approximately 92.1% (against a minimum target of 80%) at end of March 2026.

The table below shows the previous financial years comparisons:



Figure 3 – Fire Safety Training Comparison over 4 Years.

Fire incidents

There was one “reportable fire” resulting in structural damage or damage to the fabric of the building requiring fire service intervention during the reporting period. This involved a fire causing extensive damage to the ADL Kitchen in Newhaven on Fieldhead Site, Wakefield. Direct damage was confirmed in the room of origin, with minor smoke and water damage to the adjacent corridor. There were 4 minor incidents where damage was restricted to the item first ignited and there was no damage (other than minor smoke damage) to the building contents. The 4 incidents are noted below:

- Bin fire in a bedroom (suspected deliberate fire)
- Faulty Trust approved vape overheated and ignited in service users pocket
- Fire in microwave oven in ward kitchen ignited (Caused by metal objects left in the device)
- Fire in service user’s bedroom caused by mobile phone (suspected cause deliberate damage by service user)

Fire alarm activations

Unwanted fire signals (UwFS)	Fire service attended	10
False alarms	No Fire Service attendance	172

Note – In 2025/26 Cheswold Park Hospital figures were included.

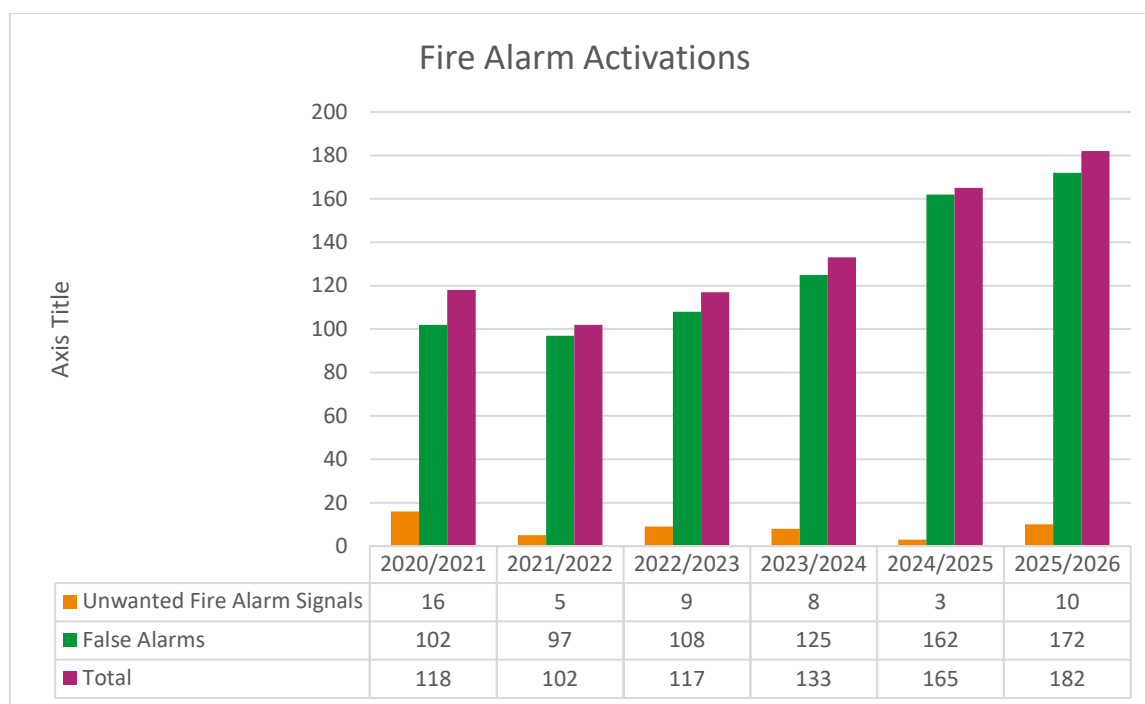


Figure 4 – Fire Alarm Activations over the last 6 Years.

Identified significant risks 2026/2027

Fire training requirements are outlined in the Fire Policy, based on the national requirements under the Fire Safety (Regulatory Reform) Order 2005 (as amended) together with NHS Firecode. Although fire training compliance (as recorded in ESR) exceeds the Trusts target of 80%. This has mainly been achieved via e-learning.

In order to meet Trust and legal requirements (and potential enforcement action in the event of a fire), it is essential that staff attended instructor lead fire training when required. This is especially important for staff in patient facing roles (clinical and non-clinical) who may be directly involved in the evacuation of patients.

Smoking

Although there has been a continued reduction in smoking related incidents recorded in Datix, it is recognised that there remains a significant risk of fires in bedrooms where service users have access to contraband lighters.

Evidence would suggest that standard operational procedures for the control of smoking in wards or grounds is not being fully sufficiently enforced. Fire risks related to smoking and vapes are included at instructor lead. fire training sessions.

Fire Safety Objectives 2026/2027

- Ensure that all fire safety risk assessments are completed and regularly reviewed for all premises owned or occupied by the trust, and that appropriate remedial measures are taken where necessary to comply with legal requirements.

- Continue to consult with Learning and Development to review that the content of the fire training meets the revised NHS national guidance and ensure the provision of sufficient face to face or practical training is available to meet legal requirements. This will include the development of fire training specific to Cheswold Park Hospital.
- Review the Trust Fire Policy taking account of the additional requirements in the 2026 version of HTM 05-01 Management of Fire Safety.

4. Security

Through robust collaborative teamwork and planning with other trust services, the security team delivered their targets throughout the year.

Achievements

- Consultation with Police and partners are continuing in subject matters, such as the PREVENT program, redress, restorative justice, and to support prosecutions, where appropriate. We now have embedded relationships and partnership working with police colleagues across the whole of the trust including, Doncaster, Barnsley, Wakefield and Kirklees and Calderdale. Current partnership working and relationships with the Police are now in a very positive position across West and South Yorkshire.
- Focused discussions and planning in collaboration with the Race Forward Group and Reach Network, ensured that the Reporting of Hate Crime incidents Procedure have been developed and staff are fully supported.
- The 3 Senior Security Officers is now employed within the team and they are a great asset to the organisation. All of the security team are fully SIA licenced.
- Crime reduction surveys are continuing to be completed on an annual, risk-based schedule, all findings are reported, and hard FM issues reported to the Estates TAG. During 2025/26, 48 surveys were completed.
- The security advisors continue to provide situational awareness training to all intakes of resident doctors and nursing staff who attend the care certificate training. Support is also offered to individual staff due to safety and security concerns raised within community settings.
- A trust wide review and upgrade of CCTV is ongoing; led by estates colleagues.
- The Security Management policy, Surveillance Systems (CCTV, Body Worn Video, ANPR) Policy, Traffic Management and Parking procedure have been reviewed during 2025. Lockdown Policy and Reporting of Violent and Anti-social Crime Procedure are due for review in 2026/27.
- The security advisors supported and advised on capital projects at seclusion room- and courtyard refurbishment at Ward 18, Priestley Unit; CCTV Upgrade at Bretton Centre, Refurbishment of Beckside Court, Extension of the OPS ward at Fieldhead, Refurbishment and planning for new Extra Care Area in Ashdale ward (deferred), Seclusion at Walton (Deferred).

Key Risks/Issues

Potentially Vulnerable Patients (PVP)

The Security team have been requested to attend 118 PVP appointments across the organisation during the financial year. This is a small reduction from the 139 requests from 2024/25. Of the 118 appointments booked, 35 resulted in DNA's (29%) and 9 (8%) cancelled within 24 hours of the appointment taking place. A breakdown of statistics, month by month is below:

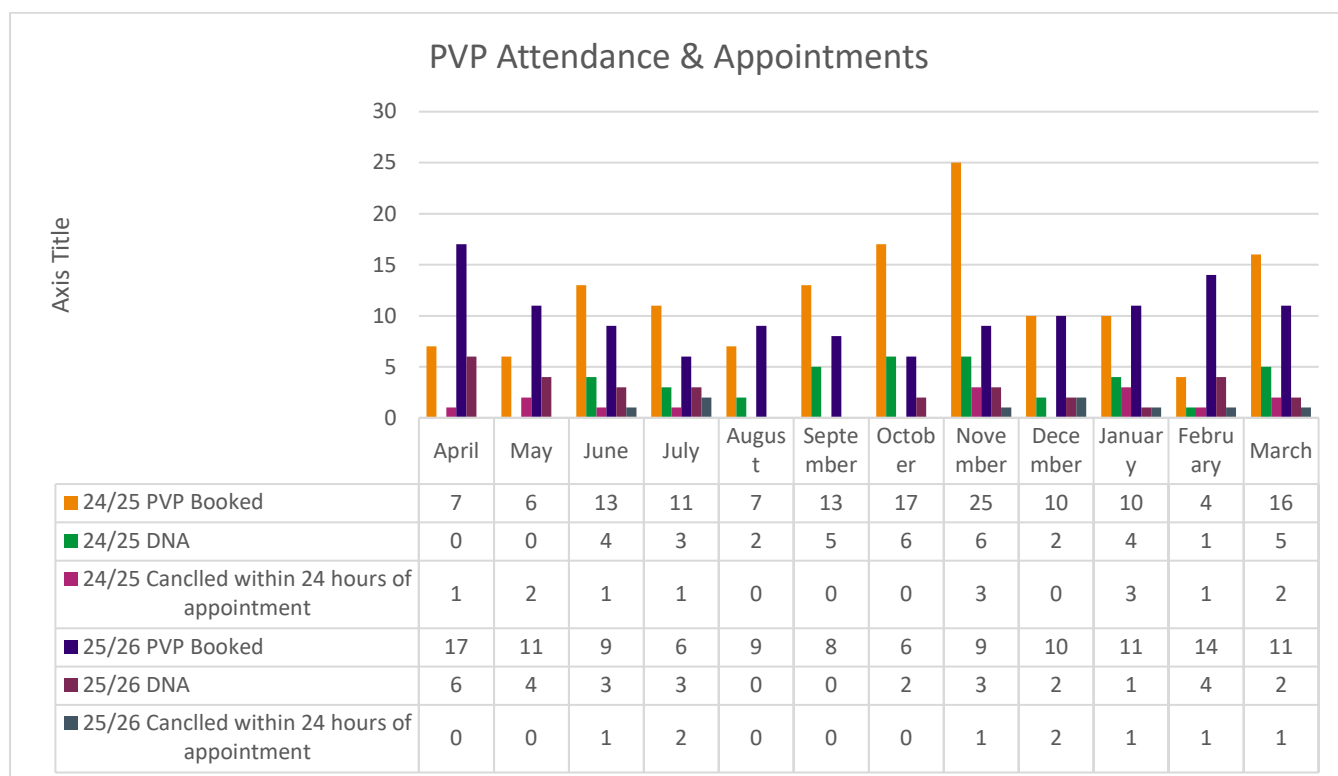


Figure 5 – PVP Attendance & Appointments over 2 years.

A PVP is a patient that has a known history of violence or potential violence to NHS staff and others. So, to support staff, the security team are invited to clinical appointments, when such patients are in attendance. This is to provide support and an additional physical presence in the event any incident occurs. These PVP appointments are normally booked in with the security team in advance of the appointment.

Security is predominantly requested to attend due to patients' previous contact with forensic inpatient services, or the criminal justice system, i.e. spent time in prison and due to Government's early release schemes from Prison this has seen an increase early on in the year. Some patients are deemed risky if they have been placed on the patient under the Special Allocation Scheme with the GP.

Most of these patients have history of violence and aggression against health professionals, nurses, GP'S, police, or social service employees. Others have history of carrying weapons such as knives, guns, axes etc.

Due to identified risks, shared by community nursing teams, associated with some patients being seen in community settings, police intelligence is occasionally requested to obtain the most up-to-date information on a patient's risk history. This ensures that all parties are informed of any recent police contact or other risks posed by the patient.

The security presence at these appointments in community settings gives added reassurance to the community staff and reassurance to other staff, patients, and visitors, who shared the premises.

Due to the small team numbers within the security team, the team cannot always meet demand at short notice or on a call of basis.

Violence & Aggression against staff statistics

Violence and aggression incidents against staff have reduced in the reporting year 2025/2026, with physical violence against staff being the highest reported category during this period.

The security team continue to work alongside the Reducing Restrictive Practises (RRP), to support staff following acts of violence by working in partnership with Police, providing advice and guidance on working within the community.

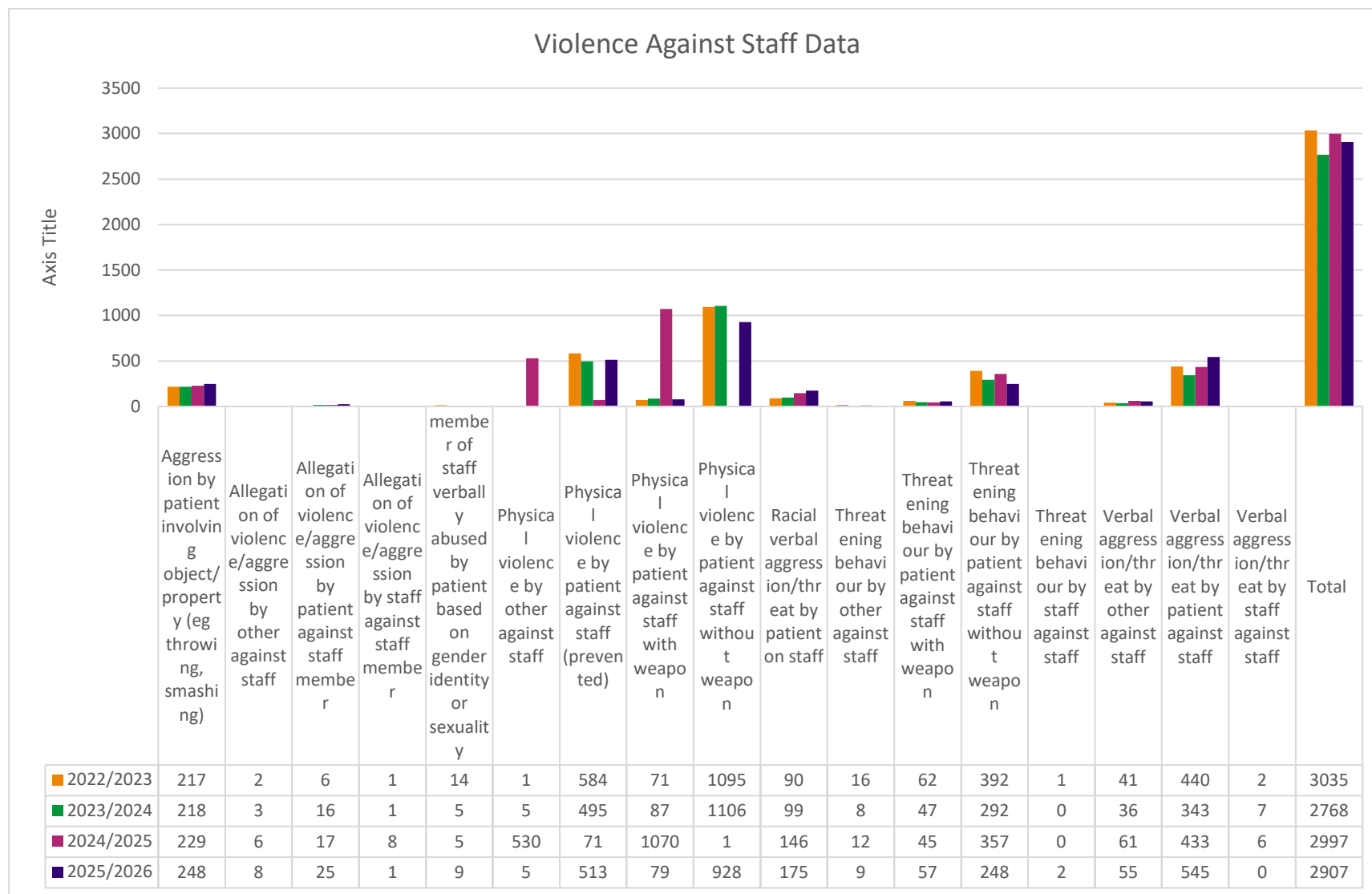


Figure 6 – Violence and Aggression Data over 4 Years.

Security objectives for 2026/2027

- Review and implementation of lockdown plans and procedures across various locations of the Trust.
- Review and implementation of Martyn's Law including the correct identification of qualifying premises, compliance with Standard or Enhanced Duty requirements and supporting adequate governance, assurance and resourcing.
- Continue to strengthen police partnerships.
- Ongoing support to community premises to address safety concerns when self-presenters attend sites and security presence during client consultations when risk assessment deems it appropriate.
- Assist estates- and IMT colleagues with CCTV upgrade and liaise with contractors re specifications for new- and upgrading of systems.
- Continued evaluation of trust wide security provision, taking a risk-based approach.
- Support compliance with The Violence Prevention and Reduction Standard in conjunction with reducing restrictive practice leads.
- Audit Key Performance Indicator's & Key Performance Target's for external security contracts.

6. Emergency Preparedness, Resilience & Response

Introduction

Progress during the year has been impacted by changes within the EPRR team, including the departure of the EPRR Lead in July 2025 and then a subsequent vacancy to the EPRR assistant shortly after the new EPRR Advisor commenced in November 2025, requiring the function to be re-established. Despite this, work has continued to progress.

At the time of reporting, the ICB has not yet released the formal Core Standards process for the 2026 submission. However, organizations have been encouraged to submit evidence on a monthly basis in anticipation that the requirements will remain broadly consistent.

The Trust remains committed to strengthening its EPRR arrangements and delivering further improvement in compliance during the next reporting cycle.

Command and Control

Command and Control structures were established on numerous occasions during the year to support the management of incidents affecting the Trust. Incidents where command and control were established were:

- ***Resident Doctors Industrial Action***

Since November 2025 Resident Doctors have taken industrial action on three separate occasions which required planning and command and control meetings. Internal meetings were chaired by the Chief Operating Officer which then fed into the ICB command meetings that were hosted, before, during and after each event with twice daily Key Line of Enquires (KLOE) reports submitted from SWYPFT to the ICB.

- ***Cheswold Park proposed Industrial Action – December 2025***

In December 2025, planned industrial action at Cheswold Park required the implementation of established command and control arrangements to support a coordinated organisational response. Unite announced planned discontinuous strike action across 18–19 December 2025, running concurrently with industrial action by BMA Resident Doctors from 17–22 December 2025. In preparation, the Trust activated its command and control structure, with internal meetings chaired by the Chief Operating Officer and engagement with NHSE colleagues due to the site's medium secure status. A structured approach to planning and oversight was adopted, supported by defined escalation processes and contingency measures. Although the industrial action was stood down at short notice, these arrangements ensured that risks were appropriately managed and that service continuity could be maintained if required.

SWYPFT Emergency Preparedness Resilience and Response Workplan

In line with the requirements of the EPRR Framework, SWYPFT maintains an annual EPRR Workplan. This document sets out the key elements of the annual assurance process, aligning risks, business-as-usual activities, and areas for improvement with the Core Standards domains. It incorporates actions identified through the previous year's assurance submission, alongside additional organisational priorities.

The Workplan supports a structured approach to evidencing compliance, ensuring that appropriate documentation is developed and key activities are undertaken in preparation for the annual submission to NHSE. This submission is typically completed in October, following review through the Safety & Resilience TAG, Audit Committee, Executive Management Team, and final approval by the Trust Board.

NHSE Annual EPRR Assurance Process

Between July and September 2025, the Trust undertook its annual EPRR assurance process, completing a self-assessment against the NHSE Core Standards and submitting evidence to the ICB. The Trust reported a compliance position of 59%, however, this was moderated to 50% following the ICB's check and challenge process, reflecting areas where further evidence or assurance was required, however the non-compliant status did not change.

Delivery of the assurance process took place during a period of transition within the EPRR function, following the departure of the EPRR Lead in July 2025 and a subsequent vacancy within the team shortly after the new EPRR Advisor commenced in November 2025. This required the function to be re-established, however, despite these challenges, progress has continued.

At the time of reporting, the ICB has not yet released the formal Core Standards process for the 2026 submission. However, organisations have been encouraged to submit evidence on a monthly basis in anticipation that the requirements will remain broadly consistent. The Trust remains committed to strengthening its EPRR arrangements and delivering further improvement in compliance during the next reporting cycle.

SWYPFT Business Continuity Programme

Following identified gaps within the Business Continuity domain of the Core Standards, the newly established EPRR team has reviewed and revised the Trust's previous Business Continuity processes to improve alignment with the NHSE Business Continuity Toolkit and the Business Continuity Domain under the Core Standards.

To support this, a new Business Continuity Management System has been introduced, integrating a Business Impact Analysis (BIA) and Business Continuity Plan (BCP) into a single, streamlined document. This approach simplifies the process for services while ensuring key risks to service delivery are identified, assessed, and appropriately mitigated.

Work is currently underway to transition legacy business continuity plans onto the new system, with the EPRR Assistant supporting services to review and update their documentation. This will ensure a consistent, standardised approach across the organisation and support improved compliance against the Business Continuity domain and wider Core Standards.

Working in Partnership

The Trust works closely with partner organisations and is represented at key regional forums such as the West & South Yorkshire Local Health Resilience Partnership meetings (LHRP), the North of England Mental Health Forum, the Mental Health & Community EPRR Group, West and South Yorkshire ICB EPRR Leads meetings, a range of briefings, and events and workshops led by NHS England and West/South Yorkshire Integrated Care Boards (ICB).

Exercises/Workshops and Training

The Trust continues to engage with multi-agency partners through the West and South Yorkshire Local Resilience Forum (LRF), including participation in training, exercising.

In 2026, SWYPFT continue to strengthen organisational preparedness through participation in several key resilience exercises. This included involvement in the NHS England Kaus Australis regional exercise, designed to test the response to a prolonged, nationwide loss of power. SWYPFT was represented by EPRR, Estates, and tactical leads, ensuring a coordinated contribution to the multi-agency scenario.

Alongside this, the EPRR Team engaged in a multi-agency COMAH exercise with external stakeholders including, West Yorkshire Fire and Rescue, Yorkshire Ambulance Service (YAS), UK Health and Security Agency (UKHSA), Yorkshire Water and others which tested the response to a 30 litre ammonia spillage which sent a plume of ammonia to Fieldhead Hospital. The security lead for Forensics also included the EPRR team in an adverse weather and power-loss exercise at Newton Lodge medium secure unit which created some great conversations. Collectively, these activities enhanced interoperability, validated internal response arrangements, and strengthened organisational resilience.

In line with the Core Standards requirements, on-call staff are required to complete Principles of Health Command (PHC) training and maintain evidence-based

portfolios to demonstrate competence. At the time of review, 36 of 56 tactical on-call staff and 7 of 9 strategic on-call staff had completed the core PHC training. Since November 2025, further work has been undertaken to strengthen compliance with PHC portfolio requirements. While many on-call leads had completed the initial NHSE tactical or strategic PHC training, additional learning has been required to evidence full competency. This includes areas such as joint decision-making, working with loggists, Incident Coordination Centre, and incident response familiarisation. SWYPFT must report their training portfolio figures to LHRP on a quarterly basis. Since I commenced post in November our training figures have been reported as below:

November 2025		0-24%	25-49%	50-74%	75-99%	100%
Strategic	9	0				
Tactical	53	0				
EPRR	1	0				

February 2026		0-24%	25-49%	50-74%	75-99%	100%
Strategic	9	4	3	1	1	
Tactical	53	20	34			
EPRR	1				1	

May 2026		0-24%	25-49%	50-74%	75-99%	100%
Strategic	9	0	2	6	1	
Tactical	53	13	28	0	2	8
EPRR	1				1	

To support command and control capability, additional training has been delivered across the organisation, this includes 12 trained loggists across multiple sites, and Initial Operational Response (IOR) training delivered to 11 frontline staff members, with a plan in place to deliver the training across the remainder of our sites.

Risks for 2025/2026

- **Capacity and resilience within the EPRR function**

Following significant staff turnover during 2025, the EPRR function has now been re-established. There remains a risk that due to a full new team there may be an impact to the pace of delivery against the workplan, including training, and exercising requirements.

- **Business Continuity compliance and implementation**

While a new Business Continuity Management System has been introduced, there is a risk that delays in transitioning all services onto the new framework and completing updated documentation **may** impact compliance against the Business Continuity domain of the Core Standards, however it must be recognised that this is beneficial in the long run.

- **On-call competency and PHC portfolio completion**

Although progress has been made in completing Principles of Health Command training, there is a risk that not **all** on-call staff will meet the full portfolio requirements, which may affect compliance and assurance of command capability.

- **Training availability and specialist capability gaps**

Continued reliance on external providers for specialist training (e.g. Legal training, EPRR comms, etc) presents a risk to compliance where training availability is limited or delayed.

- **Evolving national requirements and assurance processes**

Ongoing national changes to the NHSE Core Standards, National Occupational Standards, and assurance processes may impact compliance levels and require adaptation of local systems and processes at short notice.

- **Uncertainty in 2026 assurance process**

At the time of reporting, the ICB has not confirmed the 2026 assurance process. While monthly submissions are encouraged, there is a risk that changes to requirements or expectations may require additional work to evidence compliance.

EPRR objectives for 2026/2027

Key workstreams during 2025/2026 include:

- **Embed the revised Business Continuity Management System**

Complete the transition of all services onto the new BCM framework, ensuring Business Impact Analyses and Business Continuity Plans are up to date, quality assured, and compliant with the Core Standards.

- **Strengthen EPRR assurance and evidence processes**

Implement a structured approach to monthly evidence submissions in line with ICB expectations, ensuring continuous improvement and readiness for the 2026 NHSE assurance process.

- **Enhance command and control capability**

Continue rollout and assurance of Principles of Health Command (PHC) portfolios, including completion of supplementary learning, and expand training for loggists, initial operational response and Incident Coordination Centre roles.

Report Governance Arrangements

This report has been shared with:

- Safety & Resilience Trust Action Group
- Executive Management Team (EMT)
- Audit Committee

Health & Safety Action Plan – 2026/2027

Appendix 1

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target for Completion	Comments
Inspection and audit spreadsheet held by Health & Safety Team to be updated from results of H&S 2025/26 monitoring programme. Visits to be planned for 2026/27.	Adrian Snarr via Nick Phillips/Martin Brandon	Richard Chamberlain / Aaron Luckarift.	To ensure support can be accurately and promptly targeted to services & teams.	Q1	Planned audits, inspections and visits to teams are fundamental element of the Trust's approach to HSG65.
Implement and complete audit/inspection programme by end of March and prepare for 2026/27 monitoring programme.	Adrian Snarr via Nick Phillips/Martin Brandon	Richard Chamberlain / Aaron Luckarift.	Ensure effective Trust wide approach to health & safety monitoring & inspections for Trust Board assurance.	Q4	The annual health & safety monitoring programme, including the audit and inspection schedule all underpin Trust Board re-assurance of effective Health & Safety measures within the Trust.
Support Trust Ligature Audit Programme.	Adrian Snarr via Nick Phillips/Martin Brandon	Richard Chamberlain / Aaron Luckarift.	Ensure continued and vital aspect of Trust business.	Q4	Will be ongoing throughout the 26/27 work year.
Update to Health and Safety templates and guidance (risk assessments, coshh, sharps and appropriate guidance) including intranet pages.	Adrian Snarr via Nick Phillips/Martin Brandon	Richard Chamberlain / Aaron Luckarift.	Richard Chamberlain / Aaron Luckarift.	Q4	Templates used for health and safety documents, with relevant and appropriate information and fields required.
Cheswold Park Hospital transition to South West Yorkshire Partnership NHS Foundation Trust.	Adrian Snarr via Nick Phillips/Martin Brandon	Richard Chamberlain / Aaron Luckarift.	Richard Chamberlain / Aaron Luckarift.	Q4	Roll out of SWYT policies, guidance and training ensuring the site is compliant to current policies and complying with the HASAW 1974.
Monitoring and Support of the Lone Worker Devices that are utilized in the Trust.	Adrian Snarr via Nick Phillips/Martin Brandon	Richard Chamberlain / Aaron Luckarift.	Richard Chamberlain / Aaron Luckarift.	Q4	To ensure devices are utilized in accordance with policy, ensuring staff are safe whilst lone working.

Fire Safety Action Plan – 2026/2027

Appendix 2

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target for Completion	Comments
Ensure sufficient training capacity for face-to-face fire lectures or practical fire training sessions are available.	Nick Phillips/ Martin Brandon	Ian Cass/ Dave Bedford	To increase provision of training to all areas of the Trust to ensure a higher uptake through wider availability and to meet the needs of the Fire Safety policy and new HTM 05-03 Part A Training	Q4	2026 Fire Training dates Kendray and Fieldhead on ESR Liaising with L&D to identify ward-based staff completing e-learning instead of face to face Current totals Nov 90.6%
Reduce the number of false alarm or unwanted fire signal activations of fire alarms by 10%	Nick Phillips/ Martin Brandon	Ian Cass/ Dave Bedford	To reduce attendance of the Fire Service to UWFS, to ensure their resources are able to attend actual incidents and to avoid impacting the Trusts reputation.	Q4	Not achieved because of excessive activations caused by showers in en-suite bedrooms where shower doors have been removed. On going work to reduce activations
Maintain an effective programme to ensure that fire risk assessments and fire plans are kept under review	Nick Phillips/Martin Brandon	Ian Cass/Dave Bedford	To comply with the legal requirements of the Fire Safety Order	Q4	On target with inspection reviews at Nov 2025 Full survey scheduled for new premises at Cheswold Park will require full survey and plan mark up Fire plans on target in February 2026.
Ensure that team members are supported in maintaining professional competence by participation in relevant CPD events	Nick Phillips/Martin Brandon	Ian Cass/Dave Bedford	To ensure that fire safety advice provided meets current standards	Q4	Team members supported by attending regular CPD events to maintain competence
Review fire compartmentation in Kendray and Newton Lodge roof spaces and identify any remedial work that may be required	Nick Phillips/Martin Brandon	Ian Cass	To maintain fire safety standards to comply with the Fire Safety Order 2005	Q3	Newton Lodge updated as part of Appleton scheme Kendray and Cheswold park pending

Security Action Plan – 2026/2027

Appendix 3

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target for Completion	Comments
Review and implementation of lockdown processes and procedures across various locations of the Trust.	Nick Phillips/ Martin Brandon	Johan Celliers/ David Wilson	To ensure compliance with the NHSE Core Standards for Emergency Preparedness, Resilience and Response and also strengthen the safety of environments for staff, patients and visitors.	Q4	
Ongoing support to community premises to address safety concerns when self-presenters attend sites and security presence during client consultations when risk assessment deems it appropriate.	Nick Phillips/ Martin Brandon	Johan Celliers/ David Wilson	To provide a safe and secure working environment for staff, patients and visitors.	Q4	
Assist estates in CCTV upgrade.	Nick Phillips/ Martin Brandon	Johan Celliers/ David Wilson	Ongoing works from previous year – security input will ensure that the CCTV is sited in the most appropriate locations.	Ongoing	

Emergency Preparedness, Resilience & Response Action Plan – 2026/2027

Appendix 4

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target for Completion	Comments
Prepare for the release of the Core Standards when released, reviewing progress and updating against current standards.	Adele Fox via Nick Phillips/ Martin Brandon	Jennie Byron	The Trust compliance status in 2025 was declared as non-compliant with a workplan to progress compliance for the 2026 submission.	Q2/3	
Continue to review EPRR Plans and Policies to ensure lessons identified from incidents are embedded appropriately and Martyn's Law is taken into consideration.	Adele Fox via Nick Phillips/ Martin Brandon	Jennie Byron	To ensure all plans and policies are up to date with relevant legislation and guidance.	Q4	
Complete rollout of the new Business Continuity Management System across all services.	Adele Fox	Jennie Byron Rachael Lewyckj	Embedding the new system will create a more consistent, standardised approach to risk management and service continuity across the Trust. Without this system our Core Standard compliance will be affected.	Q4	
Increase completion of PHC training and competency portfolios for on call staff.	Adele Fox	Jennie Byron	Improving completion rates, strengthens assurance that staff can effectively lead and coordinate incidents, supporting compliance and operational resilience.	Q3	

**Trust Board
28 July 2026
Agenda item 10.9**

Private/Public paper:	Public		
Title:	Trust PAM (Premises Assurance Model) submission 2026		
Lead Director:	Adrian Snarr – Director of Finance, Estates and Resources		
Mission/values:	To ensure the Trust makes best use of resources and provides improved quality in all that we do. To aim to be outstanding and ensure we are relevant for today and ready for tomorrow		
Purpose:	To appraise the Board on the Premises Assurance Model submission and to seek Board approval for the latest submission to be uploaded to the NHS England portal in line with guidance from NHSE.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	2.11 Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The operation of a safe and effective estates is essential to the priorities of the Trust and wider goals of the wider ICB and NHS.		
Any background papers / previously considered by:	This report was presented to the Executive Management Team (EMT) on 25 June 2026 and Audit Committee on 14 July 2026. Trust Board are provided with the PAM submission on an annual basis.		

Executive summary:

The Trust estate and its related services are integral to the delivery of high-quality clinical care. Therefore, it is essential that the Trust provide a safe, high quality, efficient and effective estate.

The NHS Premises Assurance Model (PAM) is a mandatory national Estates and Facilities benchmarking tool designed to be used by NHS organisations for Board reporting, and externally to provide assurance to regulators and commissioners.

NHS PAM is a complex spreadsheet developed by NHS England, which is used to ensure Estates and Facilities services and premises are “fit for purpose based on national best practice and the current regulatory requirements”. It does this through a series of Self-Assessment Questions (SAQs) with evidence of compliance, to produce a summary report that can be used to demonstrate robust systems are in place to assure that Trust premises and associated services are safe.

The 2025-26 submission has changed significantly from previous years with a focus on evidencing compliance rather than providing assurance. The changes do not allow direct comparison to previous years’ results, but direct comparison will be a key feature of future reports.

This report provides a high-level summary overview of the NHS PAM process undertaken throughout the financial year and details the results of the self-assessment exercise. Supplementary information is also provided to provide more detail on each reporting domain.

The overall scores for the domains are set out below.

Safety Hard

This has scored **95.8%** as is rated Good

Safety Soft

This has scored **87.4%** as is rated Good

Competency

This has scored **98.7%** as is rated Good

Patient Experience

This has scored **100%** as is rated Outstanding

Board should not that these scores are excellent and show a very high level of compliance which gives assurance on overall management of the Estate.

The supplementary information highlights the areas where 100% compliance could not be met with an explanation. Work on PAM is continual and not limited to an annual submission. For medical devices, where the reported servicing figures were below the target, an improvement plan has been commenced managed through the Quality and Safety Committee. Latest results report servicing figures exceeding Trust targets.

The PAM is a reporting metric for Estates and Facilities in the Board Assurance Framework and is therefore reviewed at EMT as well as within the Estates team. Additionally, the whole submission and supporting documentation is peer

	reviewed by three external NHS providers including one acute provider and two mental health providers. NHS England also undertakes audits of supporting documentation of the submissions on a random basis.
Recommendation:	Trust Board members are asked to: • NOTE the content of the report. • NOTE the high scores the Trust has achieved, • NOTE that the yes/no answers generate an overall fail mark on Premises Assurance despite the high scores. • NOTE the only significant no answer is medical devices and an action plan is in place to address this issue. • AGREE for the PAM submission to go to Trust Board for approval for submission to NHSe

ESTATES & FACILITIES DEPARTMENT

Premises Assurance Model (PAM)

Summary Report for 2026 Submission

**Produced by Cecilia Crump
Specialist Compliance Manager**

INTRODUCTION

The NHS Premises Assurance Model (NHS PAM) supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of their estates and facilities services and provides assurances that the estate is safe, efficient, effective and of high quality. Completion of the NHS PAM is mandatory, as set out in the NHS Standard Contract Service Conditions.

This year has seen significant changes to the questions within the collection and the information required. The collection is now aimed at compliance rather than assurance with supporting evidence required for audit. It is therefore expected that there may be more questions, particularly within this first year that create a 'red' non-compliance result, as there are now only 'yes/no' options rather than the previous amber and yellow scores.

Unfortunately, the above change to the this does not allow direct comparison with previous years' results. Assuming the reporting format does not change next year, direct comparison will be a key feature of future reports.

The Trust has set a target of 75% and achieved 96.98%.

2025-26 PAM Results

A domain analysis is contained in Appendix 1 with the results summarised below.

There are only six sections which are scored, two of which are not applicable to the Trust

Safety Hard

This has scored **95.8%** as is rated Good

Safety Soft

This has scored **93.3%** as is rated Good

Competency

This has scored **98.8%** as is rated Good

Patient Experience

This has scored **100%** as is rated Outstanding

Helipads

This section is not applicable to the Trust.

Mortuaries

This section is not applicable to the Trust.

Conclusion

The overall score achieved is **96.98%**. This is due to the hard work the team has put in addressing items negatively affecting scoring as soon as they have been identified and ensuring that procedures and documentation has been put in place.

Monthly meetings have been held with NHS England to enable us to understand the questions and the answers required but these are still more pertinent to Acute Trusts and we have been asked to make a reasonable judgement of what would be expected in a Mental Health setting, giving us an ability to score higher than some other Trusts.

Peer review has been expanded and now includes Doncaster & Bassetlaw Teaching Hospitals, Sheffield Health & Social Care and Derbyshire Community Health Services NHS Foundation Trust, although due to the late release of the question sets no reviews have yet taken place and these will be scheduled for late 2026.

Recommendation

Trust Board is asked to:-

- Note the content of the report.
- Note the overall score of 96.98%
- Agree that the submission of the formal PAM return is made to NHS England.

PAM Scores 2025/2026

Soft FM compliance question set table		2024-2025 Compliance reference questions				
Main section questions		1	2	3	4	5
		Yes	No	N/A	%	Comments
SS1	With regard to Catering Services can the organisation evidence, in relation to Policy & Procedure: Does the organisation have a current, approved Food Safety Policy and an underpinning set of procedures that comply with relevant legislation and published guidance? 42 Questions	42	0	0	100%	
SS2	With regard to Decontamination Processes can the organisation evidence the following? 13 Questions	13	0	0	100%	
SS3	With regard to Cleanliness and Infection Control applying to Premises and Facilities can the organisation evidence 32 Questions	27	4	1	87%	Failures due to lack of staff to undertake efficacy audits
SS4	With regard to Linen and Laundry Services can the organisation evidence the following? 20 Questions	13	2	5	87%	Failures due to no bed change policy or minimum store levels
SS5	With regard to Transport Services and access arrangements can the organisation evidence the following? 7 Questions	7	0	0	100%	
SS6	With regard to Pest Control can the organisation evidence the following? 11 Questions	9	2	0	82%	Failures due to lack of policy and not meeting 12 visits per year, per site
SS7	With regard Portering Services can the organisation evidence the following? 14 Questions	13	0	1	100%	
SS8	With regard to the Terrorism (Protection of Premises) Act 2025, more commonly known as Martyn's Law can the organisation evidence the following? 5 Questions	5	0	0	100%	
OVERALL DOMAIN SCORE 93.3%						

Hard FM compliance question set table		2024-2025 Compliance reference questions				
Main section questions		1	2	3	4	5
SH1	With regard to the Estates and Facilities Operational Management can the organisation evidence the following? 5 Questions	5	0	0	100%	
SH2	With regard to the Design, Layout and Use of Premises [Functional suitability/Fitness for Purpose] can the organisation evidence the following in relation to functional suitability/? 4 Questions	4	0	0	100%	
SH3	With regard to Estates and Facilities Document Management can the organisation evidence the following? 2 Questions	2	0	0	100%	
SH4	With regard to Health & Safety at Work can the organisation evidence the following? 8 Questions	8	0	0	100%	
SH5	With regard to Asbestos can the organisation evidence the following? 22 Questions	22	0	0	100%	
SH6	With regard to Medical Gas Systems can the organisation evidence the following?	N/A	N/A	N/A	N/A	
SH7	With regard to Natural Gas and specialist piped systems can the organisation evidence the following? 19 Questions	19	0	0	100%	
SH8	Radon Gas - Trusts should be aware of potential Radon risk do you have testing in place where required? 3 Questions	3	0	0	100%	
SH9	With regard to Water Safety Systems can the organisation evidence the following? 22 Questions	21	1	0	94%	Failure due to 2.37% missed PPMs over entire year
SH10	With regard to Electrical Systems can the organisation evidence the following? 22 Questions	17	5	0	72%	Failure due to 5.38% missed PPMs & no AE and only 1 CP
SH11	With regard to wet heating systems, can the organisation evidence the following? 17 Questions	17	0	0	100%	

SH12	With regard to Ventilation, Air Conditioning and Refrigeration Systems can the organisation evidence the following? 20 Questions	18	2	0	88%	Failures due to no AE & No safety group
SH13	With regard to Lifts, Hoists and Conveyance Systems can the organisation evidence the following? 19 Questions	19	0	0	100%	
SH14	With regard to Pressure Systems can the organisation evidence the following? 20 Questions	18	2	0	88%	Failures due to no safety group and 6 missed PPMs
SH15	With regard to Fire Safety can the organisation evidence the following? 24 Questions	24	0	0	100%	
SH16	With regard to Medical Devices and Equipment can the organisation evidence the following? 12 Questions	11	1	0	88%	Failure as achieving 78% against a target of 90% of servicing
SH17	With regard to Resilience, Emergency and Business Continuity Planning can the organisation evidence the following? 19 Questions	19	0	0	100%	
SH18	With regard to the reporting of safety related issues and actioning of safety related alerts for estates and facilities issues can the organisation evidence the following? 2 Questions	2	0	0	100%	
SH19	With regard to ensuring estates and facilities services are safe and suitable when the organisation is not directly responsible for providing these services can the organisation evidence the following? 4 Questions	4	0	0	100%	
SH20	With regard to Contractor Management for Soft and Hard FM services can the organisation evidence the following? 7 Questions	7	0	0	100%	
SH21	The built environment - reducing harm by ligature in practice. With regards to self-harm risks associated with the built environment, can the organisation evidence that they have taken consideration for the following? 6 Questions	6	0	0	100%	

SH22	With regard to Mortuaries can the organisation evidence the following? Is your organisation responsible for the running or maintenance of one or more mortuaries? This includes Mortuaries in PFI or other out-sourced regimes.	N/A	N/A	N/A	N/A	
SH23	Switching from analogue to digital landlines 4 Questions	4	0	0	100%	
OVERALL DOMAIN SCORE 95.8%						

Estate Competency compliance question set table		2024-2025 Compliance reference questions				
Main section questions		1	2	3	4	5
C1	With regard to having a well-managed approach to performance management of the estate and facilities operations can the organisation evidence the following? 6 Questions	6	0	0	100%	
C2	With regard to having a well-managed approach to improved efficiency in running estates and facilities services can the organisation evidence the following and is this in line with the ICS infrastructure strategy? 13 Questions	13	0	0	100%	
C3	With regard to improved efficiencies in capital procurement, refurbishments and land management can the organisation evidence the following? 14 Questions	13	0	1	100%	
C4	With regard to having well-managed and robust financial controls, procedures and reporting relating to estates and facilities services can the organisation evidence the following? 7 Questions	7	0	0	100%	
C5	With regard to ensuring Estates and Facilities services are continuously improved and sustainability ensured can the organisation evidence the following? 12 Questions	12	0	0	100%	

Helipad compliance question set table		2024-2025 Compliance reference questions				
Main section questions		1	2	3	4	5
H1	Confirmation of Safe Helipad Operations The Trust must demonstrate that it has established processes to ensure the safe and efficient operation of its helipad in accordance with CAP 1264 guidance 1. Does your NHS organisation have a Hospital Helipad Landing Sites (HHLS)? If the answer is "No", then no further answers on this Domain are required. If the answer is "Yes" all the SAQ below must be answered.	N/A	N/A	N/A	N/A	N/A

Patient Experience compliance question set table		2024-2025 Compliance reference questions				
Main section questions		1	2	3	4	5
P1	With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff can your organisation evidence the following? 4 Questions	4	0	0	100%	
P2	With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory can your organisation evidence the following? 1 Question	1	0	0	100%	
P3	With regard to Travel Access (public transport, active travel, car parking) can the organisation evidence the following? 5 Questions	5	0	0	100%	
P4	How does your organisation/site ensure that NHS catering standards are provided effectively and efficiently? 7 Questions	7	0	0	100%	
OVERALL DOMAIN SCORE 100%						

Colour Key - Question Compliance
Outstanding (100%)
Good (85-99%)
Requires Minimal Improvement (41-84%)
Requires Moderate Improvement (21-40%)

Inadequate (0-20%)

**Trust Board
28 July 2026
Agenda item 10.10**

Private/Public paper:	Public		
Title:	PLACE (Patient-Led Assessments of the Care Environment) 2025 Results		
Lead Director:	Adrian Snarr - Director of Finance Estates and Resources		
Mission/values:	To ensure the Trust makes best use of resources and provides improved quality in all that we do. To aim to be outstanding and ensure we are relevant for today and ready for tomorrow		
Purpose:	To appraise Trust Board on the results of the PLACE inspections for 2024 and to provide further analysis on the scores both internally and with comparable organisations.		
Strategic aims:	Live Our Values	✓	Whilst PLACE is restricted to inpatient wards it is so far reaching that it covers most of our aims which are all rooted in quality and the improved environment for service users provides an enhanced environment for staff as well. Our excellent results reflect our ambition for excellence
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	5.2 - Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The PLACE collection whilst SWYPFT specific contributes to the wider ICB in that we can be seen to be a quality partner in the sector and is a nationally recognised mark of standards which are applied the same across the NHS.		

Any background papers / previously considered by:	This report was presented to the Executive Management Team (EMT) on the 25 June 2026 and Audit Committee on 14 June 2026.
Executive summary:	This report is designed to update Trust Board on the 2025 PLACE (Patient-Led Assessments of the Care Environment) results. PLACE assessments review the non-clinical aspects of healthcare premises identified as important by patients and the public and is a recognised nationally benchmarked set of standards which are published annually. It represents an insight into the factors that impact on the quality of care that our patients experience. The assessments provide a framework for assessing quality against common guidelines and standards on six specific domains; • Cleanliness • Combined food and hydration (based on all Organisational food and Ward food assessments) • Privacy, dignity and wellbeing • Condition, appearance and maintenance • Dementia: how well the needs of patients with dementia are met • Disability: how well the needs of patients with a disability are met Cheswold Park Hospital was assessed for the first time in the 2025 PLACE audit and results are reported separately. The key outcomes of the results for the Trust (excluding Cheswold Park) are. • National average scores for 2025 have improved in five domains compared to last year. The domain of Dementia has scored lower. • Out of the six domains, the Trust's overall scores show four domains scored higher than the national average. Positively higher are the domains Dementia (by 10%) and Privacy, Dignity and Wellbeing (by 9%). • Two domains, Cleanliness, and Condition, Appearance and Maintenance scored (2%) below the national average. • On comparison to the Trust's overall scores achieved in 2024, all six domains have scored lower in 2025. The largest decrease (4%) being in the domain of Condition, Appearance and Maintenance, followed by Cleanliness (3%), Dementia (2%), Combined food (1%), Disability (1%) and Privacy, Dignity and Wellbeing (0.5%). • PLACE exception reports have been reviewed and formulated action plans for improvement. • Two key areas to focus on for the forthcoming year have been identified, food quality and disabled access. In relation to Cheswold Park: • Four out of five domains score lower than the national average with Privacy, Dignity and Wellbeing being the one domain above the national average (not applicable for Dementia). • Condition, Appearance and Maintenance domain scores the lowest at 72.25% compared to a SWYPFT average score of 95.27%, and a national average of 97%. • Qualitative information is captured during the assessments, and this data contributes to the action plans as well as good practices being identified and shared.

	A Trust- wide action plan and a separate, localised action plan for Cheswold Park are in place. These will be monitored by the appropriate Care Group Governance Groups and the Estates Trust Action Group (TAG), with a view to making improvements required to meet the non-clinical aspects of healthcare premises identified as important by patients and the public.
Recommendation:	Trust Board members are asked to: • RECEIVE the 2025 PLACE results. • RECEIVE the scores in Appendix 1 and associated Charts. • RECEIVE the scores relative to national averages. • SUPPORT actions for improvement where appropriate.

PLACE (Patient-Led Assessments of the Care Environment) Results 2025

PLACE assessments review the non-clinical aspects of healthcare premises identified as important by patients and the public and is a recognised nationally benchmarked set of standards which are published annually. It represents an insight into the factors that impact on the quality of care that our patients experience.

The assessments provide a framework for assessing quality against common guidelines and standards on six specific domains;

- Cleanliness
- Combined food and hydration (based on all Organisational food and Ward food assessments)
- Privacy, dignity and wellbeing
- Condition, appearance and maintenance
- Dementia: how well the needs of patients with dementia are met
- Disability: how well the needs of patients with a disability are met

The criteria for each domain represent good practice as identified by professional organisations and aims to promote the principles and values established by the NHS Constitution that focus on areas that matter to patients, families and carers:

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

PLACE encourages the involvement of patients, the public and both national and local organisations that have an interest in healthcare. The 2025 assessment teams consisted of:

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

The scores awarded reflect what is seen on the day of the audit to replicate the environment as patients and visitors see it when accessing our services. The final scores are aggregated into percentage scores and are not based on pass/fail criteria overall. This report shows national comparisons as these are reported widely. National average scores are from all hospitals, including Acute Trusts.

Results

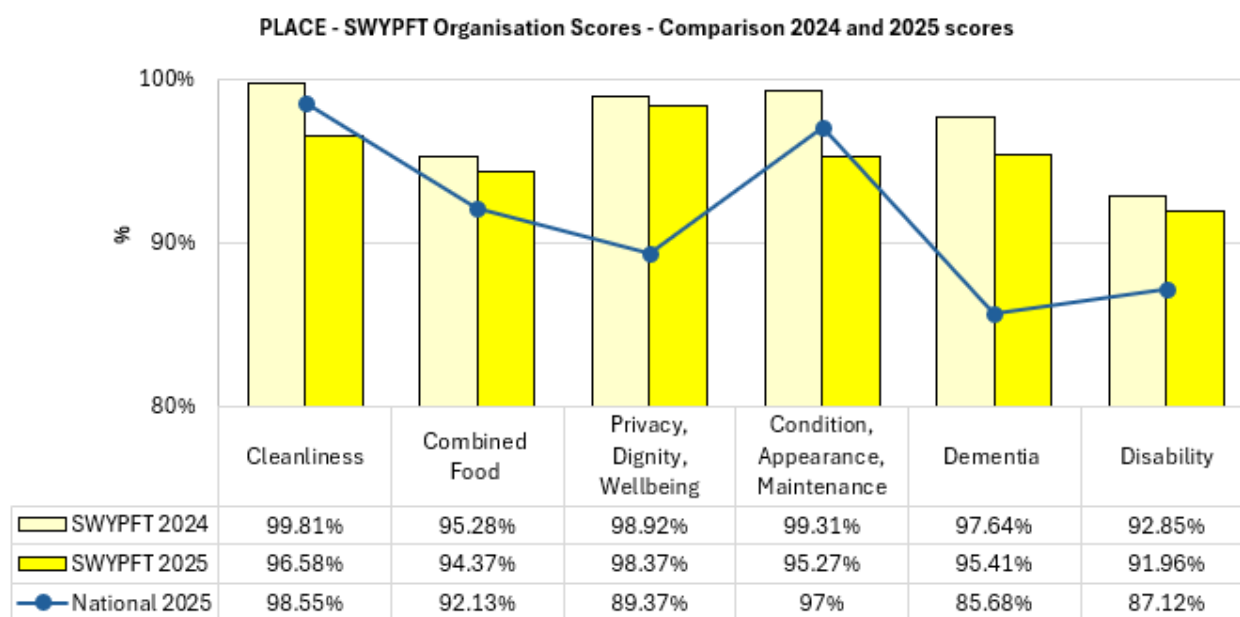
Trustwide inpatient wards (apart from Lyndhurst unit) are included in the PLACE audit and results detailed in this report. Cheswold Park Hospital was assessed for the first time in the 2025 PLACE audit and results are reported separately.

The table at **Appendix 1** details the Trust's PLACE percentage scores (overall and per Trust area) for 2025, compared with the previous year's scores in 2024, and shows the national average domain scores for 2025. This shows that;

Overall: SWYPFT Organisation Scores, Chart 1

- National average scores for 2025 have improved in five domains compared to last year with the domain of Dementia scoring lower.
- Out of the six domains, the Trusts overall scores show four domains scored higher than the national average, positively higher are the domains Dementia (by 10%) and Privacy, Dignity and Wellbeing (by 9%).
- Two domains, Cleanliness, and Condition, Appearance and Maintenance scored (2%) below the national average.
- On comparison to the Trusts overall scores achieved in 2024, all six domains have scored lower in 2025. The largest decrease (4%) being in the domain of Condition, Appearance and Maintenance, followed by Cleanliness (3%), Dementia (2%), Combined food (1%), Disability (1%) and Privacy, Dignity and Wellbeing (0.5%).
- PLACE exception reports have been reviewed and formulated action plans for improvement.

Chart 1

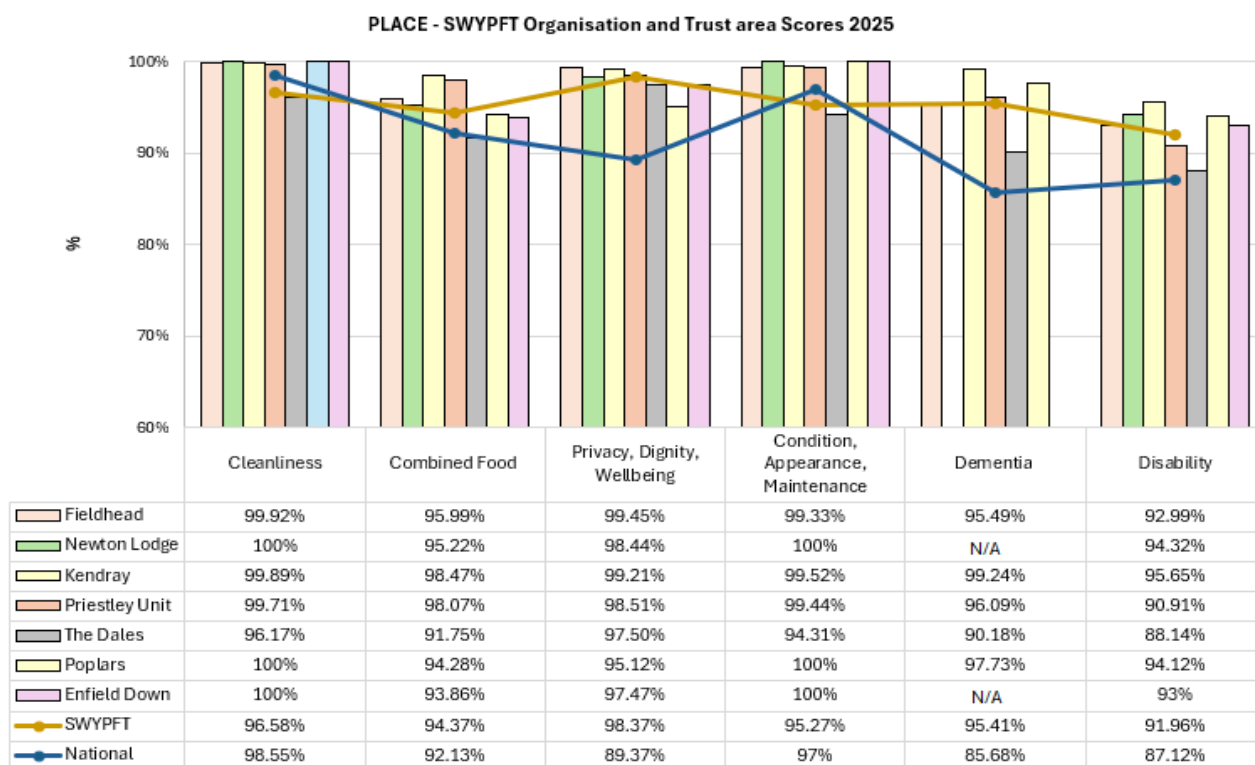


SWYPFT: Trust Area Scores, Chart 2

- Three scores across three domains are below the national average (The Dales). Trust site scores compared to the 2024 audit show;
- 38% of scores (15/40) have improved with the highest score increase at the Poplars, Combined Food, up 3.5%.
- 18% of scores (7/40) maintained last year's scores, of which 6 remain 100%.
- 22% of scores (9/40) have scored less than 1% lower than those in 2024.

- 22% of scores (9/40) have scored more than 1% lower than those in 2024, with the highest score decrease at The Dales, Dementia domain, down by 7.74%.
- Compared with 2024, the 2025 Trust area scores show the most improved domain is Disability, with all but two area scores achieving improvement.
- Although remaining well above the national average score, there is a marked decrease in the Dementia domain; Assessors noting that the correct day and date was not displayed and clearly visible in patient areas and there being no large, accurate and silent clock clearly visible in patient areas.
- Qualitative information is captured during the assessments, and this data contributes to the action plans as well as good practices being identified and shared.

Chart 2



Per Domain:

- **Cleanliness;** Three inpatient areas have scored a maximum 100% for this domain (Newton Lodge, the Poplars and Enfield Down). The Dales is below the national average. Several recommendations for improvement were actioned immediately after the audit.
- **Food;** On review of the food and hydration domain, three areas (Fieldhead, Priestley Unit and the Poplars) improved scores compared to last year's audit. The Dales scored below the national average. The Annual report by the Trust Senior Catering Dietitian provides valuable evidence and insight to support the PLACE audit, with several actions identified from the report achieved. There are still areas where improvement is required, driven by the Nutritional Steering Group.
- **Privacy, dignity and wellbeing;** Positively, all areas scored above the national average.
- **Condition, appearance and maintenance;** Three inpatient areas maintained the maximum score of 100% for this domain (Newton Lodge, the Poplars and Enfield Down) and two areas improved on last year's score (Kendray and Priestley Unit). The Dales

is below the national average. Trustwide themes for improvement being internal flooring, furniture, and walls, and external guttering and social spaces.

- **Dementia;** Two areas are not applicable to be scored in the Dementia domain. All five areas are above the national average, with one area improving scores compared to last year (the Poplars).
- **Disability;** All areas are above the national average. Five areas (Newton Lodge, Kendray, Priestley unit, the Poplars and Enfield Down) improving scores compared to the previous audit. Although above the national average, one area (The Dales) has scored (4%) lower than last year.

Similar Site type average scores, Appendix 2

The table details the Trusts area PLACE scores against similar Site type average scores so to compare against peer organisations. Site type average scores have improved in four domains compared to last year with domains of Dementia and Disability scoring lower.

Appendix 2 shows;

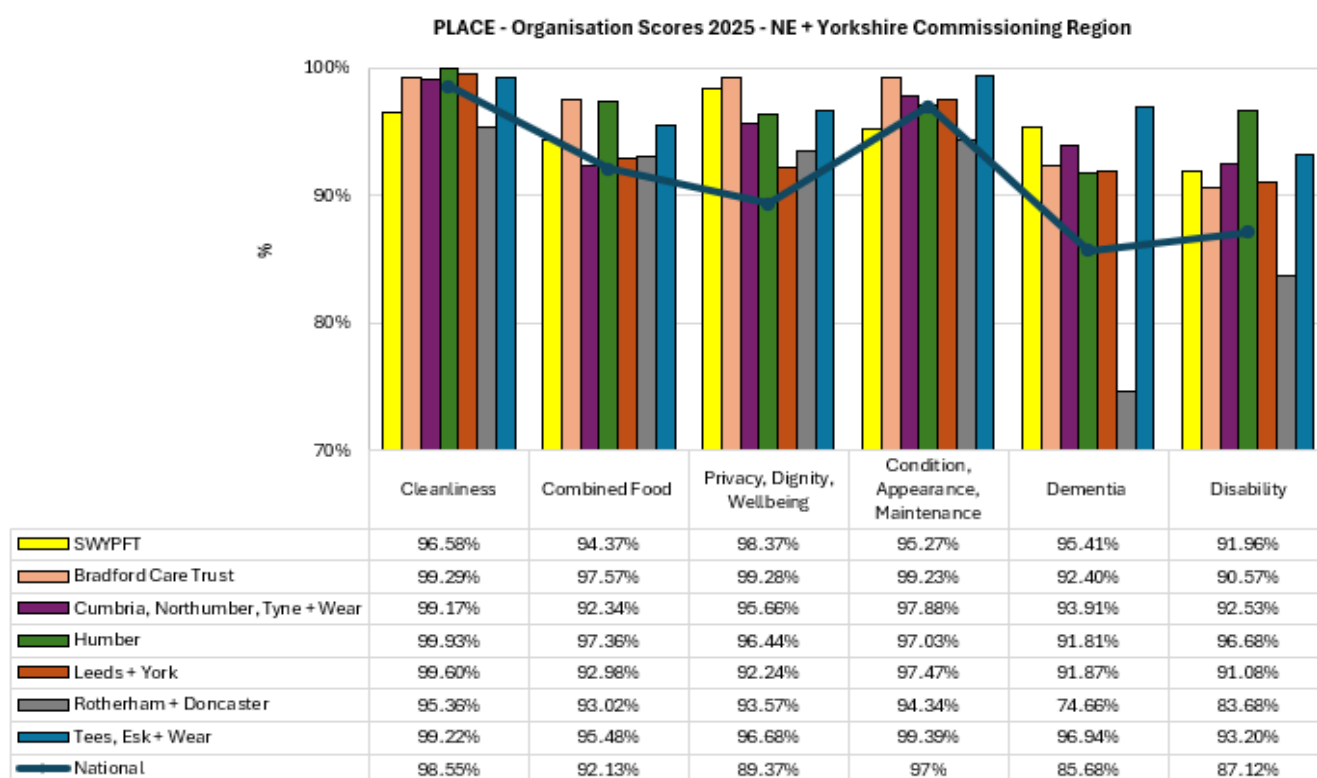
- 85% (34/40) of scores are above the similar Site type average – the same as last year's result.
- 15% (6/40) of scores are more than 1% lower than Site type average and occur across the six domains (five at The Dales and one at the Poplars).

Similar organisation scores within the North East and Yorkshire Commissioning Region, Mental Health and Learning Disabilities Trusts: Chart 3

The chart shows how hospitals are performing both nationally and in relation to other hospitals providing similar services.

- Last year, the Trust was second highest in four domains. This year, the Trust scores second highest in two domains, Privacy, Dignity and Wellbeing and Dementia.

Chart 3



Summary and Actions

The Trusts multi-disciplinary approach during the annual PLACE audit demonstrates excellent partnership working with Staff, Estates, Facilities and Infection Prevention and Control colleagues, and gives our patient representatives, a voice to shape local service provision and identify areas for improvement.

The commitment and dedication of staff across the Trust and our operatives working together to continue to achieve and provide high standards of quality is evident. In most areas the scores are positive and well-maintained providing assurance the Trust represents good practice, meeting the needs of patients, against the non-clinical aspects of healthcare.

A Trustwide action plan for improvement and a separate localised plan for The Dales are in place. These will be monitored by the appropriate Care Group Governance Groups and the Estates Trust Action Group (TAG). With a view to making improvements required to meet the non-clinical aspects of healthcare premises identified as important by patients and the public.

Recommendations

1. RECEIVE the scores in Appendices 1, 2 and associated Charts.
2. RECEIVE the scores relative to national averages.
3. RECEIVE the Cheswold Park Hospital report – separate.
4. SUPPORT actions for improvement where appropriate.

Table to show the Organisation (SWYPFT) and Areas PLACE scores

Appendix 1

Red >1% lower than 2024

	CLEANLINESS %			FOOD % (combined; organisation and ward food)			PRIVACY, DIGNITY & WELLBEING %			CONDITION, APPEARANCE & MAINTAINANCE %			DEMENTIA %			DISABILITY %		
	2024	2025	Nat %	2024	2025	Nat %	2024	2025	Nat %	2024	2025	Nat %	2024	2025	Nat %	2024	2025	Nat %
SWYPFT	99.81	96.58	98.55	95.28	94.37	92.13	98.92	98.37	89.37	99.31	95.27	97	97.64	95.41	85.68	92.85	91.96	87.12
Fieldhead	99.54	99.92	98.55	94.64	95.99	92.13	100	99.45	89.37	99.83	99.33	97	96.83	95.49	85.68	93.83	92.99	87.12
Newton Lodge	100	100	98.55	95.70	95.22	92.13	99.28	98.44	89.37	100	100	97	N/A	N/A	85.68	93.23	94.32	87.12
Kendray	100	99.89	98.55	98.58	98.47	92.13	99.24	99.21	89.37	97.86	99.52	97	99.17	99.24	85.68	94.29	95.65	87.12
Priestley Dewsbury	99.54	99.71	98.55	96.34	98.07	92.13	97.14	98.51	89.37	98.91	99.44	97	97.58	96.09	85.68	90.74	90.91	87.12
Dales Unit	100	96.17	98.55	93.03	91.75	92.13	98.68	97.50	89.37	98.74	94.31	97	97.92	90.18	85.68	92.08	88.14	87.12
Poplars	100	100	98.55	90.77	94.28	92.13	92.86	95.12	89.37	100	100	97	96.61	97.73	85.68	90.82	94.12	87.12
Enfield Down	100	100	98.55	93.86	93.86	92.13	98.70	97.47	89.37	100	100	97	N/A	N/A	85.68	89.00	93	87.12

Amber <1% lower than 2024

Green Remained the same or improved

Table to show the Organisation (SWYPFT) Areas PLACE scores against similar Site types average scores

Appendix 2

Red >1% lower than Site Type Average

Amber <1% lower than Site Type Average

	CLEANLINESS %			FOOD % (combined; organisation and ward food)			PRIVACY, DIGNITY & WELLBEING %			CONDITION, APPEARANCE & MAINTAINANCE %			DEMENTIA %			DISABILITY %		
	2025	Overall Nat.Av.	Site Type Av.	2025	Overall Nat.Av.	Site Type Av.	2025	Overall Nat.Av.	Site Type Av.	2025	Overall Nat.Av.	Site Type Av.	2025	Overall Nat.Av.	Site Type Av.	2025	Overall Nat.Av.	Site Type Av.
Fieldhead (Both mental health and learning disabilities)	99.92	98.55	98.82	95.99	92.13	93.15	99.45	89.37	96.36	99.33	97	97.37	95.49	85.68	93.29	92.99	87.12	91.97
Newton Lodge (Mental Health)	100	98.55	98.82	95.22	92.13	93.15	98.44	89.37	96.36	100	97	97.37	N/A	85.68	93.29	94.32	87.12	91.97
Kendray (Mixed Service)	99.89	98.55	98.82	98.47	92.13	93.15	99.21	89.37	96.36	99.52	97	97.37	99.24	85.68	93.29	95.65	87.12	91.97
Priestley Unit, Dewsbury (Mental Health)	99.71	98.55	98.82	98.07	92.13	93.15	98.51	89.37	96.36	99.44	97	97.37	96.09	85.68	93.29	90.91	87.12	91.97
Dales Unit (Mental Health)	96.17	98.55	98.82	91.75	92.13	93.15	97.50	89.37	96.36	94.31	97	97.37	90.18	85.68	93.29	88.14	87.12	91.97
Poplars (Mental Health)	100	98.55	98.82	94.28	92.13	93.15	95.12	89.37	96.36	100	97	97.37	97.73	85.68	93.29	94.12	87.12	91.97
Enfield Down (Both mental health and learning disabilities)	100	98.55	98.82	93.86	92.13	93.15	97.47	89.37	96.36	100	97	97.37	N/A	85.68	93.29	93	87.12	91.97

Green Higher than Site Type Average

PLACE (Patient-Led Assessments of the Care Environment) Results 2025 – Cheswold Park Hospital

PLACE assessments review the non-clinical aspects of healthcare premises identified as important by patients and the public and is a recognised nationally benchmarked set of standards which are published annually. It represents an insight into some of the factors that impact on the quality of care that our patients experience.

The assessments provide a framework for assessing quality against common guidelines and standards on six specific domains;

- Cleanliness
- Combined food and hydration (based on all Organisational food and Ward food assessments)
- Privacy, dignity and wellbeing
- Condition, appearance and maintenance
- Dementia: how well the needs of patients with dementia are met
- Disability: how well the needs of patients with a disability are met

The criteria for each domain represent good practice as identified by professional organisations and aims to promote the principles and values established by the NHS Constitution that focus on areas that matter to patients, families and carers:

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

PLACE encourages the involvement of patients, the public and both national and local organisations that have an interest in healthcare. The 2025 assessment teams consisted of:

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

The scores awarded reflect what is seen on the day of the audit to replicate the environment as patients and visitors see it when accessing our services. The final scores are aggregated into percentage scores and are not based on pass/fail criteria overall. This report shows national comparisons as these are reported widely. National average scores are from all hospitals, including Acute Trusts.

Results

Cheswold Park Hospital was assessed for the first time in the 2025 PLACE audit and results detailed within this report. Trustwide inpatient wards (apart from Lyndhurst unit) are included in the PLACE audit and results are reported separately.

The tables at **Appendix 1** detail Cheswold Park Hospitals;

- PLACE percentage scores and shows the national average domain scores for 2025.
- PLACE scores against similar Site type average scores so to compare against peer organisations.

Overall: SWYPFT Organisation Scores, Chart 1

- Out of the six domains, the Trusts overall scores show four domains scored higher than the national average, positively higher are the domains Dementia (by 10%) and Privacy, Dignity and Wellbeing (by 9%).
- Two domains, Cleanliness, and Condition, Appearance and Maintenance scored (2%) below the national average.
- On comparison to the Trusts overall scores achieved in 2024, all six domains have scored lower in 2025. The largest decrease (4%) being in the domain of Condition, Appearance and Maintenance, followed by Cleanliness (3%), Dementia (2%), Combined food (1%), Disability (1%) and Privacy, Dignity and Wellbeing (0.5%).
- PLACE exception reports have been reviewed and formulated action plans for improvement.

Chart 1

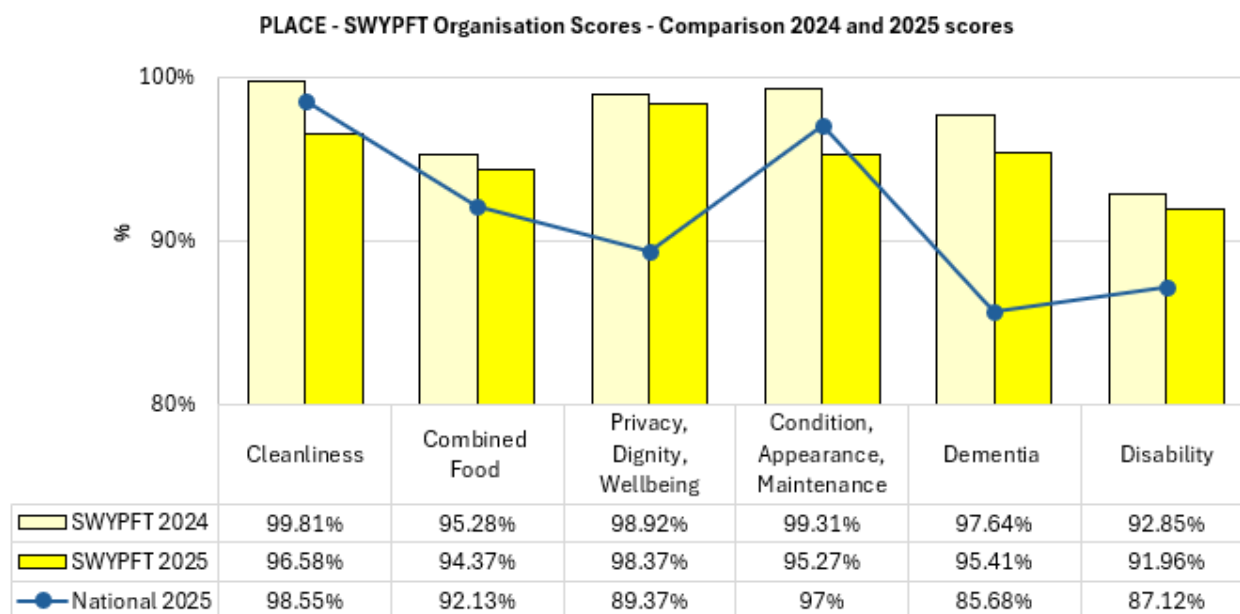
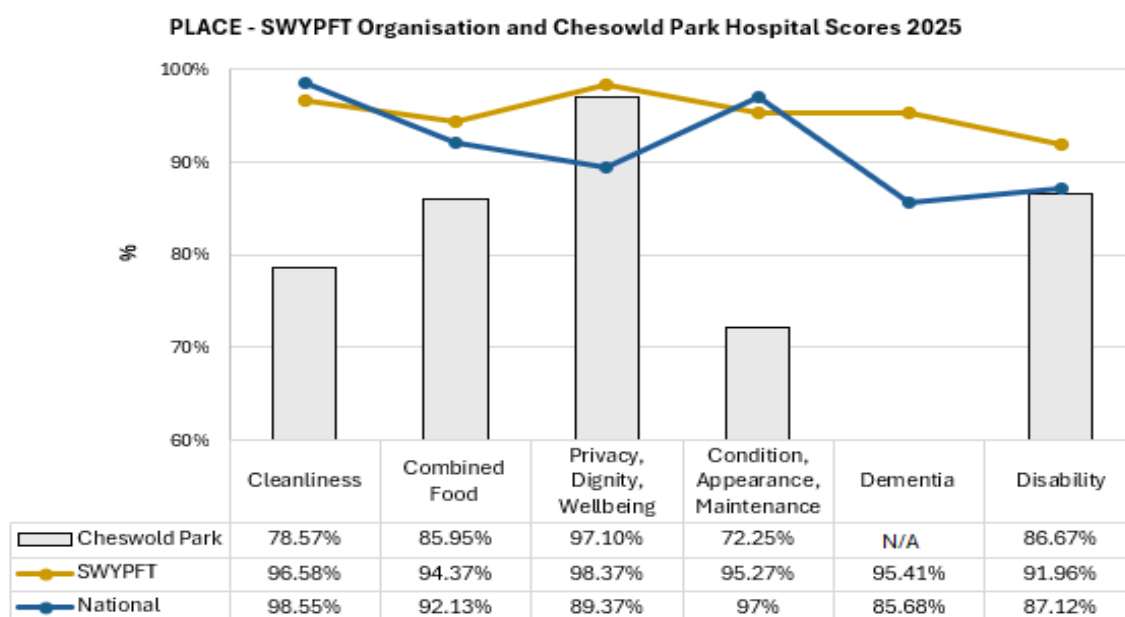


Chart 2



SWYPFT: Chesowld Park Hospital, Chart 2

- Four out of five domains score lower than the national average with Privacy, Dignity and Wellbeing being the one domain above the national average (not applicable for Dementia).
- Condition, Appearance and Maintenance domain scores the lowest at 72.25% compared to a SWYPFT average score of 95.27%, and a national average of 97%.
- Qualitative information is captured during the assessments, and this data contributes to the action plans as well as good practices being identified and shared.

Per Domain:

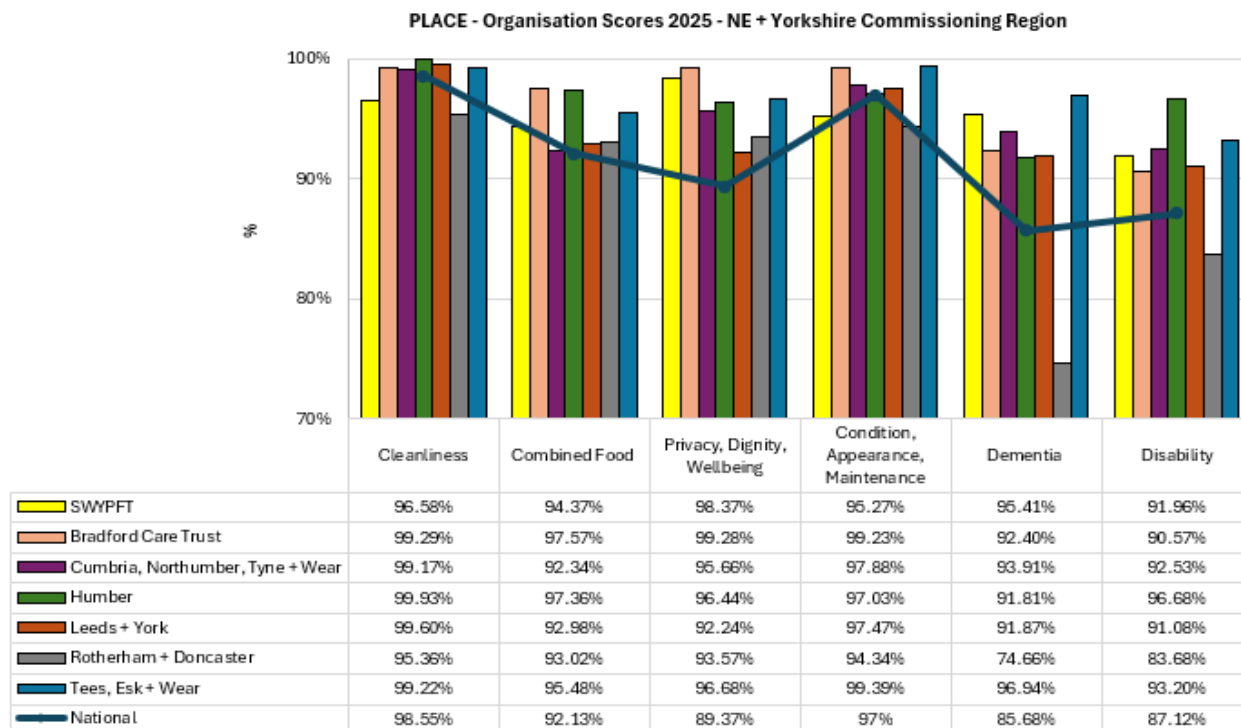
- **Cleanliness;** Below the national average. Several recommendations for improvement were actioned immediately after the audit. Routine monitoring of the cleanliness and achieved star rating to be displayed in all patient facing areas was identified to commence in April 2026.
- **Food;** On review of the food and hydration domain, Chesowld Park is below the national average. The Annual report by the Trust Senior Catering Dietitian provides valuable evidence and insight to support the PLACE audit, with several actions identified from the report achieved. There are still some areas where improvement is required, driven by the Nutritional Steering Group.
- **Privacy, dignity and wellbeing;** Positively, scored above the national average.
- **Condition, appearance and maintenance;** Below the national average. Themes for improvement being internal ceilings, flooring, furniture, and walls, social spaces and linen quality.
- **Dementia;** Not applicable to be scored in the Dementia domain
- **Disability;** Below the national average with recommendations noted for seating leading up to the building entrance for patients within the grounds, and in the reception/waiting area to provide for a range of patient's needs. Trust-wide actions include consideration of whether an access to buildings audit involving disabled people or a disability group is required, and whether a Changing Places toilet should be available within the Trust.

Similar organisation scores within the North East and Yorkshire Commissioning Region, Mental Health and Learning Disabilities Trusts: Chart 3

The chart shows how hospitals are performing both nationally and in relation to other hospitals providing similar services

- Last year, the Trust was second highest in four domains. This year, the Trust scores second highest in two domains, Privacy, Dignity and Wellbeing and Dementia.

Chart 3



Summary and Actions

The Trusts multi-disciplinary approach during the annual PLACE audit demonstrates excellent partnership working with Staff, Estates, Facilities and Infection Prevention and Control colleagues, and gives our patient representatives, a voice to shape local service provision and identify areas for improvement.

The commitment and dedication of staff across the Trust and our operatives working together to continue to achieve and provide high standards of quality is evident.

Cheswold Park Hospital has made improvements over the year and the PLACE audit results are a baseline of current status and assessment of standards seen at the time of the audit. A Trust- wide action plan and a separate, localised action plan for Cheswold Park are in place. These will be monitored by the appropriate Care Group Governance Groups and the Estates Trust Action Group (TAG). With a view to making improvements required to meet the non-clinical aspects of healthcare premises identified as important by patients and the public.

Recommendations:

1. RECEIVE the scores in Appendix 1 and associated Charts.
2. RECEIVE the scores relative to national averages.
3. SUPPORT actions for improvement where appropriate.

Table to show the Organisation (SWYPFT) and Cheswold Park Hospital PLACE scores

Appendix 1

	CLEANLINESS %			FOOD % (combined; organisation and ward food)			PRIVACY, DIGNITY & WELLBEING %			CONDITION, APPEARANCE & MAINTAINANCE %			DEMENTIA %			DISABILITY %		
	2024	2025	Nat %	2024	2025	Nat %	2024	2025	Nat %	2024	2025	Nat %	2024	2025	Nat %	2024	2025	Nat %
SWYPFT	99.81	96.58	98.55	95.28	94.37	92.13	98.92	98.37	89.37	99.31	95.27	97	97.64	95.41	85.68	92.85	91.96	87.12
Cheswold Park	N/A	78.57	98.55	N/A	85.95	92.13	N/A	97.10	89.37	N/A	72.25	97	N/A	N/A	85.68	N/A	86.67	87.12

Table to show Cheswold Park Hospital PLACE scores against similar Site types average scores

Red >1% lower than 2024 and/or (lower than the national average)

	CLEANLINESS %			FOOD % (combined; organisation and ward food)			PRIVACY, DIGNITY & WELLBEING %			CONDITION, APPEARANCE & MAINTAINANCE %			DEMENTIA %			DISABILITY %		
	2025	Overall Nat.Av.	Site Type Av.	2025	Overall Nat.Av.	Site Type Av.	2025	Overall Nat.Av.	Site Type Av.	2025	Overall Nat.Av.	Site Type Av.	2025	Overall Nat.Av.	Site Type Av.	2025	Overall Nat.Av.	Site Type Av.
Cheswold Park (Both mental health and learning disabilities)	78.57	98.55	98.82	85.95	92.13	93.15	97.10	89.37	96.36	72.25	97	97.37	N/A	85.68	93.29	86.67	87.12	91.97

Amber <1% lower than 2024

Green Higher than National / Site Type Average

**Trust Board
28 July 2026
Agenda item 11.1**

Private/Public paper:	Public		
Title:	Integrated Performance Report (IPR)		
Lead Director:	Adrian Snarr – Executive director of finance, estates, and resources		
Mission/values:	The paper supports achievement of all Trust values: Person first and in the centre; Families and carers matter; respectful, honest, open and transparent; Improve and am to be outstanding, Relevant today and ready for tomorrow.		
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for June 2026.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	All BAF risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	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 both the South and West ICBs’ strategic priorities and delivery plans.		
Any background papers / previously considered by:	The IPR is reviewed at Trust Board meetings held in public eight times a year. On months when meetings in public 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 Operational Management Group (OMG) meeting.		
Executive summary:	Performance against the Trust’s new strategy will be reported separately to the IPR for 2026/27, however, all metrics reported in the IPR have been		

mapped to the new strategic objectives as well as to the Care Quality Commission domains.

Quality and Safety

- The performance rates summary (page 5 of the IPR), shows 66.7% of the metrics are being fully achieved with 12.1% showing areas of improvement. 21.1% (7 metrics) all have quality projects associated with them to achieve continued improvement. As well as providing assurance regarding performance, this summary highlights some areas of improvement required and specifies actions in place to ensure we maintain safety across our services for staff, patients and carers.
- The proportion of responses provided within six months of the date a complaint received remain consistently strong and was 92% in June.
- 19% of complaints were responded to within three months and focus is applied to those complaints not responded to within six months to identify areas for improvement.
- The total number of reported incidents in June was 1,454 which remains in line with normal range. All incidents continue to be subject to review by the patient safety team with relevant governance and learning within the care groups.
- The number of restraint incidents in June totalled 197 which is in line within normal range. The highest number of restraint incidents were on one of our adult mental health wards Nostell (30) - 80% of these incidents related to four individuals with complex needs and behaviours, there is a women's service review in progress to support better understanding of how to improve the women's services pathway. Crofton older people's mental health ward reported 20 incidents during the month which appears to be largely attributable to the presentation of one service user (11 incidents) alongside the challenges associated with a number of new admissions and heightened environmental pressures on the ward. All incidents are reviewed, and learning is shared.
- The Trust had 18 incidents involving race against staff on mental health wards during June taking place across 12 wards. We are very aware of the personal impact this has on our colleagues and are working with colleagues to identify further wellbeing offers to increase the support in addition to the existing personal and clinical support available to safeguard staff who experience racist abuse during their work.
- Our focus on reducing the use of prone restraint continues to shows on average a continued improvement, although there were six staff led prone restraints on our mental health wards during June. Five of these incidents related to the administration of intramuscular (IM) medication and were clinically led decisions made to manage risk safely and during the incidents. Alternative seclusion exit training is embedded in both four-day initial and two-day annual refresher RRPI training. There is a piece of work to support staff to administer IM medications in alternative routes which should prevent prone restraint requirements. Where required, the RRPI trainers attend the wards to offer support for individual cases that may require a bespoke care plan.
- There were six information governance personal data breaches during June which remains at a lower level than historical averages.
- Sadly, there were three unexpected patient deaths during the month where the service users were known to the Trust's mental health services. These incidents are subject to review and any learning will be identified. Condolences and support have been offered to the families concerned in these tragic circumstances.

- There were 55 inpatient falls reported during June. 24 of these relate to service users aged 65 years and over. There were no red graded fall incidents reported this month. Across our older people mental health wards and stroke and neuro-rehabilitation wards, there were a total of 96 patients (61%) assessed as a high risk of falls. All fall incidents are reviewed regularly by the Trust's falls coordinator to ascertain any themes or actions required. Falls on inpatient wards per 1,000 bed days are notably lower than national averages.
- The Trust continues to work to improve the recording and collection of protected characteristics across all services to improve our service provision and experience of it. For the ethnicity indicator, the Trust is achieving 95.2%% against a target of 90%. Disability recording was at 57%, sexual orientation 56.7% and postcode at 99.6%. Work continues to ensure data capture across all services to support how we can improve our service offer.
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- Ethnicity
- Socioeconomic deprivation

For the data included in this months report, key points to note include:

- Our review of inpatient length of stay (LoS) data highlights important patterns. Differences in admission practices i.e. formal (compulsory) and informal (voluntary) also appear to influence LoS, with compulsory admissions tending to require more intensive interventions and longer
- discharge planning. Similarly, discharge approaches differ, with patients facing socioeconomic challenges or limited community support experiencing delays. Using the Trust's improvement methodology,
- insights are being derived and helping to identify systemic drivers and opportunities for change. Work is currently underway to engage with service users to understand their experiences. This will help us to plan and generate ideas that will inform targeted actions, ensuring that improvements in admission and discharge processes, culturally competent care, and partnership working are embedded across services.

People

- The performance rates summary (page 5 of the IPR), shows 85.8% of the metrics are being fully achieved with 14.2% showing areas of improvement (1 metric). Key points to note from this section of the report are as follows.
- Our in-month sickness absence rate for June is 5.3% which is above our target of 5%. Our long-term and short-term sickness are both higher than the same period last year. Absences related to gastrointestinal illness and anxiety/stress increased during June 2026. Care group sickness absence levels can be seen in the care group section of the report. There are also some higher levels of absence across support services (estates and facilities, people directorate, nursing qualities and professions directorate). There is a focussed piece of work with the people directorate to support people to remain in or return to work.
- In June 2026, appraisal compliance was 93.5%, achieving the Trust's KPI target. This figure includes a number of employees who are currently transitioning to the new appraisal window system.
- A new dashboard has been introduced to support the implementation of this process, and all appraisals are expected to be completed by the end of September 2026. There is a plan across all services to ensure appraisals are completed within the specified window and a weekly focus for care groups at Operational Management Group.
- Our statutory and mandatory training compliance remains above the Trust target at 95% (target greater than or equal to 80%). This represents strong commitment from all parts of the Trust.

National Metrics

- The Trust continues to perform well against most national metrics. The following should be noted:
- It is important that hearing loss is identified quickly to support a child's development including their language skills and cognitive pathways. Regarding the 6 weeks to a diagnostic appointment target, 93 out of 96 children (96.9%) received a diagnostic appointment within 6 weeks, this is now significantly above the revised national threshold. The demand in referrals consistently outweighs commissioned activity levels. Our quality improvement plan has clearly achieved a sustained improvement; this is fragile due to the small resource (2 whole time equivalent staff) within the team.
- Children & Younger People with an eating disorder – three routine referrals were not seen within the four-week national target, two of those were due to

families declining an appointment within timescale and choosing a later appointment and one breach in Barnsley was linked to clinical capacity within the team.

- The Trust had one admission for a service user under 18 years of age to an adult ward which was due to lack of nationally available beds. The Trust has robust governance arrangements in place to safeguard young people when these situations arise.
- The Trust has set itself a target to reduce adult acute and psychiatric intensive care lengths of stay by 10% by the end of March 2027. Longer lengths of stay for people discharged in June in our West Yorkshire wards have impacted the monthly average for the Trust and we have exceeded slightly our forecast position. We have also exceeded our forecast for older people lengths of stay (90.2 days against a forecast of 79 days). Reported performance is affected by discharges of patients with particularly long lengths of stay, this is associated with the availability of external placements, particularly for older people and specialist mental health support. There are robust escalation processes in place to expedite those clinically ready for discharge.

Care Groups

- Child and adolescent mental health services (CAMHS) continue to prioritise children with high levels of need and if a child's/young person's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period. For service users waiting for treatment at the end of June, 90.5% had been waiting for a period of 18 weeks or less which represents a sustained improvement. All of these cases have had some form of screening, consultation, or initial assessment before being placed on a treatment waiting list. This service is experiencing an increase in demand, particularly in Kirklees.
- Children's neurodevelopmental waits remain a significant issue given the exponential growth in demand in recent years, which has been further compounded by vacancies in the team. Neuro-development waits are part of a specific pathway review across places in line with commissioned models. There is an offer in place to support children and families whilst waiting.
- Improvement work on waiting list times in community learning disability services has led to a sustained improvement against the 18 weeks standard for patients having a completed assessment, care package and commenced service delivery within 18 weeks. Performance in June continued to exceed the local threshold reporting 95.6%.
- The number of out of area bed placements remains amongst the lowest nationally. At the end of June, the Trust had six service users placed in an inappropriate out of area bed with 137 bed days used over the month, which is an increase on recent months given particularly high demand which resulted in OPEL 4 status being declared. There is significant ongoing focus on patient flow and bed management to minimise out of area bed placements. 3 of the 6 have now either been discharged or returned to the Trust.
- Focus on patients clinically ready for discharge continues to take place across all services. At the end of June, 23 people were clinically ready for discharge but remained in a bed, accounting for a total of 674 bed days over the month. The main challenges to discharge continue to be specialist placements and housing and we are continually in dialogue with partners to identify solutions.
- 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.

- The commissioned level for ADHD pathways in Barnsley, Wakefield and Kirklees is approximately 29 cases across all three areas per month. The average number of referrals for ADHD received for these areas in the last three months was 291. As demand in all areas is significantly more than capacity, this leads to lengthy waits, and the care remains with the referrer until accepted by the service.
- Mental health bed occupancy (excluding leave) increased to 91.5% There are individual wards which have a much higher occupancy and increasing acuity of patients places further challenge on colleagues. The acuity of patients remains a challenge. Particularly with risk to self and others, therefore, requires enhanced observations to keep people safe, which has an impact on staffing and finance.
- The temporary staffing group continues to have a focus on the use of temporary workforce, ensuring safe staffing whilst delivering a sustainable workforce to meet the patient needs. Bank and locum expenditure continues to fluctuate from month to month and bank staffing remains higher than plan. Agency spend has continued to be maintained at an overall low level (£138k in June). The use of agency staff largely relates to very limited number of medical staff although some pressures are expected in the coming weeks due to pending staff retirements. Use of bank staff continues to be scrutinised, and we are planning to recruit an increasing number of substantive health support workers over the course of the year.
- Single point of access (SPA) prioritises risk screening of all referrals to ensure any urgent demand is met within 24 hours. In June, the access standard for assessed within 14 days of referral has been met in all localities despite demand and staffing challenges. There have been challenges with vacancies in Calderdale & Kirklees SPA and an increased demand for urgent assessments. The service has implemented business continuity plans, with a focus on diverting increased resource towards triage.
- Our bank fill rate for registered nurses has reduced to 81% in June due to various reasons such as an increase in sickness, higher acuity and availability for cover, however, redeployment across wards on a daily basis has occurred to ensure skill mix is safe.

Finance

- The financial performance in June 2026 is a deficit of £526k which is £120k adverse to plan in month. The year-to-date position remains in line with plan but the run rate needs to improve as the year progresses to achieve our break-even target. Although Trust actions are forecast to achieve a £5.0m reduction in bank staff the current run rate is to exceed that. For the year to date spend is £0.4m (14.1%) higher than plan.
- The Trust value for money programme is reported as ahead of plan at month 3. The largest contributors are the reduction in corporate costs and the maintained run rate reduction of spend on temporary staffing and out of area placements which commenced in 2025 / 26. The trajectory includes the identification, and delivery, of new schemes later in the year. These need to be recurrent in nature to ensure that the Trust medium term financial plan of breakeven is maintained.
- The current cash position remains positive.
- The capital programme is now behind plan due to the Older People's Inpatient scheme which continues to be developed. The forecast remains in line with allocation, including a new allocation for community hubs.

Recommendation:	Trust Board members are asked to: • NOTE the Integrated Performance Report and COMMENT accordingly.

Integrated Performance Report Strategic Overview



June 2026

With **all of us** in mind.

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Introduction

Welcome to the Trust's Integrated Performance Report (IPR) for June 2026.

The report format for 2026/27 aligns with the Trust board's focus and national priorities. In months where the report is not included on the Trust board agenda (Strategy focus) or has a shorter time allocation (Risk focus) a more data focussed report with key headlines will be produced. For Performance focus months, this will be a full report including supporting narrative and we will continue to develop more in-depth analysis over the year. Please note, data is correct at the time of reporting and will be refreshed each month. This can mean that historical months performance will change as records are updated.

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:

- Headlines
- Executive summary
- Quality and Safety
- People
- National metrics
- Care groups including ward level detail
- Finance

Our Integrated Performance Report (IPR) provides a comprehensive view of Trust performance against our targets. We have mapped this performance information against our strategic aims, values and best statements so that it is easy to see how the performance data links to the delivery of the strategy. A separate report will be provided to board with a specific focus on delivery of the Strategy. We have also mapped the metrics included in this report against the Care Quality Commission domains.

An exercise has been undertaken to review all metrics and thresholds to ensure they meet the requirements and priorities for 2026/27; the report has been updated to reflect this. In particular, the national metrics section includes those metrics contained within the NHS oversight framework, operational planning guidance for 2026/27 and NHS standard contract items.

On 1st October 2024, the Trust acquired Cheswold Park Hospital, which is a 112-bed low and medium secure mental health hospital based in Doncaster, providing services to male and female patients with a diagnosis of mental illness, personality disorder or neurodevelopmental disorders. Cheswold Park provides services to patients from South Yorkshire Adult Secure Provider Collaborative and placements for patients who may be from out of the area and need the specific treatment pathways the hospital provides. Since this time, the Trust has been undertaking an integration programme to embed Cheswold Park Hospital Services into the Trust and reporting systems. This project was completed by the end of March 2026 and as a result, reporting for this service is now integrated in the main body of the report and in the Forensic Care group section.

A review of the reducing inequalities section is to be undertaken over the next few months, this is linked to the Trust's equality, diversity and inclusion strategy it includes a number of metrics to evidence our progress towards delivering more responsive and equitable services for our communities. The strategy will guide us to being a more inclusive employer where everyone can be themselves and feel valued for their contribution. This reporting will align to the deployment of the Trusts Equality, diversity, and inclusion strategy.

Our Integrated Performance Report is publicly available on the internet.

Headlines - Performance Rates Summary

This section of the IPR shows a very high-level overview of the performance rates for each area and Care Group based on the proportion of targeted metrics that have achieved threshold.

Quality & Safety Metrics Performance Rate 7 (21.21%) 4 (12.12%) 22 (66.67%)	People Metrics Performance Rate 1 (14.29%) 6 (85.71%)	National Metrics Performance Rate 10 (20.83%) 5 (10.42%) 33 (68.75%)	Finance Metrics Performance Rate 2 (25%) 1 (12.5%) 5 (62.5%)
Barnsley Physical Health Metrics Performance Rate 4 (30.77%) 9 (69.23%)	CAMHS Metrics Performance Rate 3 (30%) 7 (70%)	Mental Health Community Metrics Performance Rate 14 (100%)	Mental Health Inpatient Metrics Performance Rate 3 (21.43%) 2 (14.29%) 9 (64.29%)
ASD/ADHD Metrics Performance Rate 4 (33.33%) 8 (66.67%)	Forensic SY Metrics Performance Rate 2 (16.67%) 2 (16.67%) 8 (66.67%)	Forensic WY Metrics Performance Rate 5 (31.25%) 3 (18.75%) 8 (50%)	

Headlines

This section of the report identifies the metrics where there has been a change in performance from non achievement to achievement or where expected levels are not being achieved. Metrics that are routinely meeting thresholds will not appear on this page. Whilst the metrics included may have seen a change since last month the assurance/variation icons where available, show if the data over time indicates that there is any action required.

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.

Quality and Safety

Metric	Change from last month	Variation/ Assurance
Complaints - Number of responses provided within six months of the date a complaint received	↑	
% of inpatients clinically ready for discharge	↑	
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	↔	
Friends and Family Test - community	↓	
% of staff receiving supervision within policy guidance - Clinical	↓	
% of staff receiving supervision within policy guidance - Management	↓	
% of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened)	↑	
% on community active caseload at month end with a care plan which has been reviewed within the last year	↑	 
% inpatient risk assessment completed within 24hrs before or after admission	↓	 
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	↑	 
Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches	↓	

People

Metric	Change from last month	Variation/ Assurance
Sickness absence - Month	↓	 

Finance

Metric	Change from last month	Variation/ Assurance
Bank spend	↓	
Capital Spend	↓	

National metrics

Metric	Change from last month	Variation/ Assurance
The number of completed non-admitted Referral to Treatment (RTT) pathways	↔	 
The number of incomplete Referral to Treatment (RTT) pathways	↑	 
Total bed days of Children and Younger People aged under 18 in adult inpatient wards	↑	 
Total number of Children and Younger People aged under 18 in adult inpatient wards	↑	 
Inappropriate out of area bed days	↓	 

LD, ADHD & ASD

Metrics	Change from last month	Variation/ Assurance
% of clients clinically ready for discharge	↑	
% Appraisal rate	↓	
% of staff receiving supervision within policy guidance - Clinical	↓	New Metric
% of staff receiving supervision within policy guidance - Management	↑	New Metric

Barnsley Physical Health and Wellbeing

Metrics	Change from last month	Variation/ Assurance
Sickness rate (Monthly)	↓	
% of staff receiving supervision within policy guidance - Clinical	↓	New Metric
% of staff receiving supervision within policy guidance - Management	↓	New Metric
% of feedback with staff values and behaviours as an issue	↓	

Mental Health Inpatient

Metrics	Change from last month	Variation/ Assurance
% Bed occupancy (excl leave)	↓	
% inpatient risk assessment completed within 24hrs before or after admission	↓	
% of clients clinically ready for discharge	↑	
Sickness rate (monthly)	↓	
% of staff receiving supervision within policy guidance - Management	↑	New Metric

Forensic - West Yorkshire

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
Sickness rate (Monthly)	↑	
% Bed occupancy (incl leave)	↓	
Information Governance (IG) training compliance	↓	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	↑	
% of staff receiving supervision within policy guidance - Clinical	↑	New Metric
% of staff receiving supervision within policy guidance - Management	↑	New Metric
% with care plan that includes service user input/views	↑	New Metric
% inpatient risk assessment completed within 24hrs before or after admission	↑	

Forensic - South Yorkshire

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	
% Bed occupancy	↑	
% of staff receiving supervision within policy guidance - Clinical	↓	New Metric
% of staff receiving supervision within policy guidance - Management	↓	New Metric

Mental Health Community

Metrics	Change from last month	Variation/ Assurance
Information Governance training compliance	↑	

Children and Young Peoples Mental Health Services (CAMHS)

Metric	Change from last month	Variation/ Assurance
% of staff receiving supervision within policy guidance - Clinical	↑	New Metric
% of staff receiving supervision within policy guidance - Management	↑	New Metric
Children & Younger People with eating disorder - % Routine cases accessing treatment within 4 weeks	↓	
Information Governance 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 (I) 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.

Summary

Quality & Safety

People

National Metrics

Care Groups

Ward Detail

Finance/Contracts

This section has been developed to give an overview of key headlines for each section of the report. More detail is included in the relevant sections of the Integrated Performance Report.

Quality & Safety

- **Performance for this section of the report shows 66.7% of the metrics are being fully achieved, this is only for metrics where we are measuring against a target or threshold.** This summary highlights some areas of improvement required and provides assurance regarding actions in place to ensure we maintain safety across our services for staff, patients and carers.
- The proportion of responses provided within six months of the date a complaint received remain consistently strong and was 92% in June.
- 19% of complaints were responded to within three months and focus is applied to those complaints not responded to within six months to identify areas for improvement.
- The total number of reported incidents in June was 1,454 which remains in line with normal range. All incidents continue to be subject to review by the patient safety team with relevant governance and learning within the care groups.
- The number of restraint incidents in June totalled 197 which is in line within normal range. The highest number of restraint incidents were on one of our adult mental health wards Nostell (30) - 80% of these incidents related to four individuals with complex needs and behaviours, there is a women's service review in progress to support better understanding of how to improve the women's services pathway. Crofton older people's mental health ward reported 20 incidents during the month which appears to be largely attributable to the presentation of one service user (11 incidents) alongside the challenges associated with a number of new admissions and heightened environmental pressures on the ward. All incidents are reviewed, and learning is shared.
- The Trust had 18 incidents involving race against staff on mental health wards during June taking place across 12 wards. We are very aware of the personal impact this has on our colleagues and are working with colleagues to identify further wellbeing offers to increase the support in addition to the existing personal and clinical support available to safeguard staff who experience racist abuse during their work.
- Our focus on reducing the use of prone restraint continues to shows on average a continued improvement, although there were six staff led prone restraints on our mental health wards during June. Five of these incidents related to the administration of intramuscular (IM) medication and were clinically led decisions made to manage risk safely and during the incidents. Alternative seclusion exit training is embedded in both four-day initial and two-day annual refresher RRPI training. There is a piece of work to support staff to administer IM medications in alternative routes which should prevent prone restraint requirements. Where required, the RRPI trainers attend the wards to offer support for individual cases that may require a bespoke care plan.
- There were six information governance personal data breaches during June which remains at a lower level than historical averages.
- Sadly, there were three unexpected patient deaths during the month where the service users were known to the Trust's mental health services. These incidents are subject to review and any learning will be identified. Condolences and support have been offered to the families concerned in these tragic circumstances.
- There were 55 inpatient falls reported during June. 24 of these relate to service users aged 65 years and over. There were no red graded fall incidents reported this month. Across our older people mental health wards and stroke and neuro-rehabilitation wards, there were a total of 96 patients (61%) assessed as a high risk of falls. All fall incidents are reviewed regularly by the Trust's falls coordinator to ascertain any themes or actions required. Falls on inpatient wards per 1,000 bed days are notably lower than national averages.
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- All services are focusing on continuing to improve performance for and the quality of risk assessments. There is a high level of scrutiny when a staying safe care plan is not completed within 24 hours. At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed and communicated to the service user and ward staff. Development work is occurring across all teams to ensure they update the risk assessment to ensure emerging risks are supported and mitigated.
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Quality and Safety Continued...

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We have undertaken a further review of the health inequalities section of the IPR and developed a revised draft for consideration as a separate document. The revisions ensure that, for 2026/27, this work is aligned to the 'Access and Waits' improvement area of focus, with measures centred on the review of:

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- Socioeconomic deprivation

For the data included in this months report, key points to note include:

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People

- **Performance for this section of the report shows 85.7% of the metrics are being fully achieved, this is only for metrics where we are measuring against a target or threshold.** Key points to note from this section of the report are as follows.

- The performance rates summary (page 5 of the IPR), shows 85.8% of the metrics are being fully achieved with 14.2% showing areas of improvement (1 metric). Key points to note from this section of the report are as follows.

- Our in-month sickness absence rate for June is 5.3% which is above our target of 5%. Our long-term and short-term sickness are both higher than the same period last year. Absences related to gastrointestinal illness and anxiety/stress increased during June 2026. Care group sickness absence levels can be seen in the care group section of the report. There are also some higher levels of absence across support services (estates and facilities, people directorate, nursing qualities and professions directorate). There is a focussed piece of work with the people directorate to support people to remain in or return to work.
- In June 2026, appraisal compliance was 93.5%, achieving the Trust's KPI target. This figure includes a number of employees who are currently transitioning to the new appraisal window system.

A new dashboard has been introduced to support the implementation of this process, and all appraisals are expected to be completed by the end of September 2026. There is a plan across all services to ensure appraisals are completed within the specified window and a weekly focus for care groups at Operational Management Group.

- Our statutory and mandatory training compliance remains above the Trust target at 95% (target greater than or equal to 80%). This represents strong commitment from all parts of the Trust.

National Metrics

- **Performance for this section of the report shows 68.7% of the metrics are being fully achieved, this is only for metrics where we are measuring against a target or threshold.** The following should be noted:

- The Trust continues to perform well against most national metrics. The following should be noted:
- It is important that hearing loss is identified quickly to support a child's development including their language skills and cognitive pathways. Regarding the 6 weeks to a diagnostic appointment target, 93 out of 96 children (96.9%) received a diagnostic appointment within 6 weeks, this is now significantly above the revised national threshold. The demand in referrals consistently outweighs commissioned activity levels. Our quality improvement plan has clearly achieved a sustained improvement; this is fragile due to the small resource (2 whole time equivalent staff) within the team.
- Children & Younger People with an eating disorder – three routine referrals were not seen within the four-week national target, two of those were due to families declining an appointment within timescale and choosing a later appointment and one breach in Barnsley was linked to clinical capacity within the team.
- The Trust had one admission for a service user under 18 years of age to an adult ward which was due to lack of nationally available beds. The Trust has robust governance arrangements in place to safeguard young people when these situations arise.
- The Trust has set itself a target to reduce adult acute and psychiatric intensive care lengths of stay by 10% by the end of March 2027. Longer lengths of stay for people discharged in June in our West Yorkshire wards have impacted the monthly average for the Trust and we have exceeded slightly our forecast position. We have also exceeded our forecast for older people lengths of stay (90.2 days against a forecast of 79 days). Reported performance is affected by discharges of patients with particularly long lengths of stay, this is associated with the availability of external placements, particularly for older people and specialist mental health support. There are robust escalation processes in place to expedite those clinically ready for discharge.

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- Child and adolescent mental health services (CAMHS) continue to prioritise children with high levels of need and if a child's/young person's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period. For service users waiting for treatment at the end of June, 90.5% had been waiting for a period of 18 weeks or less which represents a sustained improvement. All of these cases have had some form of screening, consultation, or initial assessment before being placed on a treatment waiting list. This service is experiencing an increase in demand, particularly in Kirklees.
- Children's neurodevelopmental waits remain a significant issue given the exponential growth in demand in recent years, which has been further compounded by vacancies in the team. Neuro-development waits are part of a specific pathway review across places in line with commissioned models. There is an offer in place to support children and families whilst waiting.
- Improvement work on waiting list times in community learning disability services has led to a sustained improvement against the 18 weeks standard for patients having a completed assessment, care package and commenced service delivery within 18 weeks. Performance in June continued to exceed the local threshold reporting 95.6%.
- The number of out of area bed placements remains amongst the lowest nationally. At the end of June, the Trust had six service users placed in an inappropriate out of area bed with 137 bed days used over the month, which is an increase on recent months given particularly high demand which resulted in OPEL 4 status being declared. There is significant ongoing focus on patient flow and bed management to minimise out of area bed placements. 3 of the 6 have now either been discharged or returned to the Trust.
- Focus on patients clinically ready for discharge continues to take place across all services. At the end of June, 23 people were clinically ready for discharge but remained in a bed, accounting for a total of 674 bed days over the month. The main challenges to discharge continue to be specialist placements and housing and we are continually in dialogue with partners to identify solutions.
- 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.
- The commissioned level for ADHD pathways in Barnsley, Wakefield and Kirklees is approximately 29 cases across all three areas per month. The average number of referrals for ADHD received for these areas in the last three months was 291. As demand in all areas is significantly more than capacity, this leads to lengthy waits, and the care remains with the referrer until accepted by the service.
- Mental health bed occupancy (excluding leave) increased to 91.5%. There are individual wards which have a much higher occupancy and increasing acuity of patients places further challenge on colleagues. The acuity of patients remains a challenge. Particularly with risk to self and others, therefore, requires enhanced observations to keep people safe, which has an impact on staffing and finance.
- The temporary staffing group continues to have a focus on the use of temporary workforce, ensuring safe staffing whilst delivering a sustainable workforce to meet the patient needs. Bank and locum expenditure continues to fluctuate from month to month and bank staffing remains higher than plan. Agency spend has continued to be maintained at an overall low level (£138k in June). The use of agency staff largely relates to very limited number of medical staff although some pressures are expected in the coming weeks due to pending staff retirements. Use of bank staff continues to be scrutinised, and we are planning to recruit an increasing number of substantive health support workers over the course of the year.
- Single point of access (SPA) prioritises risk screening of all referrals to ensure any urgent demand is met within 24 hours. In June, the access standard for assessed within 14 days of referral has been met in all localities despite demand and staffing challenges. There have been challenges with vacancies in Calderdale & Kirklees SPA and an increased demand for urgent assessments. The service has implemented business continuity plans, with a focus on diverting increased resource towards triage.

Finance

- **Performance for this section of the report shows 62.5% of the metrics are being fully achieved, this is only for metrics where we are measuring against a target or threshold.**
- The financial performance in June 2026 is a deficit of £526k which is £120k adverse to plan in month. The year-to-date position remains in line with plan but the run rate needs to improve as the year progresses to achieve our break-even target. Although Trust actions are forecast to achieve a £5.0m reduction in bank staff the current run rate is to exceed that. For the year to date spend is £0.4m (14.1%) higher than plan.
- The Trust value for money programme is reported as ahead of plan at month 3. The largest contributors are the reduction in corporate costs and the maintained run rate reduction of spend on temporary staffing and out of area placements which commenced in 2025 / 26. The trajectory includes the identification, and delivery, of new schemes later in the year. These need to be recurrent in nature to ensure that the Trust medium term financial plan of breakeven is maintained.
- The current cash position remains positive.
- The capital programme is now behind plan due to the Older People's Inpatient scheme which continues to be developed. The forecast remains in line with allocation, including a new allocation for community hubs.



Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks ⁵	Best Quality	Responsive	TBC	73.8%	76.1%	86.2%	85.7%	87.9%	90.5%	N/A
Complaints	% of feedback with staff values and behaviours as an issue ¹²	Best Quality	Caring	< 20%	14% (6/43)	22% (6/27)	9% (3/33)	10% (3/30)	0% (0/33)	8% (3/38)	1
	Complaints - Average number of working days to sign off for closed complaints (in month)	Best Quality	Well led	Trend monitor	101.6	109.8	134.8	101.3	119.7	131.3	N/A
	Complaints - Number of responses provided within six months of the date a complaint received ¹⁶	Best Quality	Well led	100%	94% (15/16)	94% (16/17)	83% (19/23)	100% (14/14)	91% (10/11)	92% (24/26)	
Service User Experience	Friends and Family Test - Mental Health	Best Quality	Caring	84%	91%	91%	92%	86%	93%	87%	1
	Friends and Family Test - Community	Best Quality	Caring	95%	96%	99%	96%	91%	96%	94%	1
	Number of compliments received	Best Quality	Caring	N/A	25	60	41	40	33	55	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) ⁴	Best Quality	Safe	Trend monitor	3	2	6	2	2	5	
Quality	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions ⁴	Best Quality	Safe	Trend monitor	0	0	1	0	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches ⁴	Best Quality	Safe	0	0	0	0	0	0	1	1
	Number of Information Governance breaches ³	Best Quality	Well led	<12	10	12	12	12	5	6	2
	% of inpatients clinically ready for discharge *	Person first and in the centre	Responsive	3.5%	5.3%	5.4%	5.4%	6.1%	4.8%	4.3%	3
	Total number of reported incidents	Best Quality	Safe	Trend monitor	1490	1332	1416	1448	1379	1454	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) ⁹	Best Quality	Safe	Trend monitor	34	39	41	33	30	38	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) ⁹	Best Quality	Safe	Trend monitor	0	0	1	0	0	3	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) ⁹	Best Quality	Safe	Trend monitor	0	1	4	2	1	3	
	Safer staff fill rates	Best Quality	Safe	90%	116.3%	113.8%	112.3%	114.0%	115.1%	115.0%	1
	Safer Staffing % Fill Rate Registered Nurses	Best Quality	Safe	80%	100.2%	100.6%	98.3%	99.7%	98.6%	99.5%	1
	% Bank Fill Rates - Registered Nurses	Best Quality	Safe	-	84.8%	85.1%	85.0%	90.5%	86.7%	81.0%	
	% Bank Fill Rates - Health Care Assistants	Best Quality	Safe	-	86.0%	91.1%	90.6%	95.3%	93.0%	93.0%	
	Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)	Best place to work and learn	Safe	-	87.2%	90.4%	90.1%	94.3%	91.7%	86.4%	
	Number of pressure ulcers which developed under SWYPFT care ¹	Best Quality	Safe	Trend monitor	68	47	62	55	57	51	
	Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement ²	Best Quality	Safe	0	0	0	0	0	0	0	0
	Eliminating Mixed Sex Accommodation Breaches	Best Quality	Safe	0	0	0	0	0	0	0	1
	Number of Falls (inpatients)	Best Quality	Safe	Trend monitor	59	45	61	53	65	55	
	Number of restraint incidents	Best Quality	Safe	Trend monitor	175	200	194	185	152	197	
	% of staff receiving supervision within policy guidance ¹⁵	Best place to work and learn	Well led	80%	87.9%	90.3%	92.1%	N/A	N/A	N/A	1
	% of staff receiving supervision within policy guidance ¹⁵ - Clinical			80%	Reporting commenced April 26			74.7%	78.4%	77.3%	
	% of staff receiving supervision within policy guidance ¹⁵ - Management			80%	Reporting commenced April 26			64.6%	69.2%	69.0%	
	Potential under-reporting of patient safety incidents	Best Quality	Safe								
	% people dying in a place of their choosing ¹⁴	Person first and in the centre	Responsive	80%	97.4%	84.6%	87.1%	93.5%	100%	100%	1
	Number of job start/work retention outcomes during month by individual placement and support service	Best Quality	Effective	Trend Monitor	14	8	13	10	18	21	N/A
	Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks), by ethnicity, disability, sexual orientation and deprivation	Best Quality	Effective	55%	68.8%			Due September 26			
	Number of incidents against staff on mental health wards involving race	Best place to work and learn	Safe	Trend Monitor	24	28	29	34	27	18	N/A
	Number of sexual safety incidents by patients against patients	Best Quality	Safe	Trend Monitor	Reporting commenced April 26			6	5	6	
	Number of sexual safety incidents against staff (patient on staff)	Best place to work and learn	Safe	Trend Monitor				16	8	11	
	Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Best Quality	Safe	0	7			7			
	Estates Urgent Response Times - Service level agreement (SLA)	Best Quality	Well led	95%	97.9%	95.6%	96.9%	99.0%	95.9%	99.4%	
	Compliance with statutory requirements (Water, Gas, Electricity, Refrigeration, Pressure, Loler and Asbestos)	Best Quality	Well led	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	% of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened)	Best Quality	Well led	100%	100.0%	100.0%	100.0%	100.0%	87.1%*	96.0%	

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Section	KPI	Strategic Objective	CQC Domain	Target	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Year End Forecast*
	Percentage of service users who have had their equality data recorded - ethnicity	Best Quality	Responsive	90%	96.3%	96.4%	96.5%	96.5%	96.1%	95.2%	
	Percentage of service users who have had their equality data recorded - disability	Best Quality	Responsive	50%	59.7%	59.5%	59.1%	58.7%	58.0%	57.0%	
	Percentage of service users who have had their equality data recorded - sexual orientation	Best Quality	Responsive	50%	60.1%	59.8%	59.1%	58.7%	57.6%	56.7%	
	Percentage of service users who have had their equality data recorded - deprivation (postcode)	Best Quality	Responsive	90%	99.4%	99.5%	99.5%	99.6%	99.6%	99.6%	
	Timely completion of equality impact assessments (EIAs) in services and for policies (snapshot figure)	Best Quality	Responsive	Service timely completion - 75% Policy - 95%	100% Service	98.4% Service	99.4% Service	95.2% Service	92.7% Service	92.7% Service	
	EIA policy reporting refers to policies signed off by the Executive Management Team (EMT) with an up to date EIA in place				100% Policy	100% Policy	100% Policy	100% Policy	100% Policy	100% Policy	
	% on community active caseload at month end with a care plan which has been reviewed within the last year	Person first and in the centre	Caring	25/26 Interim trajectory: 75-80% April 26: 95%	91.1%	94.1%	92.6%	93.9%	94.3%	94.9%	
	% with care plan that includes service user input/views	Person first and in the centre	Caring		94.5%	96.9%	96.5%	97.1%	96.7%	96.2%	
	% inpatient care plans commenced within 24hrs before or after admission	Person first and in the centre	Caring		97.8%	96.3%	96.8%	97.4%	96.7%	95.6%	
	% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe		90.5%	89.7%	86.0%	91.4%	92.0%	89.3%	
	% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe		93.9%	92.5%	94.1%	93.9%	93.8%	94.0%	
	Number of prone restraint incidents during the month - (where we have purposefully placed the person in the prone position)	Best Quality	Safe	Dec & Jan - 4, Feb & Mar - 2, 26/27 stretch target to reduce to zero	3	1	5	3	2	6	
	No of times staff access Yorkshire & Humber care record / Interweave during month	Best Quality	Safe	Trend Monitor	187	97	98	73	144	54	N/A
	Number of Monthly Active Users (Patients accessing patient knows best system)	Best Quality	Safe	Trend Monitor	9,726	10,035	9,960	12,000	11,968	13,289	N/A
	Medical Devices compliance rate	Best Quality	Safe	Trend Monitor	Reporting commenced April 26			75%	75%	82%	
	Infection Prevention (MRSA & C.Diff) All Cases	Person first and in the centre	Safe	6	0	0	0	0	0	0	1
	C Diff avoidable cases	Person first and in the centre	Safe	0	0	0	0	0	0	0	1
	E. Coli bloodstream infection rate	Person first and in the centre	Safe	0	0	0	0	0	0	0	
Improving Resource	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Person first and in the centre	Safe	0	0	0	0	0	0	0	
	NHS Oversight Framework segmentation	All	Well led	1/2	1			Due September 2026			
	Overall CQC rating	All	Well led					Good			
	CQC well - led rating	All	Well led					Good			

Quality & Safety Headlines

- Children and young people mental health services referral to treatment - June saw a further increase in the number of young people waiting less than 18 weeks for their treatment appointment. Following a period of focussed work on this metric since December 2025, performance has improved and has been above 80% for the last four months. Data for the metric will continue to be monitored to ensure we see a sustained improvement trend in the coming months.
- Complaints - Number of responses provided within six months of the date a complaint received – reporting against this metric aligns to the NHS Complaints (England) Regulations 2009 stating that complaints should be responded to/closed within six months of the date received. The Trust is undertaking work to review the time taken for complaints to be investigated and responded to, to help understand any areas for improvement and how this can be monitored locally. Of the 26 complaints responded to during the month, 24 these were undertaken within six months of the complaints being received, and the average number of working days these complaints were open was 131.3 days. Before the response is sent back to complainant, sign off is required which includes formulation of a written response and review by the customer services office manager, following a review by the Care Group trio (general manager, clinical lead and quality and governance lead), the director of service, an executive director and final sign off from the Chief Executive. Complaints vary in complexity and this is sometimes reflected in the amount of time taken to investigate and to move through the sign off process.
- Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches - One breach was reported in Cheswold Park in June. A verbal apology was given to the service user within the 2 days after the incident, however, the letter wasn't completed until 2 days after the 10-day period. Learning has been identified following the after action review process.
- There were six information governance personal data breaches during June. Information disclosed in error continues to be the highest reported category. Work taking place to review the incidents and ensure learning is embedded to prevent future occurrences.
- Focus on patients clinically ready for discharge continues to take place across mental health and learning disabilities, with support from colleagues within place with improvements recognised. The main challenges continue to be specialist placements and housing. At the end of June, 23 people were clinically ready for discharge but remained in a bed. Delays are spread across all our places and services.
- The trust has recently reviewed its supervision policy and as a result from 1st April, has moved to a new method of reporting splitting out management and clinical supervision and reporting against a 60 day standard and also widened the scope to include all staff not just registered staff as previous. This now shows some under performance against the 80% standard and targeted work is taking place in care groups to address and ensure staff are fully supported.



Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Year End Forecast*

- The total number of reported incidents in June increased compared to the previous month. A breakdown of this data can be seen in the care group dashboards. All incidents continue to be subject to review by the patient safety team with relevant governance within the care groups.
- Sadly, there were three patient safety related deaths during the month where the service user was known to the Trust's mental health services. These incidents are subject to review and any learning will be identified. Condolences and support have been offered to the family concerned in these tragic circumstances.
- The Trust had 18 incidents against staff on mental health wards involving race during June. Five incidents in Forensics Care Group across four wards/teams; nine incidents in MH inpatients across six wards/teams - ward 18 had the highest number (4); four incidents in Cheswold Park Hospital across two wards/teams. We are very aware of the personal impact this has on our colleagues. We are working with the People Directorate colleagues to identify further wellbeing offers to increase the support. 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.
- There were six incidents of sexual safety incidents against patients in June. The most common themes for these incidents were inappropriate sexual behaviour and alleged sexual assault. The sexual safety working group focused on patient related sexual safety incidents is well established and represented from across the Trust. This meeting reviews incidents related to patients and has developed support and guidance to staff on managing and supporting patient related sexual safety. Individual incidents are reviewed at this meeting and themes and trends used to the support the development of ways to reduce sexual safety incidents in inpatient settings. This includes a trauma informed approach to current and historical sexual safety incidents. This group reports into the sexual safety oversight group.
- There were 11 incidents of sexual safety incidents against staff (by patients) in June. The most common themes for these incidents were inappropriate sexual behaviour and sexual harassment. We are very aware of the personal impact this has on our colleagues. We are working closely with colleagues from the People Directorate to identify further wellbeing offers and strengthen support.
- Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations) - There were seven incidents in June, six of these were due to violence and aggression and one was due to manual handling. In each violence and aggression case, staff have been supported through their recuperation and follow ups made with occupational health and welcome back meetings with the Department Managers if they have returned.
- The percentage of ligature jobs completed within timeframe remained under threshold this month, this related to 2 jobs out of 50, these have now been completed.
- The number of restraint incidents increased this month from 152 reported in May to 197. The highest number of incidents were on Nostell (30), with 24 of these incidents relating to four complex service users. Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remain within expected range – all incidents are reviewed, and learning is shared.
- There were 55 inpatient falls reported during June 2026, this is a decrease from last month. Further detail can be seen in the falls section of the report.
- Our focus on reducing the use of prone restraint has shown significant improvement over the last few months, however there has been an increase in incidents in June with six staff led prone restraints on our mental health wards. Five incidents related to the administration of intramuscular (IM) medication and were clinically led decisions made to manage risk safely and during the incidents. The service user's physical health was monitored throughout, no concerns were identified, and all positions were maintained for the shortest duration necessary to ensure safety and dignity. Alternative seclusion exit training is embedded in both four-day initial and two-day annual refresher RRPI training. Where required, the RRPI trainers attend the wards to offer support for individual cases that may require a bespoke care plan.
- For risk assessments and care plans, the Trust's aim is to work towards achievement of 95% against each of these standards. The metrics do show an overall increase in performance, however 95% has not been achieved across all 5 metrics in all areas – detail can be seen in the care group and ward level sections of the report. All risk assessments and care plans that have not been completed within the timescale have oversight and scrutiny from the Care Groups.
- Forensic risk assessments are completed prior to admission as part of the admission assessment and planning process. In line with good clinical practice these are then reviewed at the point of admission to ensure they are still clinically accurate, the admitting clinician will record this review within the risk assessment going forwards, which will enable capture of risk assessment. This is alongside the required Historical, Clinical Risk Management 20 tool (HCR20) required for a patient in forensics.
- All services are focusing on continuing to improve performance for risk assessments. Staying Safe plans are now captured as part of the My Care and Safety Plan, rather than the FIRM risk assessment. There is a high level of scrutiny when a staying safe care plan is not completed within 24 hours. At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed and communicated to the service user and ward staff. There is development work occurring with community teams to ensure they update the risk assessment before admission to support inpatient staff to understand the change in risk and reason for admission.

Patient Safety Incident Response Framework (PSIRF)

The review of the Trust's PSIRF plan and policy is currently underway. Several workstreams have been underway to revise procedures, processes in response to reflects on the past 2 years of working under PSIRF. The draft PSIRF plan is currently being finalised for approval.

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Quality & Safety Headlines Cont...

Quality & Safety Dashboard Footnotes:

1 - Number of pressure ulcers which developed under SWYPFT 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. 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 – Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement - 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. Please note, the wording of this metric has changed from the November 2024 report to align with wording used in the national reporting. This relates to complaints received during the month and until investigation process is complete, this may result in not all of those being upheld.

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.

16 - Formal complaints should be responded to/closed within 6 months of the date received as is written into the NHS Complaints (England) Regulations 2009

* - figure may be refreshed in following month due to a potential duplication issue.

Summary

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National Metrics

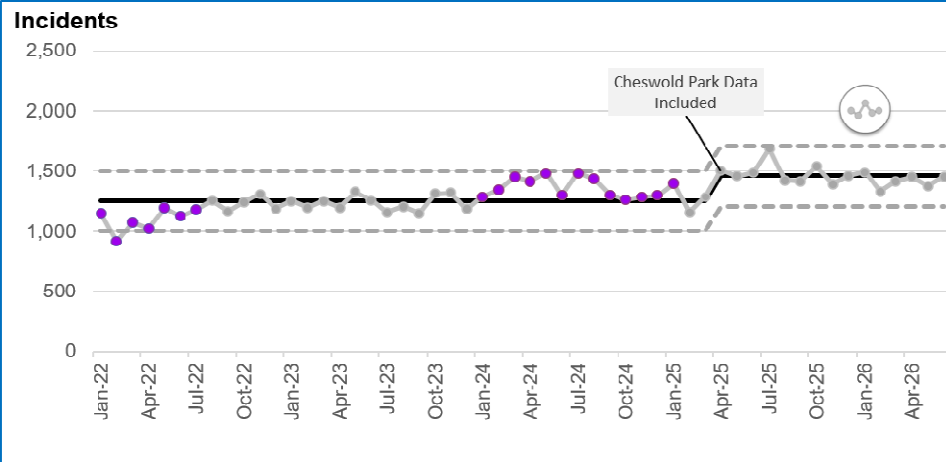
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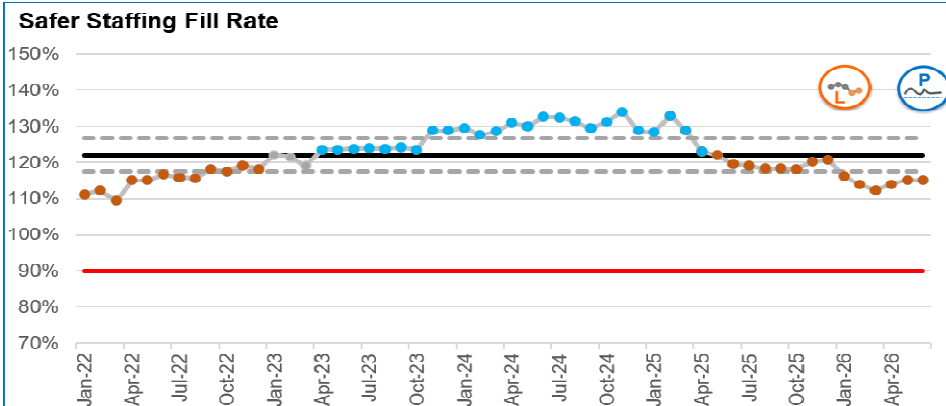
Statistical process control charts

Incidents



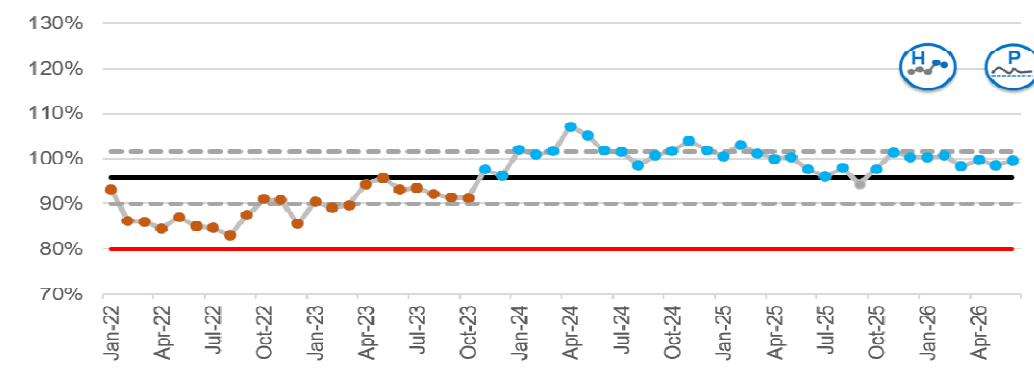
We have recalculated the chart from April 2025 due to the inclusion of Cheswold Park Hospital data. The chart shows that we are in a period of common cause variation (no concern). It should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. We encourage reporting 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. 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 Trustwide learning events, briefing papers and the production of Situation Background Assessment Recommendation (SBARs).

Safer Staffing Inpatients



The chart above shows that in June 2026 we remain in a period of special cause concerning variation (something is happening and should be investigated). There has been an increase in demand which means more shifts are being requested, there has been a smaller increase in the number of shifts being filled however this is being outstripped by demand and that means that the number of unfilled shifts is actually increasing. Put into the mix the very deliberate reduction of agency this all leads us to where we are at the moment.

Safer Staffing Registered Nurses



The chart above shows that in June 2026 we remain in a period of special cause improving variation (something is happening and this should be investigated) and we are expected to meet the target.

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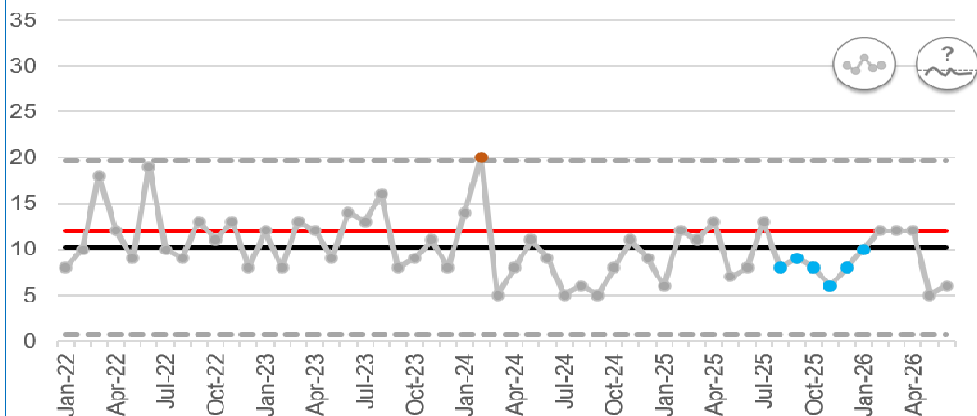
Ward Detail

Finance/Contracts

Statistical process control charts

Information Governance (IG)

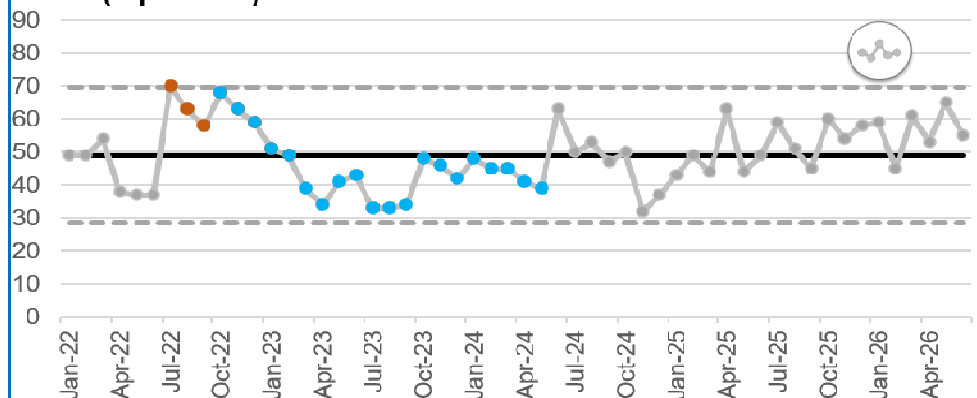
Information Governance Breaches



This SPC chart shows that as at June 2026 we have remain in a period of common cause variation (no concern).

Falls (Inpatient)

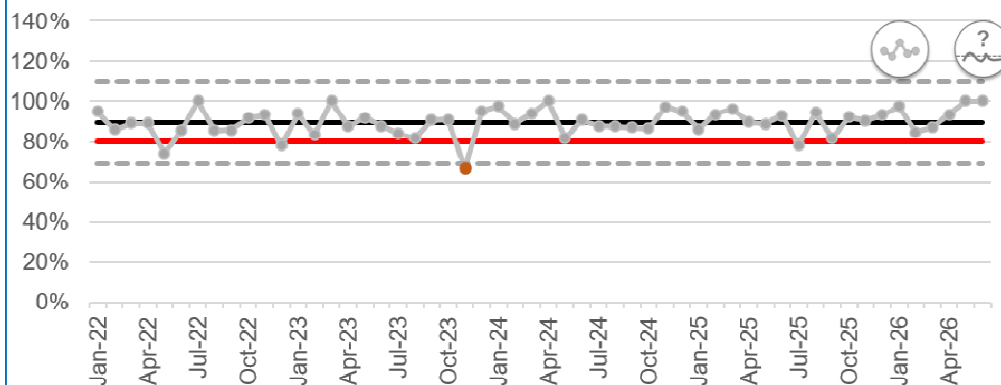
Falls (Inpatients)



The SPC chart above shows that in June 2026 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

End of Life



The chart above shows that in June 2026 the performance against this metric remains in common cause variation (no concern). The performance for the month remains above the target.

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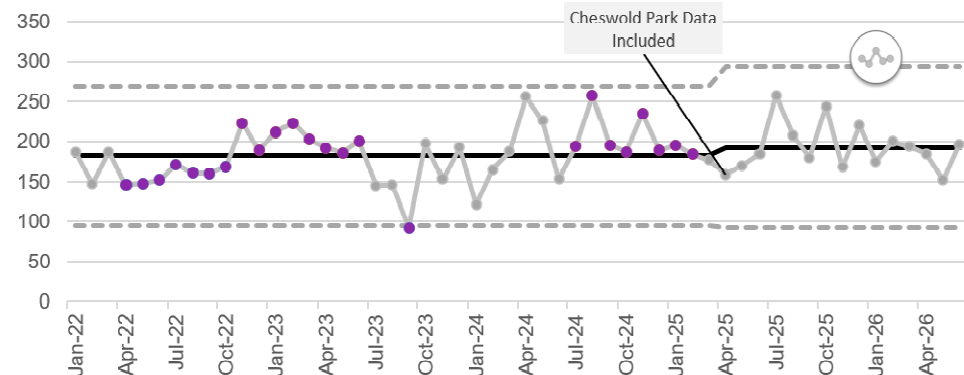
Ward Detail

Finance/Contracts

Statistical process control charts

Restraints

Total Restraint Incidents

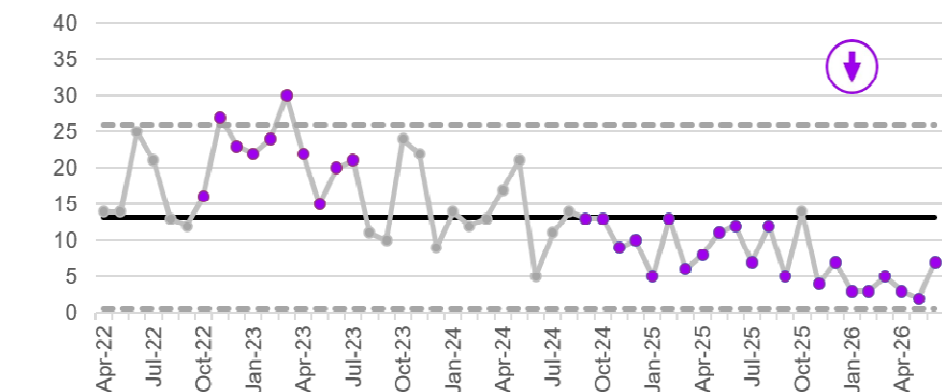


This SPC chart shows that in June 2026 we remain in a period of common cause variation (no concern).

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

We have recalculated the chart from April 2025 due to the inclusion of Cheswold Park Hospital data.

Prone Restraint (Total Number)

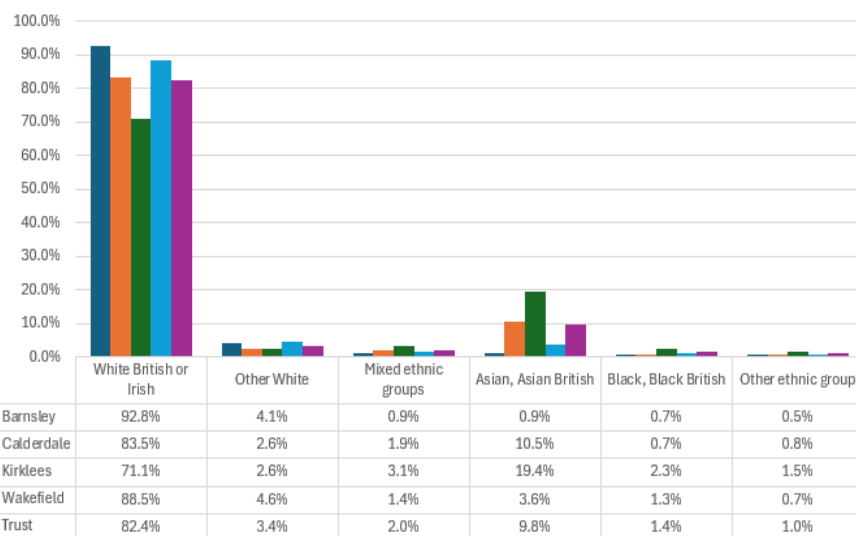


The total number of prone restraints continues to show a decreasing special cause variation in line with the continued work to reduce prone restraints. Six of the seven prone restraints in June 2026 were staff led.

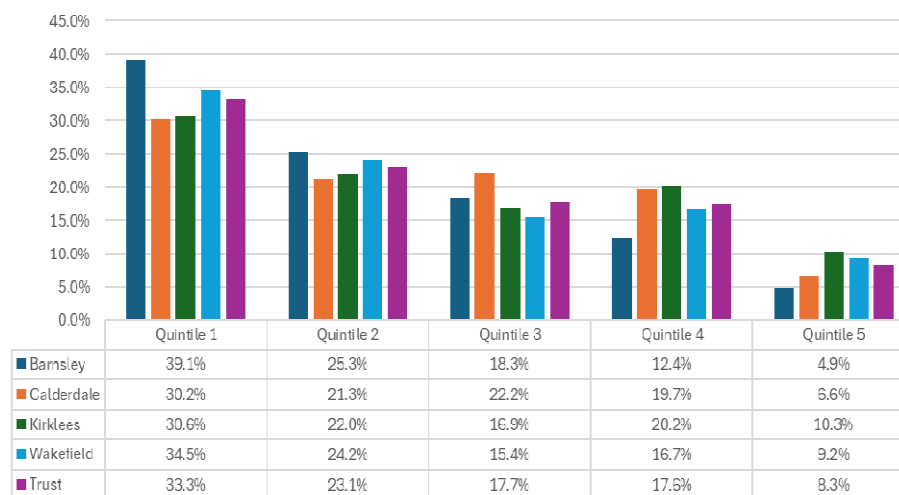
Reducing Inequalities

This section of the report has been added to give focus to a number of metrics to evidence our progress towards delivering more responsive and equitable services for our communities and will guide us to being an inclusive employer where everyone can be themselves and feel valued for their contribution. We will continue to further develop this section of the report over the coming months in line with the deployment of our Equality, diversity and inclusion (EDI) strategy.

Population Served by the Trust and each of its Main Localities Split by Ethnicity



Population Served by the Trust and each of its Main Localities Split by Deprivation Level

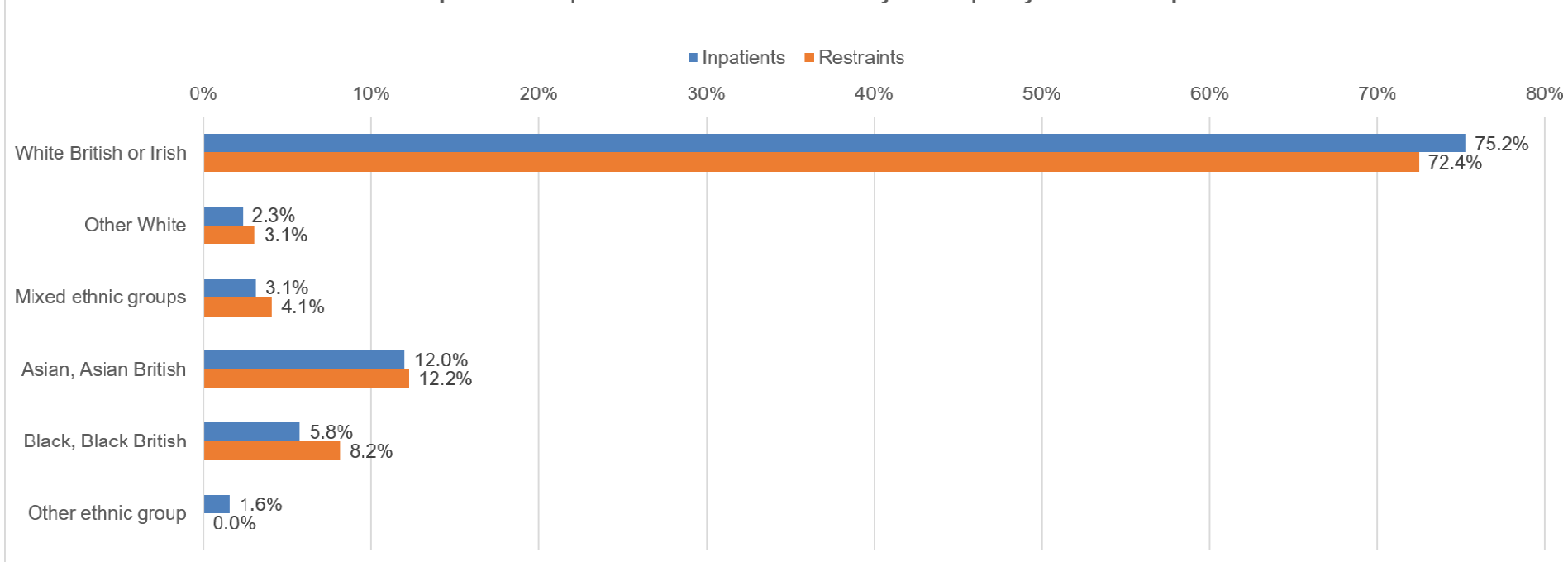


The data on this page will not be refreshed except when population estimate data is published. However this page helps to provide important context about the varied population our Trust serves in terms of ethnic make-up and levels of deprivation. We can measure the relative deprivation of an area using 7 distinct domains of deprivation, which are: 1) Income 2) Employment 3) Health deprivation and disability 4) Education, skills & training 5) Crime, 6) Barriers to housing and services, 7) Living environment. These can be examined individually or collectively and as a collective these are known as Indices of Multiple Deprivation (IMD). IMD can be shown grouped as quintiles or deciles (5 levels or 10 levels respectively), with IMD 1 (quintile or decile) being the most deprived. From the Trust data it is possible to see that a significant proportion of all our populations experience higher levels of deprivation. The charts below show the populations of the main areas we serve as well as a Trust total split by Ethnicity and deprivation level.

Reducing Inequalities

The data on this page continues to be developed and in this edition only data for May 2026 is included. We are working to refresh this and looking to adopt a 12m rolling data review to provide more meaningful actions. The purpose of this data is to understand whether there is any disproportion in the proportional levels of restraint experienced by inpatients of different ethnic groups. The population of the Trust split by ethnic group is shown alongside for ease of comparison. Early conversations are underway to aid the identification and understanding of some of the context around protected characteristics as part of restraint, seclusion, and other restrictive practices. Specific actions relating to this data will be formulated and held in governance via the EDI Operational Group.

Proportion of Inpatients and Restraints in May 2026 Split by Ethnic Group



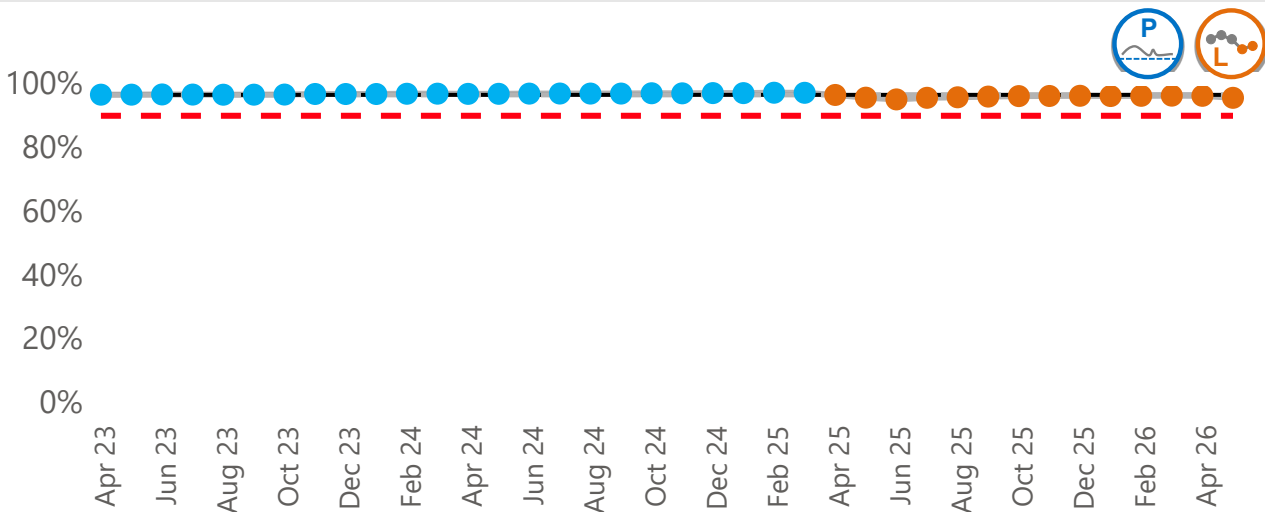
Reducing Inequalities

Data as of : 16/06/2026 12:02:49

In order to ensure equitable access to our services it is important to monitor the levels of our service users who have their equality data, such as ethnicity, disability status, sexual orientation, and postcode, completed. Data quality is vital to ensure we are able to offer services the meet the needs of the populations we serve. A priority area of equality diversity and inclusion has been agreed at EMT to align to strategic priority programmes to Improve our Clinical Pathways, apply the Patient Carer Race Equality Framework core actions to reduce the gap in inequalities and improve access, experience and outcomes for communities faring worse across all of our mental health, learning disability and community health services. This work involves the specific focus of improving the systematic collection and analysis of data (both numbers and voice) according to protected characteristics and continue to promote ‘All of You’ campaign. All services continue to work hard to maintain their data quality and future monitoring will form a standing agenda item in Care Group Data Quality meetings with specific actions held in governance via the EDI Operational Group.

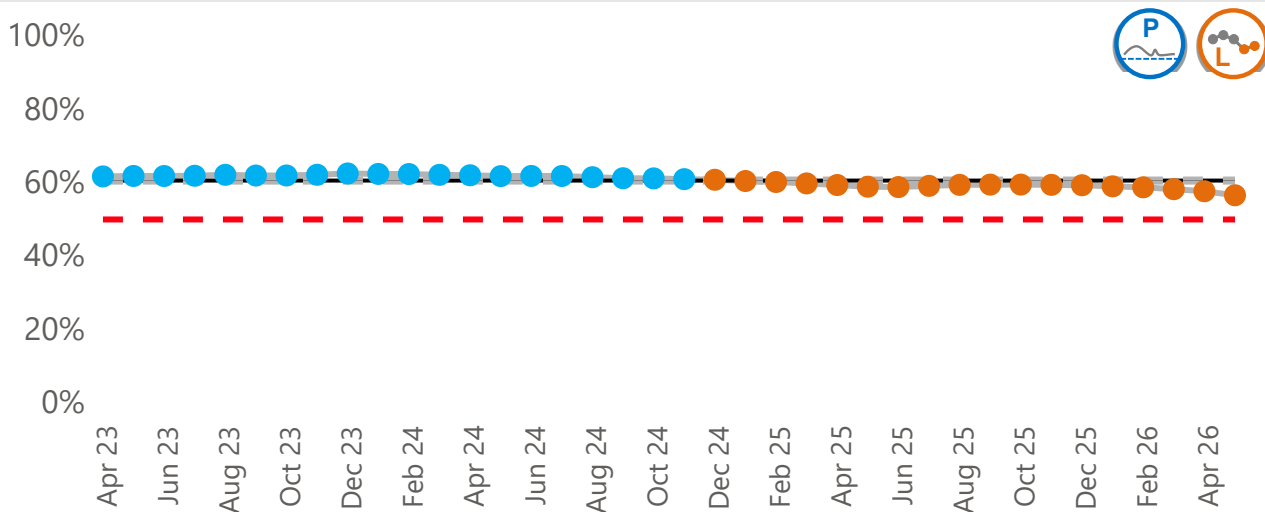
The SPC charts below show the completion rates for these measures.

M92 - Percentage of service users who have had their equality data recorded - ethnicity



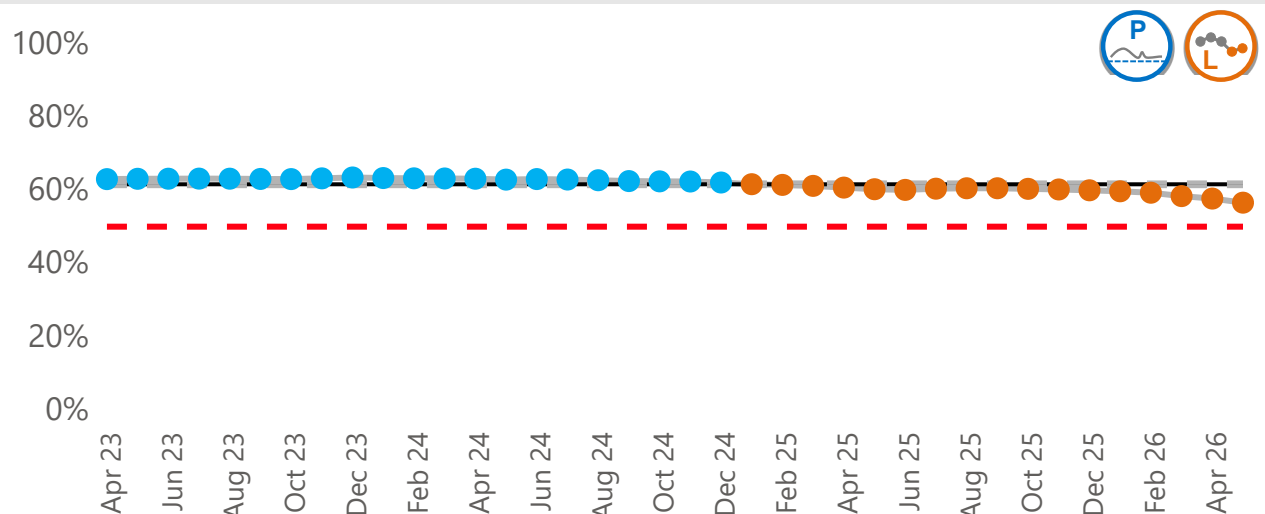
The Statistical Process Control (SPC) chart shows that in April 2026 due to the continued dip in performance we remain in a period of special cause deteriorating variation (something is happening and should be investigated). We are expected to meet the target against this metric.

M93 - Percentage of service users who have had their equality data recorded - disability



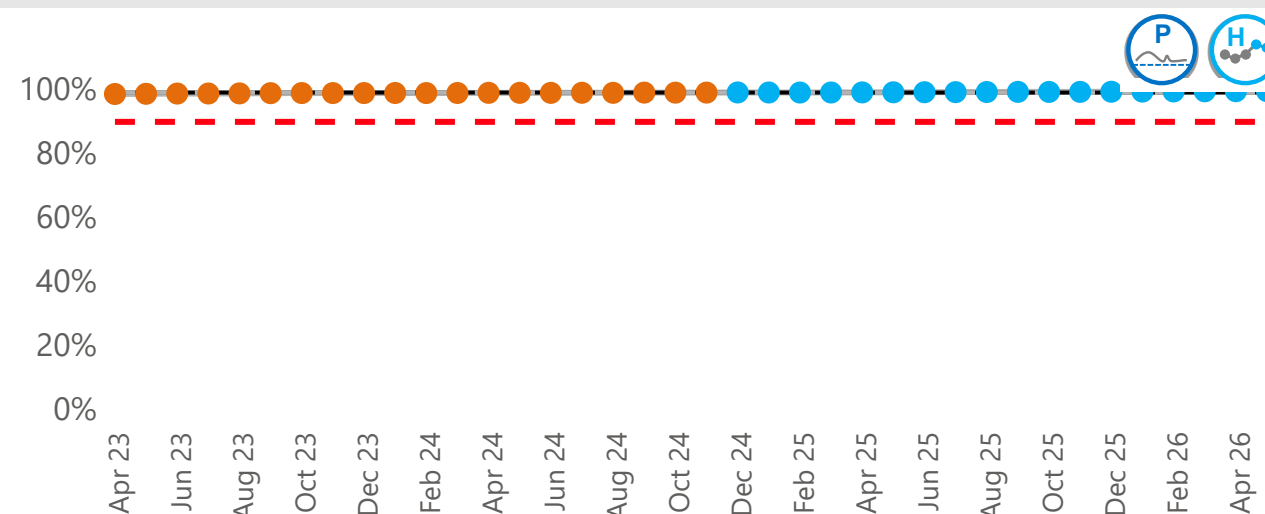
The SPC chart shows that in April 2026 we remain in a period of special cause deteriorating variation (something is happening and should be investigated) following a sustained decline in performance over the past 12 months. We are expected to meet the target against this metric. There are a number of service lines where data quality has reduced over the last 12 months and further work is being done to understand the contributing factors and direct improvement.

M94 - Percentage of service users who have had their equality data recorded - sexual orientation



The SPC chart shows that in April 2026 we remain in a period of special cause deteriorating variation (something is happening and should be investigated) following a sustained decline in performance over the past 12 months. We are expected to meet the target against this metric. There are a number of service lines where data quality has reduced over the last 12 months and further work is being done to understand the reasons for this.

M95 - Percentage of service users who have had their equality data recorded - deprivation (postcode)



The SPC chart shows that in April 2026 we remain in a period of special cause improving variation (something is happening and should be investigated) following a sustained increase in performance. We are expected to meet the target against this metric.

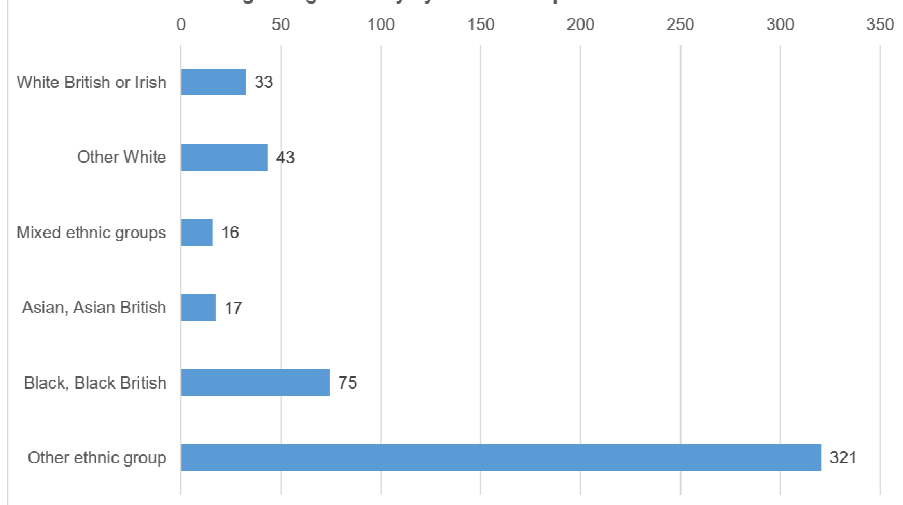
Reducing Inequalities

The charts show the average lengths of stay (ALOS) for our Acute and PICU, adult and older adults wards, for the financial year 2026/2027 (excluding 136 Suite and out of area stays). This data is calculated at the point of discharge and is therefore affected by skew where a patient is discharged following an extended LoS. It is noted that the data below only includes data from April 26. We are working to refresh this and looking to adopt a 12m rolling average review.

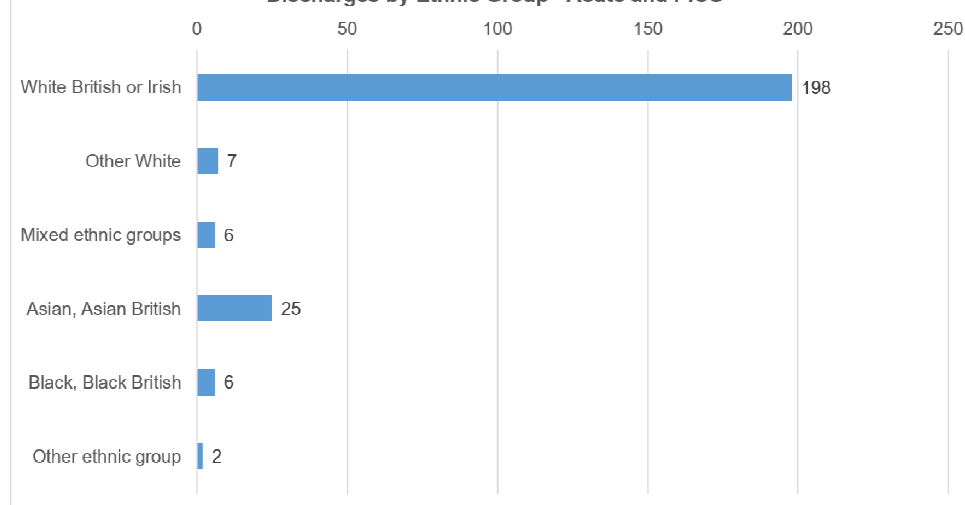
Our review of inpatient length of stay (LoS) data highlights important patterns. Employing our quality improvement methodology and data driven approach we have been able to identify opportunities for further understanding. Examining variance of the median LoS (alongside the traditional measure of mean) has enabled us to have a better understanding of the average length of stay which accounts for the differences in cohort size. We have identified that LoS appears to vary significantly across clusters of conditions when reviewing the characteristics of individuals e.g. deprivation and ethnicity.

Differences in admission practices i.e. formal (compulsory) and informal (voluntary) also appear to influence LoS, with compulsory admissions tending to require more intensive interventions and longer discharge planning. Similarly, discharge approaches differ, with patients facing socioeconomic challenges or limited community support experiencing delays. Using the Trust's improvement methodology, insights are being derived and helping to identify systemic drivers and opportunities for change. Work is currently underway to engage with service users to understand their experiences. The first phase of this work is to engage with service users who have been admitted via A&E. The findings from this work will continue to be shared with the Acute Pathways and Inpatient Improvement Programme Steering Group and the Improving Access to Care Group to ensure informed decision making and opportunities for sharing good practice can be maximised. This will help us to plan and generate ideas that will inform targeted actions, ensuring that improvements in admission and discharge processes, culturally competent care, and partnership working are embedded across services.

Average Length of Stay by Ethnic Group - Acute and PICU



Discharges by Ethnic Group - Acute and PICU



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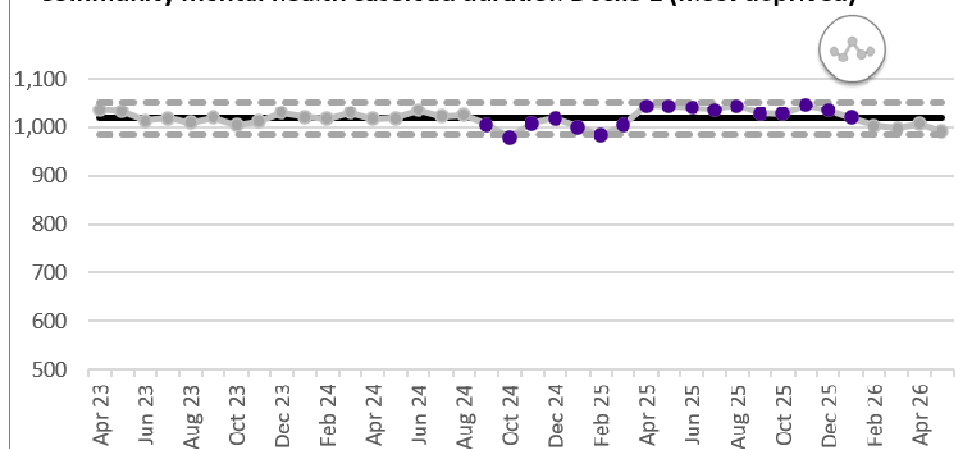
Ward Detail

Finance/ Contracts

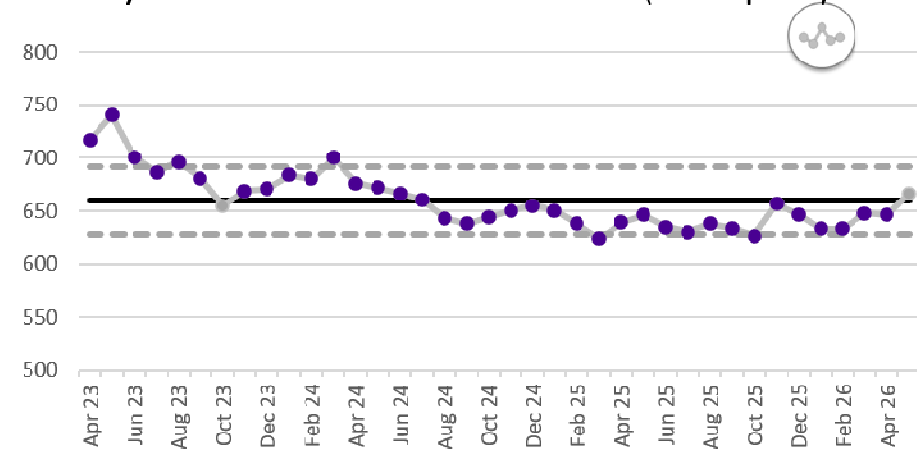
Reducing Inequalities

The charts below show the average caseload length for patients on the caseload of a community health team by those with a post code in the most deprived areas (Decile 1) and those with a post code in the least deprived areas (Decile 10). This data has remained consistent since 2023 and work is underway to understand the service areas for which there is the greatest variance. This work will also encompass and expand on our place data shown on the next page. Work is underway to understand the May increase in caseload duration for those in IMD10, however early indications are that this may be part of a subtle annual variation linked to service user choice, rather than service change.

Community mental health caseload duration Decile 1 (most deprived)



Community mental health caseload duration Decile 10 (least deprived)

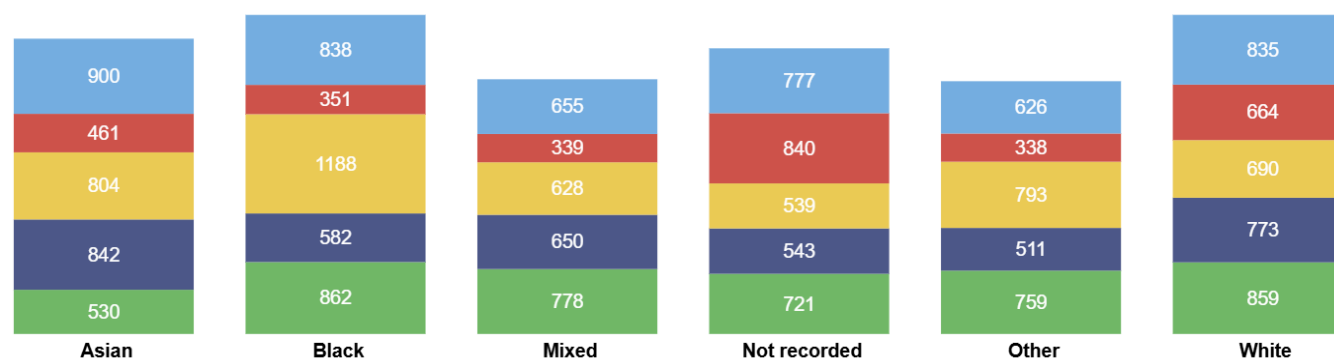


Reducing Inequalities

The charts below show the average caseload length (days) for the group of patients on a community mental health caseload split by ethnic group, and deprivation decile, and also split by Place. We can see that the pattern of lower duration on caseload in IMD10 is mirrored accross all our places. Further work is underway to direct future work but it is important to remember that for the data on this page, the different number of service users in each group (IMD or ethnicity) is different in each place and comparisons are therefore representative, rather than a direct comparison.

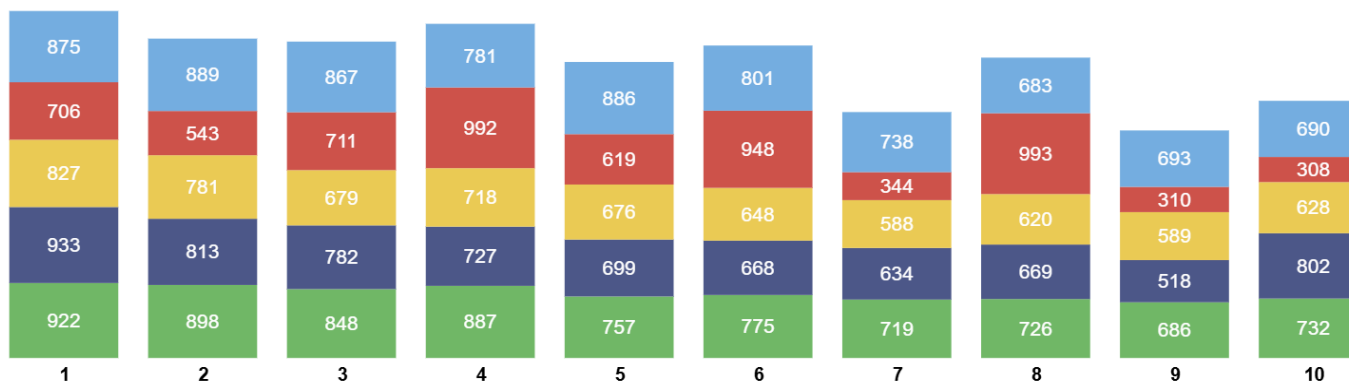
Average Days on Caseload Split by Ethnic Group and Place - Mental Health Rolling 12 Months

Place ● Barnsley ● Calderdale ● Kirklees ● Other ● Wakefield



Average Days on Caseload Split by Deprivation Decile and Place - Mental Health Rolling 12 Months

Place ● Barnsley ● Calderdale ● Kirklees ● Other ● Wakefield



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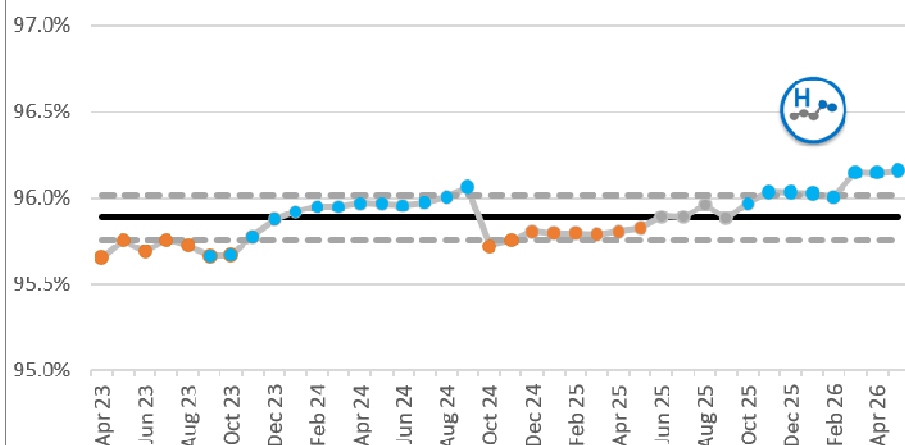
Finance/
Contracts

Reducing Inequalities

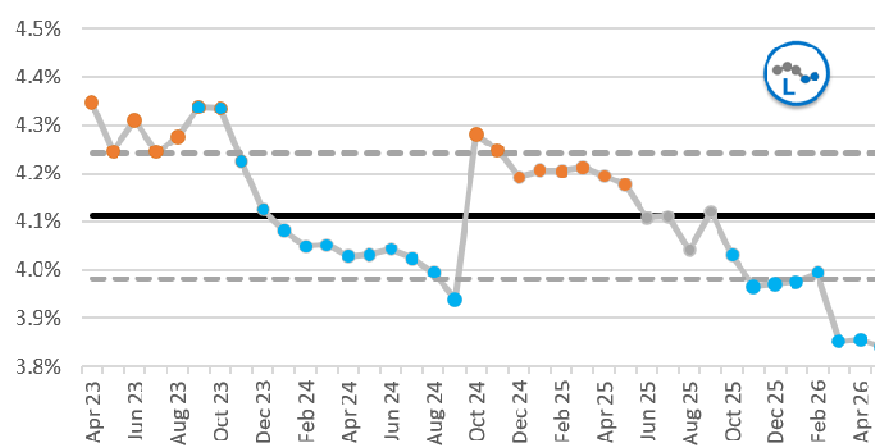
Disability Confidence and Data Transparency

Objective: Foster a culture where more colleagues feel safe and supported in disclosing their disability status.

Percentage of staff who have had their disability status recorded



Percentage of staff who have a disability status of 'unknown' recorded



Further development of people related metrics will be undertaken over the coming months with focus being on the following areas: Increase Diversity in Senior Leadership, Fair and Trusted Processes, Wellbeing with Inclusion at the Core.

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People - Performance Wall

Trust Performance Wall									
	Strategic Objective	CQC Domain	Threshold	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Vacancy Rate	Best place to work and learn	Well led	8%	Reporting Commenced April 2026			6.4%	6.6%	6.2%
Turnover external (12 months rolling)	Best place to work and learn	Well led	25/26 - 13% 26/27 - 10%	9.1%	9.0%	8.2%	8.4%	9.3%	9.0%
Starters	Best place to work and learn	Well led	-	51.4	47.5	39.0	37.3	14.8	39.6
Leavers	Best place to work and learn	Well led	-	29.0	35.6	36.2	28.9	39.3	25.7
Proportion of staff in senior leadership roles who are from ethnic minority background (relates to staff in post band 7 and above, excludes bank staff and medics) *	Best place to work and learn	Well led	-	125 (10.8%)	125 (10.8%)	131 (11.2%)	132 (11.2%)	134 (11.4%)	132 (11.2%)
Proportion of staff in senior leadership roles who were women (relates to staff in posts band 7 and above, excludes bank staff)	Best place to work and learn	Well led	-	962 (71.8%)	975 (72.1%)	986 (72.2%)	985 (72.3%)	985 (72.3%)	985 (72.4%)
Sickness absence - Year-to-Date (YTD)	Best place to work and learn	Well led	<=5%	5.5%	5.5%	5.4%	4.9%	4.9%	5.0%
Sickness absence - Month	Best place to work and learn	Well led		5.8%	5.2%	4.9%	4.9%	4.8%	5.3%
Appraisals - rolling 12 months	Best place to work and learn	Well led	90%	89.2%	87.8%	88.7%	92.2%	92.8%	93.5%
Carbon Impact (tonnes CO2e) - business miles	Best use of resources	Well led	<76	69	66	60	64	65	64
Sexual Safety Incidents - Staff	Best place to work and learn	Safe	Trend Monitor	Reporting Commenced April 2026			0	0	0
Mandatory Training - TOTAL	Best place to work and learn	Well led	>=80%	95.4%	95.3%	95.3%	95.2%	95.4%	95.0%

Our workforce supply

Turnover

June 2026 turnover was 9.0%, which is below the target. However, turnover in the Support Services (10.5%) and Forensic Services (12.1%) Care Groups remained above the target. Turnover has decreased across all Care Groups compared with the previous month.

Vacancy Rate

The vacancy rate decreased slightly in June 2026, driven by a higher number of starters than leavers. As a result, the overall workforce increased during the month. Within the Forensic Care Group, the CPH teams continue to experience a high level of vacancies, particularly within the CSW workforce. A targeted recruitment campaign is currently underway to help reduce these vacancies.

We are safe and healthy

Sickness Absence

The overall monthly sickness absence rate increased in June 2026; however, the year-to-date rate remains within the KPI target at 5.0%. Both long-term and short-term sickness absence levels are slightly higher than those recorded at the same point last year. Absences related to gastrointestinal illness and anxiety/stress increased during June 2026. People Business Partners (PBPs) are working closely with areas reporting sickness absence rates below the KPI target, in partnership with the People Relations team, to strengthen the management of long-term absence and improve overall attendance performance. Care group sickness absence levels can be seen in the care group section of the report. There are some higher levels of absence across support services (estates and facilities, people directorate, nursing qualities and professions directorate).

Employee Relations

Although there are currently three suspensions exceeding 90 days, all cases are being actively managed by the Deputy Chief People Officer in collaboration with the People Relations team to ensure appropriate oversight and progress.

We are compassionate and inclusive

Appraisal Compliance

In June 2026, appraisal compliance was 93.5%, achieving the Trust's KPI target. This figure includes a number of employees who are due an appraisal and are currently transitioning to the new appraisal window system. A new dashboard has been introduced to support the implementation of this process, and all outstanding appraisals are expected to be completed by the end of September 2026. The Forensic Care Group remains below the KPI target, with a compliance rate of 80.9%, and continues to be a key area of focus.

Training Compliance

Overall compliance across the Trust remains above the KPI target. However, while Information Governance compliance improved to 94.7% in June 2026, it remains below the required KPI target. A continued focus on improving compliance within the Support Services Care Group is expected to increase Information Governance compliance and further strengthen overall Trust performance.

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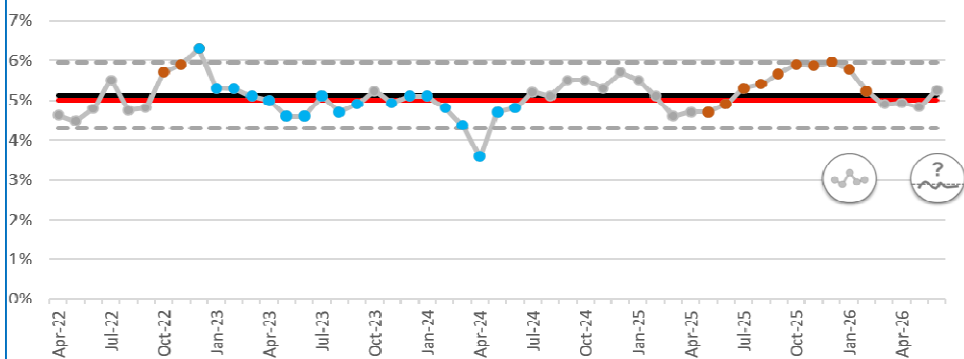
Care Groups

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Finance/ Contracts

Statistical process control charts

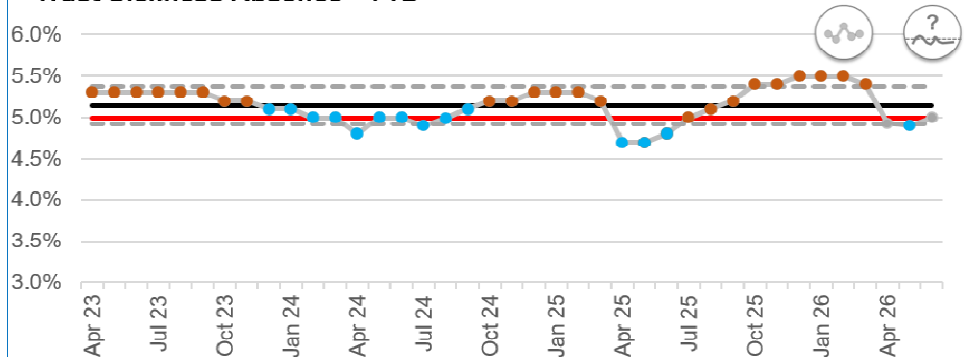
Trust Sickness Absence - In Month



The SPC chart shows that in June 2026 we remain in a period of common cause variation (no concern) following a decrease in the sickness rate.

From April 2025 this data includes Cheswold Park Hospital.

Trust Sickness Absence - YTD



The SPC chart shows that in June 2026 we have entered a period of common cause variation (no concern) following a decrease in the sickness rate.

From April 2025 this data includes Cheswold Park Hospital.

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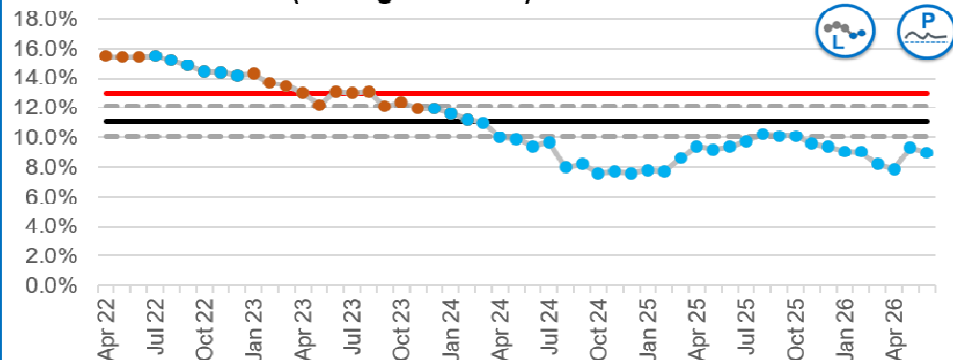
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Trust Staff Turnover (Rolling 12 month)

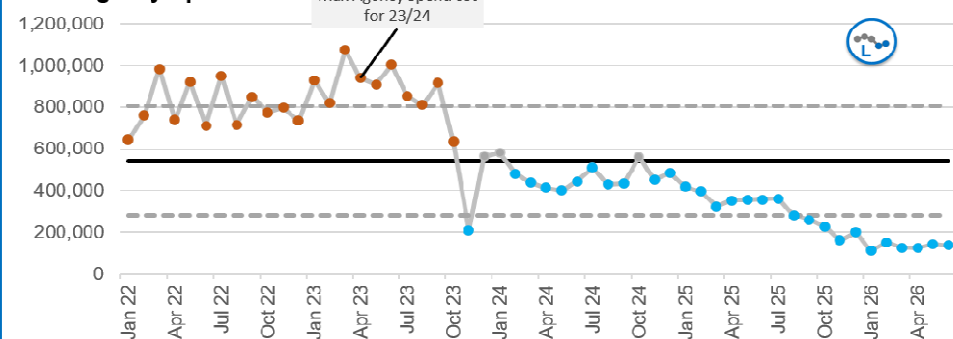


In June 2026 overall Trust turnover was 9.0%, which is below the target of 10%. There are some areas experiencing a higher level of turnover such as Support Services (10.5%) and Forensic care group (12.1%) . Turnover has decreased across all Care Groups compared with the previous month.

The SPC chart shows that we remain a period of special cause improving variation (something is happening and this should be investigated) following an overall decrease in the turnover percentage.

From April 2025 this data includes Cheswold Park Hospital.

Trust Agency Spend



Agency spend is currently being maintained at a historically low level. Spend in June 2026 is £138k, within plan and is constricted to a limited number of medical posts. This is forecast to increase over the coming months due to pending staff retirements.

The SPC chart shows that due to the sustained overall reduction in spend, in June 2026 we remain in a period of special cause improving variation.

From April 2025 this data includes Cheswold Park Hospital.

Please see the Finance Report for further information.

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Headlines

- 88% of the medics that were due to have an appraisal in quarter 1 were appraised within the timeframe.
 - Of the 4 medics that were not appraised in time, the main themes were sickness, imminent retirement and lack of time of the appraiser.
- 100% of revalidation recommendations were made.
- No active concerns under the Maintain High Professional Standards procedures.

MEDICAL APPRAISALS	Q1
Number of doctors due to have an appraisal meeting in the reporting period	44
Number undertaken in period	40
Number not undertaken for which the RO accepts postponement is reasonable	4
Percentage of appraisals taken place and submitted on time	88%

MEDICAL REVALIDATIONS	Q1
Number of revalidation recommendations due in period	10
Number of positive recommendations	10
Number of deferrals	0
Number of non-engagements	0
Percentage of revalidation recommendations made	100%

RESPONDING TO CONCERNS	Q1
Number of active cases under Maintaining High Professional Standards procedures	0

National Metrics

Data as of : 22/07/2026 15:26:13

South West
Yorkshire Partnership
NHS Foundation Trust

This section of the report includes the Trust performance against a range of national operational metrics including national priorities, operational planning and NHS Oversight Framework performance.

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26
M1	Incomplete Referral to Treatment (RTT) pathways of 52 weeks or more	Best Quality	Responsive		0			0	0	0	0	0	0	0	0	0	0	0	0
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive		92%			97.7%	97.5%	97.2%	97.1%	97.8%	97.5%	96%	95.6%	96.4%	97.5%	97.5%	97.1%
M204	RTT waiting list within 18 weeks (monthly RTT data)	Best Quality	Responsive		3680			4151	4319	4554	4641	4514	4287	3868	3946	4162			
					4043												4273	4354	4454
M206	Diagnostic test activity	Best Quality	Responsive		190			206	239	305	273	247	263	294	235	265			
					193												249	205	277
M171	% Admissions gate kept by crisis resolution teams	Best Quality	Safe		95%			98.7%	96.3%	100%	98.9%	100%	100%	100%	100%	99.1%	100%	100%	98.2%
M2	Inappropriate out of area bed days	Best Quality	Responsive		0			196	203	234	155	97	76	52	28	73	90	82	137
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	Best Quality	Responsive		5			7	8	7	3	4	2	1	1	2	2	2	6
M7	72 hour follow-up from psychiatric in-patient care	Best Quality	Safe		80%			91.1%	88.6%	88.2%	89.0%	87.8%	87.6%	91.1%	87.7%	87.3%	86.5%	87.2%	86.7%
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Best Quality	Effective		60%			95.5%	87.5%	93.3%	94.7%	96.4%	96.9%	89.7%	96.4%	96.2%	85.3%	86.8%	90%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months	Best Quality	Effective		95%			96.0%	96.1%	96.4%	96.9%	96.7%	97.4%	97.0%	96.6%	96.5%	95.9%	96.7%	97.1%
M34	% Clients in settled accommodation	Best Value	Effective		60%			82.9%	76.0%	82.8%	82.9%	83.3%	83.0%	83.0%	83.2%	83.2%	82.9%	83.4%	82.7%
M35	% Clients in employment	Best Value	Effective		10%			13.3%	12.6%	13.3%	13.6%	14.0%	13.7%	14.0%	14.1%	14.2%	14.1%	14.2%	13.6%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0			0	0	6	16	2	4	0	2	4	12	25	1
M9	Total number of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0			0	0	1	1	1	1	0	1	1	1	2	1

National Metrics

Data as of : 22/07/2026 15:26:13



MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	Best Quality	Effective		95%			100%	100%	100%	100%	75%	100%	100%	100%	100%	100%	100%	100%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	Best Quality	Effective		95%			81.4%	88.2%	83.8%	94.4%	94.4%	92.9%	91.2%	100%	89.7%	95%	100%	92.3%
M47	Virtual ward occupancy	Best Quality	Responsive		80%			84%	89.3%	92%	74.7%	70.7%	72%	70.7%	85.3%	62.7%	108%	78.7%	86.7%
M188	Community services waiting list, over 52 weeks	Best Quality	Responsive		0			0	0	0	0	0	0	0	0	0	0	0	0
M30	Number of detentions under the Mental Health Act (MHA)	Best Quality	Safe					87	99	102	102	83	106	98	101	116	113	122	132
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin	Best Quality	Responsive					23.0%	24.2%	24.5%	22.5%	16.9%	17.0%	22.4%	13.9%	22.4%	24.8%	23.8%	22.0%
M10	Talking Therapies - Treatment within 6 Weeks of referral	Best Quality	Effective		75%			99.7%	99.4%	99.5%	99.3%	99.4%	98.9%	97.7%	98.9%	98.6%	99.8%	99.6%	98.1%
M11	Talking Therapies - Treatment within 18 weeks of referral	Best Quality	Effective		95%			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
M23	Talking Therapies - Completion of outcome data for appropriate Service Users	Best Quality	Well Led		90%			99.7%	99.6%	99.5%	99.5%	99.4%	98.1%	99.1%	99.3%	99.5%	99.3%	99.0%	99.1%
M178	Talking Therapies - Reliable Recovery	Best Quality	Effective		48%			53.4%	47.2%	52.5%	52.9%	48.7%	50.2%	50.1%	50.5%	54.0%	56.8%	54.2%	52.6%
M179	Talking Therapies - Reliable Improvement	Best Quality	Effective		67%			71.8%	65.8%	70.4%	70.5%	72.2%	68.5%	69.0%	69.7%	71.7%	73.2%	72.8%	70.1%
M15	Data Quality Maturity Index	Best Quality	Well Led		95%			99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.5%	99.5%	99.6%	99.7%	99.7%	99.1%
M43	Community health services two hour urgent response standard	Best Quality			70%			91.4%	92.1%	92.0%	87.3%	89.5%	88.5%	88.1%	88.7%	91.2%	89.9%	90.7%	88.9%

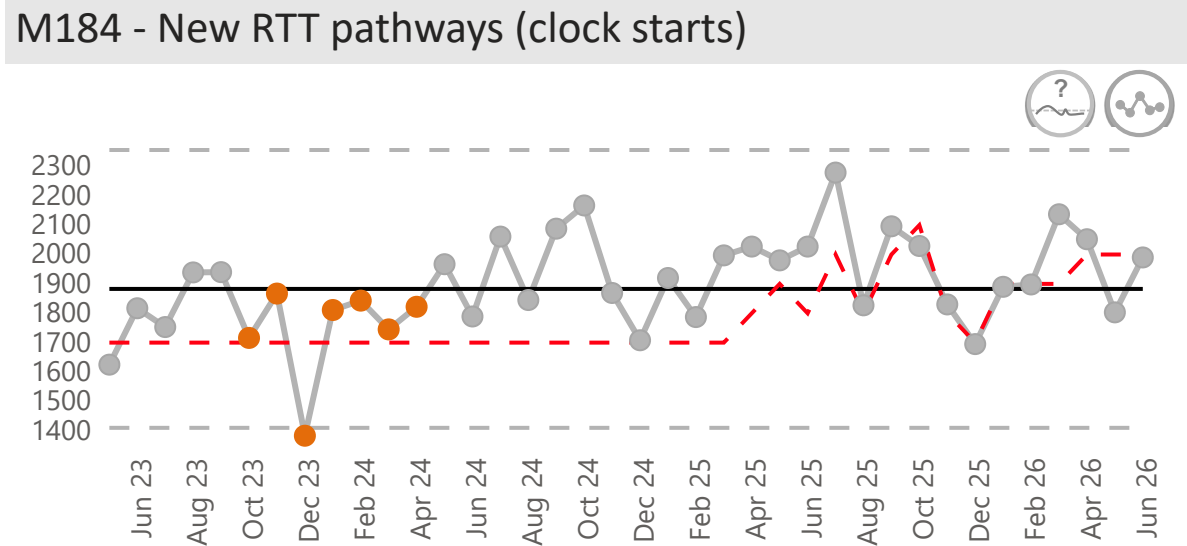
National Metrics

Data as of : 22/07/2026 15:26:13

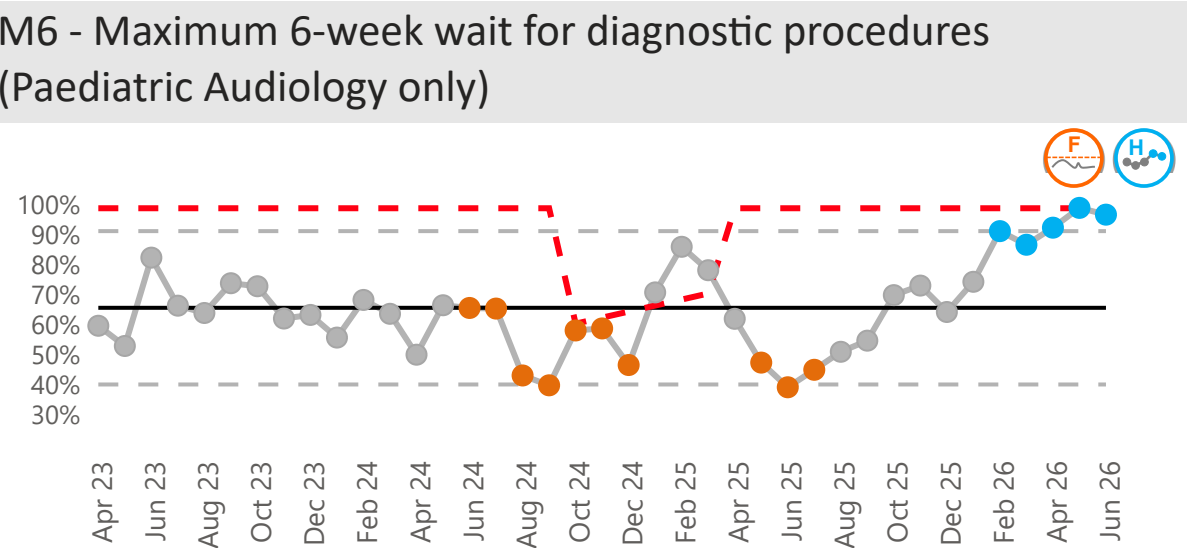
South West
Yorkshire Partnership
NHS Foundation Trust

The following metrics have Place based targets which have been updated for the 2026/2027 financial year. Data for the previous financial year therefore is no longer shown.

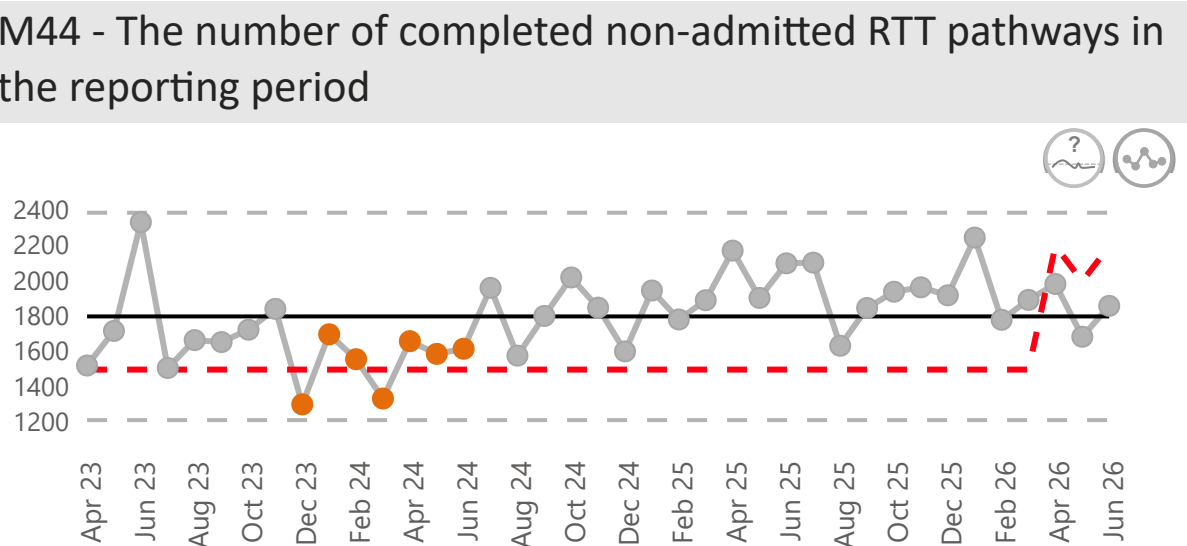
MetricID	Metric	Strategic Objective	CQC Domain	GroupCategory	GroupName	Target	Assurance	Variation	Apr 26	May 26	Jun 26
M4	Talking Therapies - proportion of people completing treatment who move to recovery	Best Quality	Effective	Trust	Trust	50%			59.9%	55.4%	55.1%
				Place	Barnsley	50%			59.4%	50.5%	52.8%
					Kirklees	50%			60.1%	58.9%	56.6%
M185	NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment	Best Quality	Effective	Trust	Trust				571	514	578
				Place	Barnsley	2451 Year end			219	206	218
					Kirklees	tbc			352	308	360
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months	Best Quality	Responsive	Trust	Trust	13400			15100	15082	15069
				Place	Barnsley	2900			2747	2689	2615
					Calderdale	1400			1501	1469	1483
					Kirklees	4800			5248	5300	5372
					Wakefield	4300			4775	4798	4765
M181	Women Accessing Specialist Community Perinatal Mental Health Services	Best Quality	Responsive	Trust	Trust				2098	2030	1968
				Place	Barnsley	283			344	333	334
					Calderdale	247			311	287	282
					Kirklees	541			760	738	711
					Wakefield	406			573	560	535



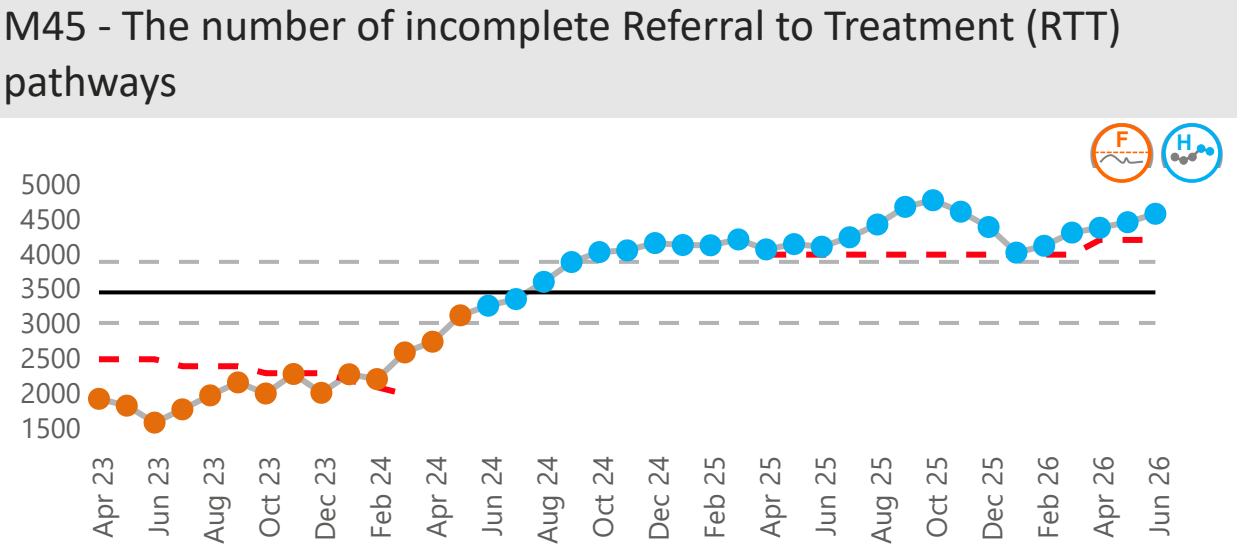
The Statistical Process Control (SPC) chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers. A new moving target is in place for 2025/26.



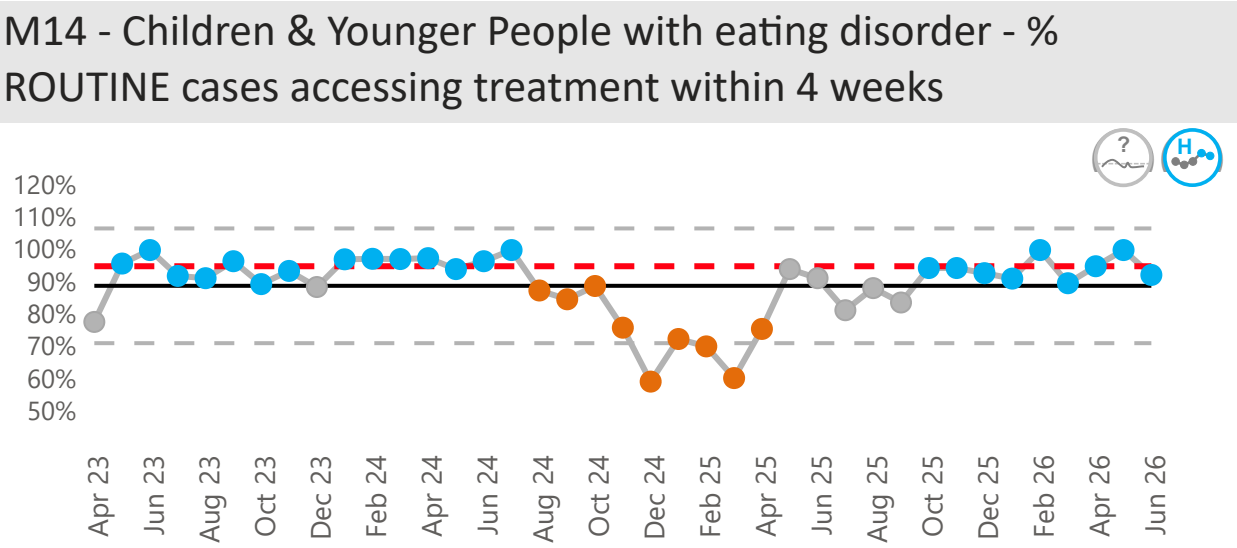
The SPC chart shows that we have entered a period of special cause improving variation (something is happening and should be investigated). Though we are not expected the meet the target of 99%.



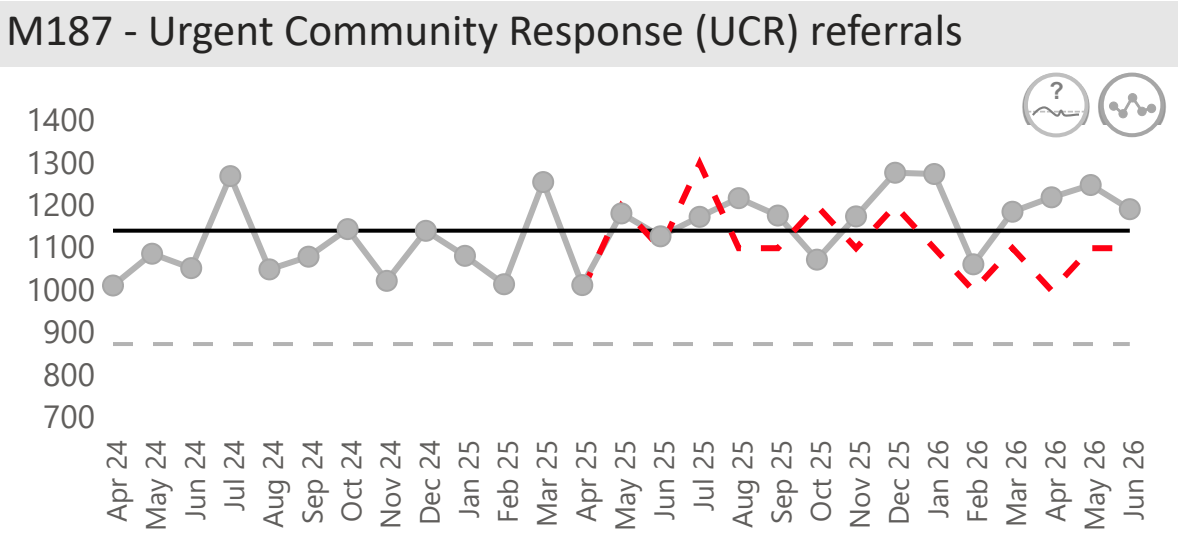
The SPC chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers this time last year.



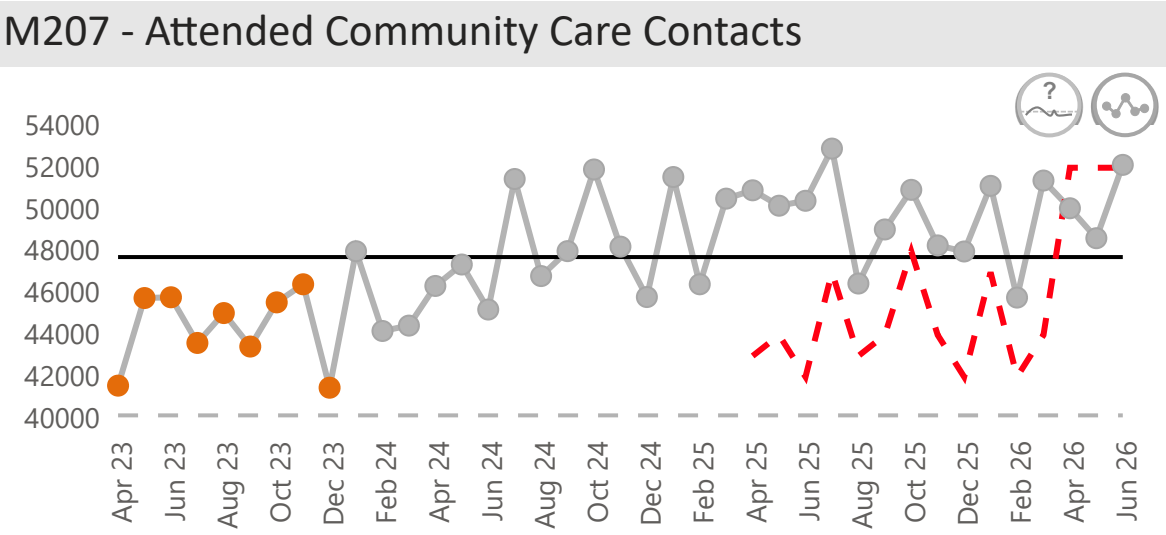
The SPC chart shows that we remain in a period of special cause concerning variation (something is happening and should be investigated) following a sustained increase in numbers of incomplete pathways over the past 12 months. We are not currently forecast to meet the target though current performance is above the target.



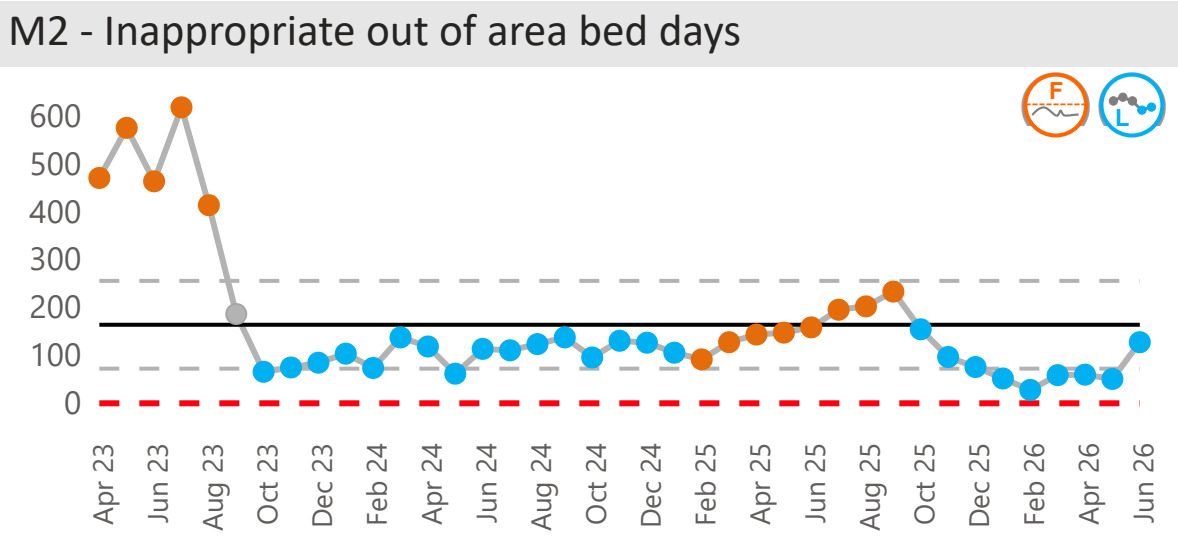
The SPC chart shows that we have entered a period of special cause improving variation (something is happening and should be investigated) following a continued increase in performance.



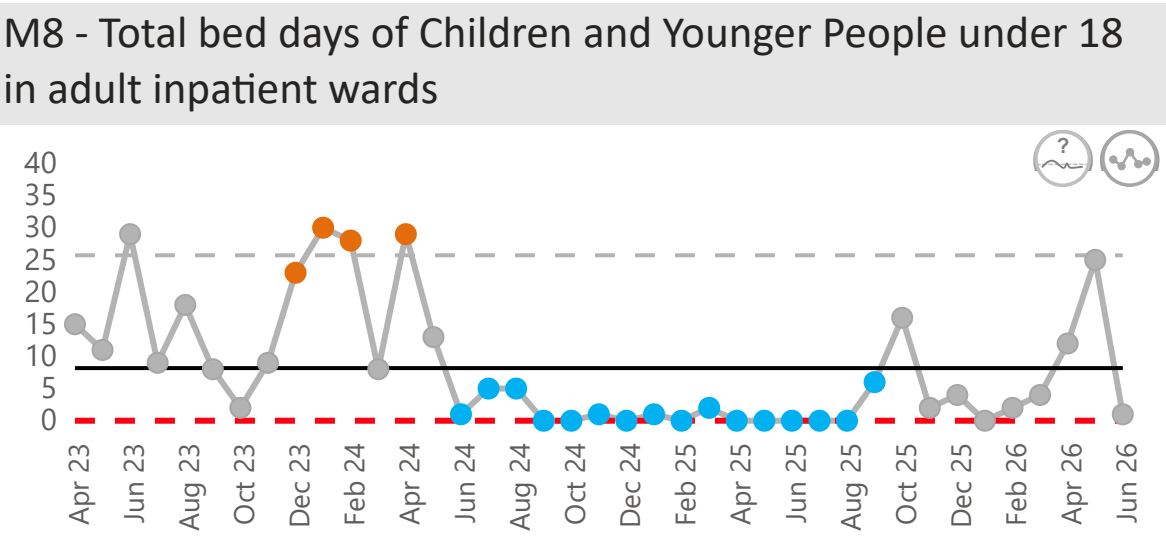
The SPC chart shows that we remain in a period of common cause variation (no concern).



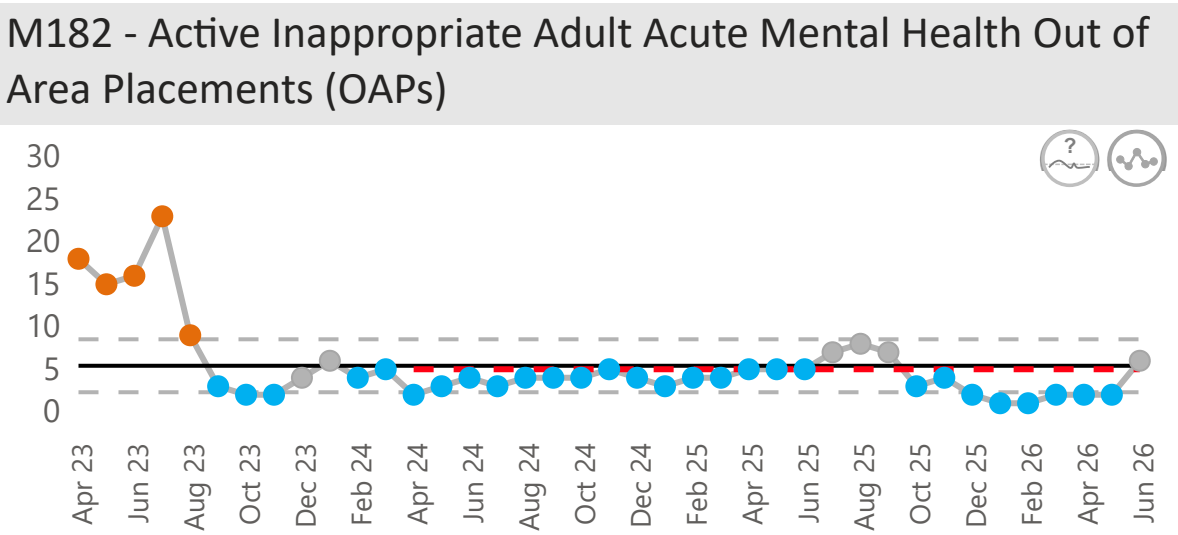
The SPC chart shows that we remain in a period of common cause variation (no concern).



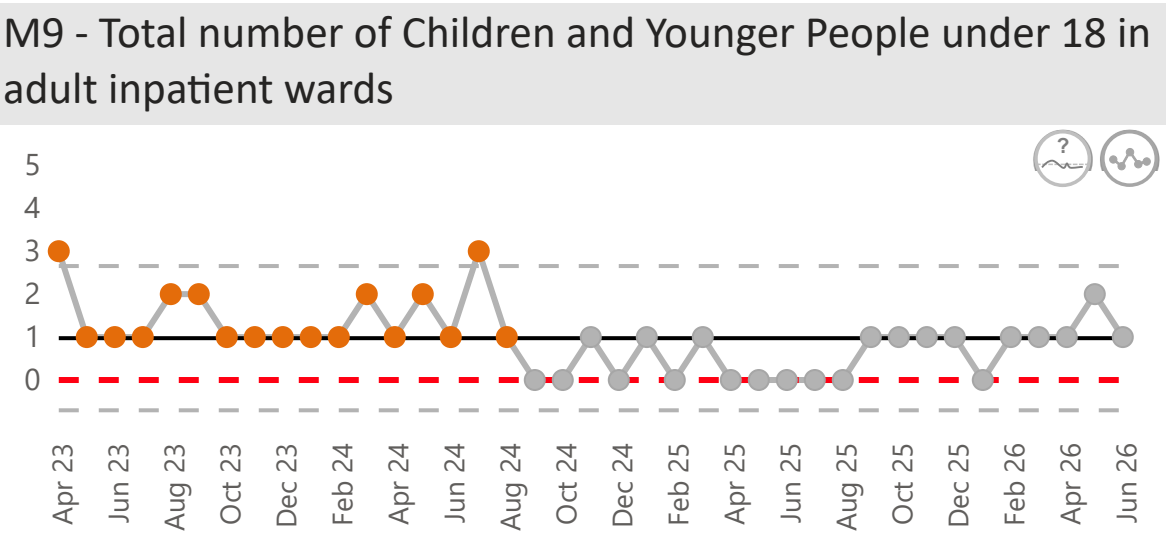
The SPC chart shows that due to the continued improvement in the number of out of area bed days we remain in a period of special cause improving variation (something is happening and should be investigated). Though we are still not anticipated to achieve the target of zero.



The SPC chart shows that although there has been an increase in this month in the number of under 18s admitted we remain in common cause variation (no concern).



The SPC chart shows that due to the continued improvement in the number of out of area placements we have entered a period of special cause improving variation (something is happening and should be investigated).



There was one admission of an under 18 year old to an adult ward in June 2026. Their length of stay was 1 day.

Whilst the SPC chart shows us that this is an improving position when we compare it to the range of admissions we have had in the past, it is recognised that any admission of an individual under 18 is due to the national unavailability of a bed for young people to meet their specific needs. 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.

Summary	Quality & Safety	People	National Metrics	Care Groups	Ward Detail	Finance/ Contracts			
KPI				Strategic Objective	CQC Domain	Target	Apr-26	May-26	Jun-26
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Trust				Best Quality	Responsive	Apr - 455 May - 451 Jun - 447	Due August 26		
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Barnsley				Best Quality	Responsive	Apr - 83 May & Jun - 82			
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Calderdale				Best Quality	Responsive	44			
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Kirklees				Best Quality	Responsive	Apr - 258 May - 256 Jun - 254			
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Wakefield				Best Quality	Responsive	35			
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - Trust				Best Quality	Responsive	Apr - 48.0 May - 49.1 Jun - 47.1	47.7	45.6	47.7
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - South Yorkshire				Best Quality	Responsive	Apr - 58.1 May - 60.0 Jun - 56.7	44.6	48.7	46.0
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - West Yorkshire				Best Quality	Responsive	Apr - 44.7 May - 45.7 Jun - 43.8	46.4	42.9	44.1
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - Trust				Best Quality	Responsive	Apr - 82.2 May - 81.7 Jun - 79.0	89.1	92.9	90.2
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - South Yorkshire				Best Quality	Responsive	Apr - 76.8 May - 79.3 June - 76.8	72.4	73.3	64.2
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - West Yorkshire				Best Quality	Responsive	Apr - 77.4 May - 78.7 Jun - 76.2	96.0	100.0	97.8
Access to Mental Health Support Teams Mental Teams in schools and colleges - Kirklees				Best Quality	Responsive	Apr - 800 May - 830 Jun - 860	995	1004	1018
Access to Mental Health Support Teams Mental Teams in schools and colleges - Wakefield				Best Quality	Responsive	1300	1802	1833	1834
Number of patients accessing Individual Placement Support services - rolling 12-month - Calderdale				Best Quality	Responsive	Apr - 158 May - 160 Jun - 162	128	131	126
Number of patients accessing Individual Placement Support services - rolling 12-month - Kirklees				Best Quality	Responsive	Apr - 296 May - 304 Jun - 311	255	253	248
Number of patients accessing Individual Placement Support services - rolling 12-month - Wakefield				Best Quality	Responsive	Apr - 279 May - 281 Jun - 285	401	395	406
Percentage of people on entire waiting lists who are waiting 18 weeks or less				Best Quality	Responsive	78% by March 27	87.5%	89.0%	90.4%
Percentage of people on waiting lists for Adult Community Services per system who are waiting 18 weeks or less as proportion of entire Adult waiting list				Best Quality	Responsive	78% by March 27	97.5%	97.8%	97.4%
Percentage of people on waiting lists for CYP Community Services per system who are waiting 18 weeks or less as proportion of entire CYP waiting list				Best Quality	Responsive	78% by March 27	58.0%	61.0%	65.9%

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 June the following data quality issue has been identified in the reporting:

- The reporting for employment and accommodation shows 14.7% of records have missing employment and/or accommodation status with a further 1.7% that have an unknown employment status and 1.2% 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.

Operational Planning

Monthly performance against the national activity metrics for operational services can be seen in the dashboard. Where metrics have carried forward into 2026/27, there may have been a change in threshold, this is reflected in the dashboard. There are a number of new metrics related to operational planning for 2026/27 and these can also be seen in this section.

NHS Oversight Framework

The 2026/27 framework was published by NHS England on 11th June 2026. A greater number of metrics are applicable to the Trust for this year and work is underway to review the metrics and interpret the new national guidance. Quarter 1 performance is expected to be published in September. A further update will be provided as more information becomes available.

The Trust continues to perform well against national metrics with performance against the majority within acceptable variance.

- M8 & M9 - There was one admission to an adult mental health ward where the person was under 18 years old; they were admitted for one night. It is recognised that any admission of an individual under 18 is due to the national unavailability of an appropriate bed for young people to meet their specific needs. 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.
- M2 - The number of out of area bed placements remains amongst the lowest in the North-East, Yorkshire and Humber region. At the end of June, the Trust had six service users placed in an inappropriate out of area bed with 137 bed days used over the month. This has been supported by significant ongoing focus and improvements on patient flow and bed management, however, during June the service were under considerable pressure which impacted on out of area use and were reporting OPEL 4 (integrated operational pressures escalation level); level 4 indicates very high clinical risk levels. The Trust also places patients on behalf of the commissioner for Barnsley place which also contributes to provider placement numbers, and for June this related to five service users.
- M13 & M14 - The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within four weeks was 100% in June. The routine access to treatment measure achieved 92.3%, which related to 3 children and young people not seen in time.
- M47 - Virtual Ward occupancy rate is 86.7% in June achieving the target of 80%.
- M6 - The percentage of service users waiting for a diagnostic appointment (Paediatric Audiology service only) within 6 weeks remains above the threshold at 96.9% in June. The continued increased in performance has meant that we remain in a period of special cause improving variation (something is happening and should be investigated).
- Reduction in our mental health length of stays are now split between adult acute and psychiatric intensive care unit (PICU) and older people. The Trust has set itself a target to reduce adult acute lengths of stay by 10% by the end of March 2027 from August 2025 baseline. At Trust level, we are slightly above our forecast position for June for adult and PICU lengths of stay (47.7 days against a forecast of 47.1 days) but have exceeded our forecast for older peoples' lengths of stay (90.2 days against a forecast of 79.0 days). It is important to note that the performance will be affected by discharges of patients with particularly long lengths of stay and this may be impacted by the availability of external factors as identified when we highlight our performance against the clinically ready for discharge metric.
- Performance against number of patients accessing Individual Placement Support services is monitored at Place level and is an operational planning activity metric. IPS services help people with severe mental illness gain and maintain paid employment. This metric counts the number of people who have accessed the service over a rolling 12 month period. There is currently some under performance against target in both Calderdale and Kirklees and this in part relates to our performance only including SWYPFT activity and not activity for primary care workers – work is to take place to review this issue to ensure data flowing correctly. Wakefield performance is currently operating above target however focused work is on-going in terms of developing secondary care referral rates, specifically for the unemployed cohort which may further improve the access numbers.
- As a whole our community services are achieving the national expectation of 78% of being seen within 18 weeks, achieving 90.4% for June. We do however, continue to have some long waiters in our Children’s Speech and language (SALT) therapy service and as a result this is impacting the percentage of people on waiting lists for children and young people (CYP) community services who are waiting 18 weeks or less as proportion of entire CYP waiting list. This is linked to an increase in complex patients requiring a longer stay on the caseload. A full review of the Children’s SALT service has begun as part of the Trust’s value for money workstream which has identified and escalated a financial shortfall across children’s therapy services. In addition the review will look to improve service efficiencies alongside a reduction in waiting time.

Summary

Quality & Safety

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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 italics are provisional and will be refreshed next month.

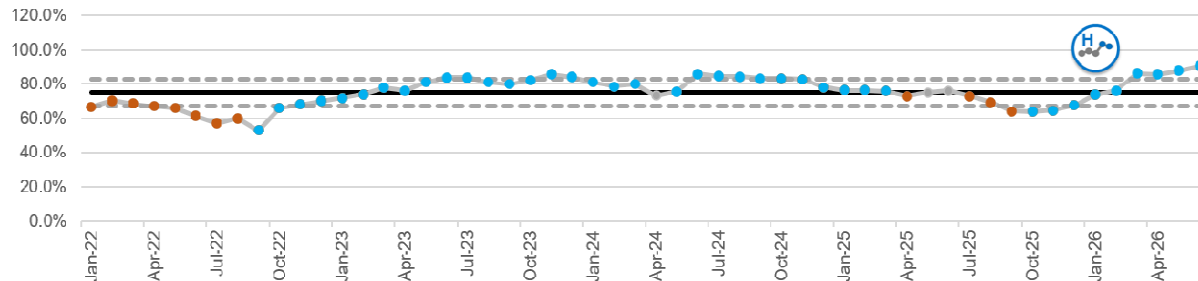
Child and Adolescent Mental Health Services (CAMHS)

Headlines

Neurodevelopment waits remain a concern and discussions are underway with commissioners about how we can further strengthen the offer to reduce any impact on those who require assessment or support. Medical staffing issues related to long-term sickness and leavers are impacting on medical capacity within the team, directorate are undertaking recruitment and exploring alternatives with workforce colleagues.

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	May-26	Jun-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	94.2%	93.2%	93.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/7)	0% (0/3)	0% (0/5)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	73.5%	76.2%	86.5%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	75.1%	75.7%	79.4%	
CAMHS - Crisis Response 4 hours	Best Quality	Responsive	N/A	100.0%	98.1%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.9%	82.2%	81.9%	
Eating Disorder - Routine clock stops	Best Quality	Effective	95%	94.9%	100.0%	92.3%	
Eating Disorder - Urgent/Emergency clock stops	Best Quality	Effective	95%	100.0%	100.0%	100.0%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.4%	90.9%	91.6%	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	91.4%	91.8%	92.1%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.2%	5.2%	4.8%	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	Best Quality	Responsive	126 days	590	648	732	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	Best Quality	Responsive	126 days	1,065	1,156	1,084	
Total number of reported incidents	Best Quality	Safe	Trend monitor	70	42	53	

CAMHS Referral to Treatment



In June 2026, the SPC chart indicates that we remain in a period of special cause improving variation (something is happening and this should be investigated). See narrative below for further information.

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Alert/Action

- Kirklees & Calderdale medical workforce is currently running at 57% of establishment due to leavers and long-term sickness. Working with Directors of service and Workforce colleagues to focus on recruitment of both substantive vacancies and temporary staffing. Reduced capacity for routine & emergency appointment and to cover medical on call.
- Kirklees CAMHS ADHD waiting list continues to rise due to increased referrals, Kirklees ICB RtC decision making, medical staffing vacancies and limited NMP support (0.6wte). Current longest wait (non-allocated appointment) is 75 weeks. Escalated to DoS and contracting colleagues.
- Kirklees Keeping in Mind (KKiM) MHST (mental health support into schools) is still experiencing significant challenges around referral numbers and recruitment and retention. The service continues develop its offer to align with its provision with the national model, working collaboratively with schools, local authority and ICB. Wave 16 funding has been agreed in principle, and a decision tree is being prepared for EMT.
- Wakefield CAMHS ReACH Team and Primary Intervention Team (SPA), continues to experience challenges recruiting to posts. The Service remains red on the risk register due to long term sickness and position and vacancies awaiting recruitment. Paediatric Liaison has been streamlined and formalised to ensure this resource complements ReACH. Core team long term sickness and maternity leave is impacting on waits for psychotherapy interventions. The action plan remains in place and is monitored in the wait's improvement group.
- Secure CAMHS – discussions have been undertaken with NHSE to determine the responsibilities and associated finance for the prescribing of mental health medications in the secure children's homes in accordance with contractual arrangements. A business case submitted in relation to this was rejected. Further discussions are taking place internally with our contracting and finance colleagues.
- Barnsley CAMHS - continue to experience challenges with transitions to adult services for children and young people with ADHD and on prescribed medication. This is impacted by the current position regarding shared care agreements being taken by primary care. Discussions at place and with partners are ongoing. ADHD referrals for assessments are rising above capacity to deliver expectations; this compounds the challenge with patient flow through the pathway.

Advise

- Barnsley CAMHS- The business proposal approved by commissioners for two posts for learning disability nursing will positively impact health inequalities and service user experience. Mobilisation plans are in place, and the service have successfully recruited into post. Funding has been approved for phase 2 of the model, which is a more comprehensive team for CAMHS LD. Staff members have been recruited and funding has flowed since the beginning of the finance year.
- Calderdale & Kirklees CAMHS experiencing increased referrals and reduced resources which are impacting waiting times for ADHD medication activity. Increased prevalence of ADHD has led to SWYFT receiving an increased number of referrals for medication assessment and titration from Right to Choose (RtC) providers specifically within Calderdale. Kirklees numbers are directly related to the number of diagnosed assessments undertaken by the Neuro Developmental assessment team in Kirklees. Calderdale commissioners are considering business proposal for increasing capacity with Calderdale ADHD. Kirklees ICB commissioners have instructed GPs wishing to pursue Right to Choose pathway for ASD/ADHD assessments that these will need to be first screened by Kirklees CAMHS Neuro Assessment Service. This has led to an increase in referrals to the service and changes in practice for allocation to SWYFT ND assessment waiting list. Additionally, the increasing use of right to choose by GPs will have a direct impact on Kirklees CAMHS ADHD medication waiting list.
- Calderdale & Kirklees CAMHS Crisis team continues to receive in the region of 100 referrals per month for CYP requiring emergency or urgent support. In addition, the C&K CAMHS Crisis line receives in the region of 100 calls per month and also a further 20calls per month from NHS 111. The Service continues to work with IM&T to maximise telephony provision to streamline calls more productively.
- Calderdale & Kirklees CAMHS Waiting numbers for autistic spectrum condition (ASC) / attention deficit hyperactivity disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees continue to remain challenging. This is further impacted by staff vacancies. This has been recorded on the risk register. Commissioners are sighted on these challenges.
- The rate of clinical supervision was 86.5% and 79.4% for management supervision across the care group. This is an improvement on the May 2026 figures.

Assure

- The sickness level across children young people services in June was 3.6%.
- Medical devices servicing across the children and young people services stands at a 94% compliance rate.
- The work of the weekly rapid improvement group established to reduce CAMHS treatment waits continues to have a positive impact on the services.

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Mental Health Care Group

Headlines

Acute wards have continued to manage high levels of acuity. During June sustained pressure triggering OPEL level 4 for a period of 2 weeks. .

General managers have a firm grip on sickness absence with staff being supported and managed in line with Trust policies. Community services sickness has been maintained under local threshold but there has been an increase in across Mental Health inpatient services.

Mental Health Community

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	May-26	Jun-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	94.9%	96.4%	96.5%	
% Assessed within 14 days of referral (Routine)	Best Quality	Responsive	75%	87.9%	85.8%	87.4%	
% Assessed within 4 hours (Crisis)	Best Quality	Responsive	90%	100.0%	99.1%	97.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	7% (1/15)	0% (0/15)	0% (0/15)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	83.1%	88.1%	87.1%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	73.4%	83.0%	85.0%	
% service users followed up within 72 hours of discharge from inpatient care	Best Quality	Safe	80%	86.5%	87.2%	85.4%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	94.6%	95.8%	96.2%	
% Treated within 6 weeks of assessment (routine)	Best Quality	Responsive	70%	97.4%	96.7%	96.2%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	85.8%	86.2%	85.6%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95%	97.7%	97.5%	97.8%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.7%	94.1%	95.1%	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	90.6%	92.0%	92.6%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	5.3%	4.8%	5.0%	
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses - Trust	Best Quality	Responsive	Trend Monitor	13,221	13,206	13,194	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	120	122	129	

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Mental Health Inpatient

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	May-26	Jun-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	96.9%	96.8%	96.1%	
% Bed occupancy (excl leave)	Best Quality	Safe	85%	85.2%	89.6%	91.5%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	33% (1/3)	0% (0/7)	14% (1/7)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	83.5%	83.1%	81.0%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	81.8%	75.7%	79.1%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.8%	86.7%	84.4%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	9.9%	7.3%	6.8%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	92.5%	93.0%	89.6%	
Inappropriate Out of Area Bed days	Best Quality	Responsive	150 (June)	90	82	137	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.8%	95.2%	97.1%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	11	14	22	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	60	52	69	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	90.3%	90.1%	89.8%	
Restraint incidents	Best Quality	Safe	Trend Monitor	128	106	136	
Safer staffing (Overall)	Best Quality	Safe	90%	119.0%	121.3%	122.6%	
Safer staffing (Registered)	Best Quality	Safe	80%	102.4%	100.8%	101.5%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5%	4.8%	5.4%	6.3%	
Readmissions within 28 days	Best Quality	Safe	Trend Monitor	11	13	13	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	581	584	631	

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Alert/Action

- Acute wards have continued to manage high levels of acuity. During June sustained pressure triggering OPEL level 4 for a period of two weeks.
- High occupancy levels across wards and capacity to meet demand for beds remains a challenge. Plans are in place to mitigate any impact on safety 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.
- There continues to be people who are clinically ready for discharge but are delayed. This is an area of focus as part of the priority programme work and is being addressed with the ICB's through the MADE meetings as well as a weekly Director of Services led challenge meeting with general managers.
- Workforce challenges have led to continued use of temporary staffing, primarily bank. Throughout June some acute wards have worked above establishment. This is closely monitored by senior managers.
- Work to maintain effective patient flow continues, with the use of out of area beds being closely managed. The situation remains challenging in June and the pressure to meet the demand for admissions in a timely way has intensified. The impact of reduced usage of out of area beds on inpatient wards, Intensive Home-Based Treatment Teams, and community teams is triangulated and monitored.
- Intensive Home-Based Treatment (IHBT) teams in Calderdale and Kirklees are experiencing ongoing workforce challenges, recruitment is underway.
- Barnsley and Kirklees IHBT are amber for 4hr assessment in June. Barnsley were under the locally agreed 95% target at 90.91%. This was one breach due to operational pressures and service user choice, and they were seen the same day. Kirklees did not achieve their 90% target at 87.5%. In the first instance, the 4hr assessment was carried out by the police liaison practitioner who is part of IHBTT, and P&BI are looking at why this contact did not get reflected in reporting. The other instance was a breach by 20 minutes, and this was due to service pressures.
- All areas are focussing on continuing to improve performance for FIRM risk assessments. FIRM percentage compliance for inpatient services is significantly impacted due to the relatively small number of admissions. There is a high level of scrutiny when a FIRM risk assessment is not completed or reviewed and updated within 24 hours pre or post admission. At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed. A Staying Safe risk management care plan is also implemented within 24hrs of admission. The care group are reviewing the locally agreed standards for documenting the review of FIRM risk assessments on admission, and this work will be shared into the trust wide risk assessment quality improvement work.
- Care plan metrics for community capture the whole community caseload rather than only individuals on CPA. The care group are working with P&BI to ensure the metric reflects practice. Continued improvement in June in all areas. Care Programme Approach (CPA) review performance is above target in Calderdale, Kirklees and Wakefield. Barnsley are under the 95% target this month 92.1% respectively. Action plans and support from Quality and Governance Leads remain in place and all areas are expected to be above threshold in July.
- The sickness rate is above the Trust threshold on some wards. Wards and teams with high sickness are where there are a number of people with long term sickness in addition to short term sickness. General Managers have a firm grip on absence with staff being supported and managed in line with Trust policies.
- The service is actively engaged in the trust wide improvement work with regards to minimising prone restraints during seclusion exit and when administering intra-muscular medication. Matrons attend the monthly restraint oversight meeting chaired by RRPI specialist advisors and includes an in-depth review of all prone restraint incidents for learning.
- SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment remains at risk of being delayed in all areas. In June the access standard for routine assessment within 14 days of referral has been met in all localities. There have been challenges with vacancies in Calderdale & Kirklees SPA and an increased demand for urgent assessments. The service has implemented business continuity plans, with a focus on diverting increased resource towards triage.

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- Improvement work is underway to understand the capacity and demand pressures on inpatient services and is monitored via the Inpatient Priority Programme. In addition, there is a focus on implementing the culture of care standards to improve the therapeutic nature of inpatient care for both service users and staff.
- 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 and crisis alternatives, trauma informed care and effective intensive home treatment.
- Supervision reporting changed as of 1st April with separate 60-day targets for clinical and management supervision. Inpatient services have achieved the 60 day target overall for both clinical and management supervision. Community services have also achieved both targets with the exception of management supervision in Calderdale and Kirklees Community which has dipped under the 80%. There is an action plan in place and an expectation of improvement to above target at the end of July.
- The Talking Therapies recovery rate for June is 52.78% for Barnsley and 56.63% for Kirklees, both achieving the national standard of 50%.
- The care group holds monthly meetings to track and review progress of Equality Impact Assessments (EIAs). Performance remains strong. Delay in completion of EIAs in some areas have been due to manager changes/sickness and the service line Trios are supporting the teams in their completion.
- Equality data – we are working with a trust wide quality improvement group to enhance how equality information is captured on System One. Completeness of equality data is on our data quality improvement action plan.
- There were four incidents of prone restraint in June. One incident was service user led and three incidents were staff led for clinical reasons specific to the individuals and related to administration of medication. All prone restraints are reviewed by RRP specialist advisors and any identified learning shared to the clinical team. The care group continue to work collaboratively with colleagues in Nursing, Quality, and Professions to support the Trusts ambition for zero staff led prone restraint.

Assure

- IHBT teams continue to perform well in gatekeeping admissions to our inpatient beds.
- Mandatory training compliance for the care group is 95.1%.
- The care group achieved 95.4% of appraisals completed within 12 months.

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Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) / Learning Disability (LD) Care Group

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:

There has been an improved position in waiting list times for community learning disability services referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks. The Learning Disability team continue to have robust oversight of all waits and are carrying out profession specific actions to address waits within individual disciplines.

LD, ADHD & ASD							
Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	May-26	Jun-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	88.5%	91.0%	80.1%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	33% (1/3)	0% (0/2)	0% (0/2)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	69.2%	69.0%	68.8%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	64.1%	62.4%	62.8%	
Bed occupancy (excluding leave) - Commissioned Beds	Best Quality	Safe	N/A	50.0%	42.3%	45.0%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.5%	88.4%	85.7%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	100.0%	100.0%	81.8%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	95.1%	95.2%	96.3%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	Best Quality	Responsive	90%	81.7%	98.1%	95.6%	
Physical Violence - Against Patient by Patient	Best Quality	Safe	Trend Monitor	0	1	0	
Physical Violence - Against Staff by Patient	Best Quality	Safe	Trend Monitor	11	12	6	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.7%	91.4%	92.1%	
Safer staffing (Overall)	Best Quality	Safe	90%	133.7%	120.2%	121.6%	
Safer staffing (Registered)	Best Quality	Safe	80%	167.9%	162.0%	161.1%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	3.0%	3.1%	2.8%	
Restraint incidents	Best Quality	Safe	Trend Monitor	8	8	5	
Average length of stay	Best Quality	Safe	Trend Monitor	N/A	524	N/A	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	49	53	44	

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Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) services:

Alert/Action

ICB West Yorkshire Neurodiversity Project

A number of commissioning developments are taking place across the region which may shape the future delivery of neurodevelopmental and specialist services. This includes ongoing work to review support pathways and strengthen alignment across systems. The Trust continues to engage proactively with commissioners and partners to support service development, share learning and ensure local services remain responsive to the needs of children, young people and families. Developments will continue to be monitored through established governance arrangements.

Waiting Times ADHD

ADHD waiting times continue to increase across a number of localities, reflecting sustained growth in demand for assessment, diagnosis and intervention. Referral rates remain significantly above commissioned and operational capacity, resulting in a widening gap between demand and service availability. The position is being further influenced by increasing public awareness of neurodevelopmental conditions, changes in referral patterns and growing complexity within the population accessing services. Actions are underway to maximise available clinical capacity, review pathways and explore opportunities for system-wide solutions with commissioners and partner organisations. However, without additional sustainable investment and wider pathway transformation, waiting times are expected to remain under significant pressure.

Compliance with Annual Risk Assessment Reviews

Reported compliance with annual risk assessment reviews remains an area of focus. A review of current processes has identified opportunities to improve recording and reporting arrangements, ensuring performance data more accurately reflects clinical activity. Some of the issues identified span multiple services and will require changes to recording practices and processes across a wider range of clinical teams to support consistency and assurance. Work is progressing to strengthen data quality and documentation standards, with ongoing oversight through governance structures to ensure continued improvement in reporting and compliance.

Advise

Data Quality - The service is working with the business intelligence team to strengthen data quality and reporting arrangements, with a number of proposed solutions currently under review. This work is intended to improve the accuracy of performance reporting, provide greater assurance regarding compliance, and support targeted improvement activity where required.

Potential Opportunities - Discussions continue with commissioners and system partners regarding the development of neurodevelopmental pathways, including potential screening and triage arrangements in Calderdale, to support sustainable service delivery and improve access to appropriate support.

Regional neurodevelopmental commissioning developments are being monitored through established governance arrangements to ensure the Trust remains well positioned to respond to emerging opportunities, support service development and manage changes in demand.

Assure

- All key performance indicator targets met.
- Excellent levels of supervision, appraisal and mandatory training.
- Low level of vacancies.
- All mandatory training meeting the threshold.

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Learning disability services:

Alert/Action

Community

- Learning Disability Services continue to operate with reduced psychiatry capacity, impacting the timeliness of specialist assessments, formulations and clinical reviews, and creating additional pressure across community pathways. Mitigating actions are in place, including workforce planning and prioritisation of clinical activity, although capacity constraints continue to affect service delivery and responsiveness.
- LeDeR Report (delayed 2024 Report) has now been published following resolution of technical data issues. The report shows a reduction in the proportion of avoidable deaths among adults with a learning disability, from 46.3% in 2021 to 39.0% in 2024. While this represents improvement, the rate remains significantly higher than that seen in the general population and highlights the continued need to address health inequalities.

Horizon – Assessment and Treatment Unit (ATU)

- ATU Review -A comprehensive review of Assessment and Treatment Unit (ATU) provision across West Yorkshire is progressing in partnership with system partners through established collaborative workstreams. The review is nearing completion, with the options appraisal in its final stages to support the development of a sustainable, system aligned model that reflects demand, quality expectations and financial considerations.
- Patient Flow: Four service users currently in the service. Three patients are currently identified as ready for discharge, with discharge destinations agreed and planned discharge dates in place, supporting continued patient flow through the pathway.

Advise

Community

- Waiting Times: Performance against waiting time standards has improved, with recent data showing compliance has returned above the required target. This reflects the impact of focused operational oversight and actions taken to manage demand and capacity across the service.
- ICONIC Research Project: The ICONIC research project has now commenced. Participation in this programme strengthens the service's contribution to the national evidence base for learning disability services and provides opportunities to further develop research activity, innovation and best practice.
- STOMP: STOMP remains well embedded across all localities and continues to support the safe and appropriate use of psychotropic medication. A number of local teams have reported positive outcomes, including reductions in medication and, in some cases, successful discharge from specialist services where needs can be managed through mainstream or community-based support.

Horizon – Assessment and Treatment Unit (ATU)

- Medication Safety: A comprehensive review of medication errors reported over the last 12 months has been completed. Findings have informed a targeted action plan, which is now being implemented to strengthen practice, reduce recurrence and support ongoing improvements in medication safety.
- Post-Incident Debriefs: The ward has reviewed and strengthened its arrangements for staff debriefs following incidents of violence and aggression. Improvements to documentation and processes have been introduced to ensure staff receive timely support, learning is captured consistently, and actions are followed through.

Assure

- Annual health checks in all four localities have exceeded the 75% threshold.
- FFT – 100%

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Forensic Care Group

Headlines

The monthly sickness rate continues to be an issue for our West Yorkshire services, hotspot areas can be seen in the ward level breakdown of the report. The people directorate business partner continues to work closely with the care group regarding 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.

Work on pathways with the collaborative is underway to address the underoccupancy in medium secure services.

Focus remains on ensuring staff have a timely and comprehensive appraisal, although external issues with access to the appraisal system are impacting on reported performance.

Liaison with the collaborative is underway to find appropriate solutions for the patients waiting for high secure placements.

Forensic - West Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	May-26	Jun-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	78.5%	79.9%	81.0%	 
% Bed occupancy (incl leave)	Best Quality	Safe	90%	89.0%	90.8%	89.4%	 
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/0)	0% (0/1)	0% (0/3)	 
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	64.2%	66.5%	68.1%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	46.2%	45.7%	52.4%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	97.3%	100.0%	100.0%	 
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.1%	81.1%	81.5%	 
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	 
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	100.0%	80.0%	100.0%	 
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95.0%	86.6%	89.5%	89.6%	 
% with care plan that includes service user input/views	Best Quality	Safe	95.0%	90.6%	90.0%	92.1%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	96.1%	94.6%	94.3%	 
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	7	2	1	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	2	6	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.1%	89.8%	94.0%	 
Restraint incidents	Best Quality	Safe	Trend Monitor	24	8	17	
Safer staffing (Overall)	Best Quality	Safe	90%	111.8%	119.5%	116.0%	 
Safer staffing (Registered)	Best Quality	Safe	80%	101.3%	100.8%	99.3%	
Sickness rate (Monthly)	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	6.4%	5.6%	7.1%	 
Average length of stay	Best Quality	Safe	Trend Monitor	1,049	1,389	949	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	176	156	162	

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Forensic - West Yorkshire:

Alert/Action

Future Capacity & Demand

Work continues through the West Yorkshire Provider Collaborative, in partnership with regional colleagues, to model future demand and strengthen system-wide planning for specialised services. This includes detailed analysis of activity, length of stay, patient flow, bed utilisation, and emerging demand trends, enabling a more proactive and evidence-based approach to service configuration, workforce planning, and capacity management. The collaborative is using this intelligence to support sustainable service development and ensure future provision is aligned to population need and anticipated system pressures.

The Best Place to Work and Learn

Programme delivery continues, with a focused review of culture across West Yorkshire Forensic Services. Staff engagement has been positive and has provided valuable insight into current culture and areas for improvement. Communication with staff has commenced, with targeted improvement actions being developed and governance and oversight arrangements being established under Executive leadership to support delivery and assurance.

Bed Occupancy

Occupancy across Newhaven, Newton Lodge and the Bretton Centre remain broadly stable. Variation continues to be most evident within the learning disability pathway, where four of the eight beds remain unoccupied, reflecting the ongoing challenges in demand across this service area.

- Newton Lodge: 89.04%
- Bretton Centre: 93.52%
- Newhaven: 81.25%

Vacancies

HCA vacancies remain a challenge and continue to place pressure on rota coverage and operational resilience, contributing to the ongoing reliance on temporary staffing. However, recruitment activity is beginning to have a positive impact, with vacancy levels showing gradual improvement. While turnover within this staff group continues to offset some of the gains made, targeted recruitment and retention actions are helping to stabilise the workforce and reduce overall vacancy numbers.

Risk Assessment

Compliance with completion of risk assessments within 24 hours has improved and returned to 100% this month. While this provides assurance that required assessments are being completed in a timely manner, performance will continue to be monitored closely to ensure improvements are sustained and embedded within routine practice.

Supervision

Supervision compliance remains mixed across the service. Newhaven has demonstrated significant improvement in clinical supervision, increasing from 67.7% to 90.3% and exceeding the 80% target. Newton Lodge has shown modest improvements in both management and clinical supervision, although performance remains below target. Compliance at the Bretton Centre remains below the expected standard, with only marginal improvement recorded this month.

Management supervision at Newhaven has reduced from 83.9% to 71.0% and will continue to be closely monitored. Targeted recovery actions remain in place across all areas below target, with oversight through local performance management arrangements. Despite the current variation, supervision compliance has historically been strong across West Yorkshire Forensic Services and work is underway to restore performance to expected levels and ensure sustained improvement.

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Advise

Sickness Absence – Sickness absence continues to be a key area of focus across the service. A targeted programme of work remains underway, supported by the People Directorate, to enable teams to better understand and address the underlying drivers of absence and to strengthen overall attendance.

Sickness absence has increased slightly at Newton Lodge (5.1%), while Newhaven continues to report low levels at 0.8%. Absence at the Bretton Centre has reduced to 10.1%, though this area remains a relative hotspot. The management team is continuing to review contributory factors and implement targeted actions to support improvement.

Forensic Improvement Programme – The programme continues to progress, with workstreams focused on enhancing service user experience, improving outcomes, and strengthening operational effectiveness. Delivery is coordinated across the Care Group and monitored through established governance structures, including the Operational Management Group, providing oversight of progress, risk management, and delivery against agreed objectives and milestones.

Mandatory Training Compliance – Overall compliance remains strong. Areas below the required threshold include CPR at Newton Lodge (78.4%) and Information Governance training (93.8%), with Newhaven also slightly below target for IG at 94.1%.

Targeted actions are in place, including focused follow-up with staff, planned training sessions, and oversight from local management. Compliance continues to be monitored through established governance processes, with improvement expected over the next reporting period.

Appraisal – Planning is underway to improve appraisal compliance alongside the implementation of the new system. This is being supported through targeted training, management briefings, and enhanced support for staff and managers. A phased rollout and improved oversight arrangements are expected to strengthen compliance, improve timeliness, and support sustainable performance as the new system becomes embedded.

Turnover – Below 10% across all service lines.

Assure

- High levels of Data Quality across the Care Group.
- 100% compliance for HCR20 completed within 3 months of admission.
- CPA – 100%
- 25 hrs meaningful activity 100%
- Positive relationships with West Yorkshire Provider Collaborative partners

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Forensic - South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	May-26	Jun-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	75.4%	80.5%	80.2%	 
% Bed occupancy (incl leave)	Best Quality	Safe	90%	85.3%	86.2%	86.8%	 
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/1)	0% (0/2)	0% (0/1)	 
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	69.8%	86.0%	75.0%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	54.2%	79.6%	70.9%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.6%	89.7%	84.7%	 
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	 
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	97.3%	95.7%	95.8%	 
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	2	2	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	5	1	6	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	83.3%	87.5%	88.0%	 
Restraint incidents	Best Quality	Safe	Trend Monitor	7	8	23	
Safer staffing (Overall)	Best Quality	Safe	90%	107.9%	109.0%	108.2%	 
Safer staffing (Registered)	Best Quality	Safe	80%	87.9%	87.3%	85.9%	
Sickness rate (Monthly)	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	2.8%	2.3%	3.4%	 
Average length of stay	Best Quality	Safe	Trend Monitor	1,075	2,449	1,894	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	164	151	163	

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Forensic - South Yorkshire:

Alert/Action

Capacity and Demand Modelling

A system-wide capacity and demand modelling exercise is underway across South Yorkshire, West Yorkshire and the Humber to inform future service configuration and support longer-term strategic planning across forensic pathways. Bringing together activity, patient flow, acuity and population demand data, the work aims to develop a shared understanding of current and future service need. This will support evidence-based planning across the pathway, taking account of national policy direction, including the Provider Collaborative agenda and the continuing emphasis on community-based care. Current forensic bed capacity across the service is 81 beds.

Appraisal

Appraisal compliance is 80.2%, a slight reduction from the previous month and below the organisational target. This reflects the current position within the annual appraisal cycle. Actions are in place to improve compliance, including strengthened management oversight, enhanced monitoring, and the introduction of a new appraisal system, which is expected to improve completion rates, quality, and visibility of performance.

Turnover

Turnover is 17% following a recent workforce deep dive. Further analysis is underway to understand the drivers and inform targeted retention actions.

Advise

FIRM Risk Assessment & Care Planning – Implementation continues following completion of staff training. Compliance remains at 50%, with progress slower than anticipated. Additional oversight and support are being provided to understand barriers to implementation and improve uptake, with performance continuing to be closely monitored through governance arrangements.

Cheswold Park – Integration into the Forensic Care Group continues, with Trust governance and operational frameworks embedding. Quality and safety remain key priorities, supported through the internal Quality Improvement Group and ongoing external assurance. Strategic focus remains on stabilisation, service development, and future planning, including development of a clear clinical and operational model.

Supervision – Compliance remains below target following the introduction of separate managerial and clinical supervision arrangements. Current performance is 70.9% for managerial supervision and 75.0% for clinical supervision. Recovery actions are in place across all services, supported by local management oversight, improved monitoring and clearer expectations. Performance will continue to be closely monitored to ensure recent improvements are sustained and compliance returns to expected levels.

Assure

- Relationships with the South Yorkshire Provider Collaborative are much improved with joint working regarding future bed modelling continuing to be a priority.
- SWYPFT policy integration continues.

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Barnsley Physical Health and Wellbeing Care Group

Headlines

The care group continue to perform well against most metrics. Achieving the Trust targets for supervision remain challenging despite work to share information on types of supervision and standardised documentation and continued focussed work is taking place within the care group to improve this position.

The sickness rate remains above threshold and the care group has a firm grip of sickness and the management of sickness absence policy is being followed in all cases, however, the care group are experiencing a number of long term sickness issues.

Barnsley Physical Health and Wellbeing

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	May-26	Jun-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	95.9%	97.7%	88.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/1)	0% (0/3)	40% (2/5)	
% people dying in a place of their choosing	Person first and in the centre	Responsive	80%	93.5%	100.0%	100.0%	
% of staff receiving supervision within policy guidance - Clinical	Best Quality	Safe	80%	65.2%	67.4%	61.3%	
% of staff receiving supervision within policy guidance - Management	Best Quality	Safe	80%	42.2%	44.5%	37.8%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	88.2%	86.8%	88.7%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	97.5%	96.4%	96.6%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive	92%	97.5%	97.5%	97.1%	
Safer staffing (Overall)	Best Quality	Safe	90%	96.4%	95.7%	93.0%	
Safer staffing (Registered)	Best Quality	Safe	80%	90.2%	91.9%	93.0%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	5.9%	5.3%	5.4%	
Maximum 6 week wait for diagnostic procedures	Best Quality	Responsive	25/26 - 99% 26/27 - 52.6%	93.5%	99.1%	96.9%	
Community services waiting list - All	Best Quality	Responsive	Trend monitor	7,070	7,029	7,012	
Total number of reported incidents	Best Quality	Safe	Trend monitor	265	261	265	

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Barnsley Physical Health and Wellbeing Care Group

Alert/Action

• Staff receiving supervision – following the introduction of the new separate 60-day targets for clinical and management supervision, the care group is undergoing a period of monitoring and reviewing the revised statistics and their impact on the achievement of compliance for this measure. Figures for June against the target of 80% are showing a small reduction:

Clinical supervision – 61.3%

Management supervision – 37.8%

Achieving the targets for supervision remain challenging despite work to share information on types of supervision and standardised documentation. Supervision targets are also discussed with each general manager in their governance and performance meetings. The care group Professional Lead is visiting all teams to discuss supervision, understand and address barriers. This has highlighted that access to supervision data is restricted due to reporting hierarchies and management of information. This has been escalated to the Assistant Director for Nursing, Quality and Professions and to the Chief Nurse, and steps are being taken to resolve. Each individual responsible for a team who are below target are being contacted.

• Overall sickness rates have increased slightly for the month of June at 5.4%. We continue to have some instances of long-term sicknesses relating to serious illnesses. The care group 12-month rolling figure is 5.39%. People Directorate colleagues are supporting the care group in reviewing long term sickness absence and triangulating with other data which may impact e.g. number of additional shifts/vacancies, whilst excluding some reasons e.g. elective surgery and diagnosis of cancer. In terms of short-term sickness, we are also looking at any correlation between high levels of staff up taking bank shifts alongside increased short-term sickness. We are also ensuring we use the resources available to us in respect of staff off work sick due to stress & anxiety, whether this be home or work related. We have done some significant work to understand the impacts of Musculo-skeletal issues as a cause for sickness within our care group and are supporting good health & safety practices including lifting and handling, back care and the use of equipment.

Advise

• 2 instances of feedback with staff values and behaviours as an issue has been recorded during June. The instances relate to one of our Neighbourhood Nursing Team (NNS) and the other to Urgent Community Response (UCR) team. We are currently awaiting consent from the patient/family via the Trust's Customer Services team and will be investigating further once the scope has been agreed.

• 18-week waiters - Overall, our community services are achieving the national expectation of 78% of being seen within 18 weeks, with a slight increase to 90.4% for June.

We continue to undertake focussed work on the long waiters in our Children's SALT (Speech and Language Therapy) service which are impacting the percentage of people on waiting lists. However the number of C&YP waiting over 18 weeks is reducing. Longer wait times are linked to an increase in complex patients requiring a longer stay on the caseload. Ongoing work includes the remedial action plan and the full review of the Children's SALT service. This is part of the Trust's Value for Money workstream which has identified and escalated a financial shortfall across Children's Therapy services. In addition, the review will look to improve service efficiencies alongside a reduction in waiting times.

• Medical devices – compliance has improved substantially to approximately 81%, close to the Trust-wide level of 82%. Assurance has been provided that out-of-date medical devices are not being used and contingency arrangements are in place. One of the challenges in achieving compliance that the care group is experiencing recently is that staff have been taking their kit for servicing and the provider has been running out of time to complete these during the advertised session. These instances have been reported via Datix.

• Friends and Family Test (FFT) – 94% of people would recommend community services; this is very slightly below the target of 95%. The total number of responses is still lower than previous years following the introduction of the new system in April but has seen a good increase in volume during June 2026.

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Assure

Assure to provide positive news on performance, best practice or celebrate awards!

- Appraisal reporting is transitioning from the requirement to have an appraisal in the last 365 days to being based on having an appraisal within the financial year with a completion date of the end of September.

The first target was for Bands 8a and above to have a completed appraisal by 30 June.

To note: Appraisal compliance using the previous system is at 96.9% for June (as at 21.7.26).

The overall care group figure for progress against the new timelines as at 21.7.26 is > Band 8a - 98.2%

The next target is for Bands 7 and below to have a completed appraisal by 30 September.

- Paediatric Audiology 6-week target for diagnostic procedures is maintaining compliancy with the national trajectory, achieving 96.9% for June.

The total number on the waiting list as at 12.7.26 was further reduced to 84 patients, with only 1 waiting over 6 weeks.

- Virtual Ward occupancy levels for June are achieving compliance at 86.7%. We are continuing to closely monitor occupancy levels moving into quarter 2 based on capacity to safely support patients on both pathways.

- Information Governance training has achieved 96.6% for June, maintaining compliancy with a continued focussed effort on monitoring by managers.

- Urgent Community Response Service 2-hour target has achieved 81.8% for June which continues to be well above the 70% threshold.

- Musculo Skeletal Service (MSK) are seeing a continued achievement against the national target of 92% for 18-week RTT (Referral to Treatment) – 97.12% for June.

- People dying in their place of choosing remains fully compliant and has sustained 100% for June, exceeding the 80% threshold.

- CPR training maintains compliance at 88.7% for June.

- Clinically Ready for Discharge – the Care Group is fully compliant at 0%. Sustained compliance on our 2 wards is due to most admissions/discharges being planned. Anticipated discharge dates are set on admission and discussed at the weekly MDT, adjusting when clinically appropriate.

- 52-week waiters – the care group continues to achieve compliance at 0%.

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The following section of the report has been created to give assurance regarding the quality and safety of the care we provide on our inpatient wards. A number of key metrics have been identified the wards and performance against these for the past three months is stated. The wards in Cheswold Park Hospital are now incorporated into this report and the monthly data will be added over the financial year so that a three month rolling position is also shown. Figures in bold and italics are provisional and will be refreshed next month.

Ward Level Headlines - Working Age Adults, Older Peoples (WAA and OPS) and Rehab Services

During June the service operated at OPEL level 3, with the pressure being sustained and triggering OPEL level 4 for a 2-week period. Lead nurses, ward managers, and matrons have prioritised support of the clinical pressures and as a consequence, we are noting some impact on performance oversight. Nostell is red in a number of performance areas. This is linked to a high number of registered staff being on preceptorship and Band 5 absence (sickness, maternity leave). The ward manager and lead nurse have worked in clinical numbers to support, and this is impacting on their ability to maintain oversight of both performance and quality (e.g. risk assessment compliance). The Mental Health Nursing Lead for the Care Group is meeting with the matron and leadership team to discuss a plan to provide additional support to the preceptees. Additionally, the Senior Leadership Team has met with colleagues from NQ&P to review the support offer from the Non-Medical Education Team, including restorative supervision. Nostell will also link into the quality improvement group work being undertaken on Elmdale with Chief Nurse oversight to share data insights, learning, and improvement ideas.

Appraisal

- Several wards are outside of the 90% compliance threshold in June.
- Reporting is based on appraisals completed within the last 12months and there will be variance in appraisal compliance rates due to ward teams transitioning to the new fixed appraisal window and aligning with timeframes for cascading appraisals.
- Ward teams are working to have all appraisals completed by 30th September as per the newly implemented appraisal window.
- Oversight of appraisal performance is maintained by the senior leadership team at the weekly inpatient quality and performance meeting.

Sickness

- 8 wards have sickness rates below 5% compliance threshold.
- Sickness improved to below threshold in June on Willow, Ward 19 Male, Enfield Down and Lyndhurst.
- Sickness increased to above threshold on Beamshaw (7.3%), Nostell (5.2%), Ashdale (6.4%), and Beechdale (5.8%) due to both short-term and long-term sickness. A theme in short-term sickness is both cold/flu and gastrointestinal issues. A theme in long-term sickness is anxiety/stress/depression – a mix of both personal and work-related factors.
- Walton sickness has increased above threshold to 16.3% due to both short-term and long-term sickness. A theme in the short-term sickness is work-related injury following incidents of violence and aggression.
- Although still above threshold, sickness on Stanley (8.7%) and Crofton (8.4%) has reduced following the return of staff from long-term sickness.
- Sickness remains above threshold and has increased on Poplars (14.5%) and Ward 19 Female (7.5%) due to both long-term and short-term sickness absences (no themes).
- Ward managers are supported by People Directorate colleagues to actively manage long term sickness and timely referrals to occupational health are made.

Supervision

- 11 wards are above the 80% compliance target for clinical supervision in June.
- 10 wards are above the 80% compliance target for management supervision in June.
- Nostell are considerably below compliance for both clinical (59.4%) and management (53.1%) supervision because of both the ward manager and lead nurse working in clinical numbers on multiple occasions to support safer staffing and ensure registered nurse cover to support preceptees. The care group are working closely with NQ&P colleagues to review the support offer to Nostell, including restorative supervision delivered by the NMET team.
- Clark is below compliance for both clinical (63%) and management (66.7%) due to both acuity and ward manager absence. Oversight is being supported by the matron.
- Stanley is below compliance for both clinical (66.7%) and management (63.9%) due to clinical acuity. Efforts have been made by the leadership team to prioritise staff outside compliance and current compliance is 79.5% for both clinical and management (as of 20.7.26).
- Walton and Ashdale are below the 80% supervision compliance for both clinical and managerial but are above 70% and have been impacted by high clinical pressures. Ashdale are also impacted by ward manager absence, and oversight is being supported by the matron.
- Crofton are above compliance for clinical supervision but remain below compliance for management supervision (69.6%) impacted by ongoing ward manager absence. However, performance has improved compared to May following focused efforts from the ACP and Band 6 supported by the matron.
- Lyndhurst compliance for both clinical (76.9%) and management (76.9%) is still under compliance but has improved compared to May following the return of the ward manager who is overseeing a plan to target staff outside of compliance.
- The senior leadership team maintain close oversight of supervision compliance via the weekly inpatient quality and performance meeting – a theme identified from this oversight is the impact of increased acuity (both on delivery of supervision and in terms of releasing staff to attend).

Mandatory Training

Information Governance (IG)

- 14 wards are above 95% compliance target for June.
- Enfield Down (94.1%) performance has improved comparative to May. Further focused work has been undertaking to target the 3 staff members outstanding and current compliance is 100% (as of 20/07/26).
- Clark (92.9%) and Ashdale (94.6%) have all dropped under threshold. Staff outside of compliance are being supported to complete the e-learning training as a priority.
- The senior leadership team maintain close oversight of information governance training compliance via the weekly inpatient quality and performance meeting.

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Ward Level Headlines - Working Age Adults, Older Peoples (WAA and OPS) and Rehab Services Continued

Mandatory Training Continued

Cardiopulmonary resuscitation (CPR)

- 13 wards are at or above the CPR training compliance threshold in June.
- Ward 18 (68.4%) remains below compliance. The Ward Manager has booked staff onto the earliest available dates and all staff outside compliance are booked to attend training throughout July, August, and September.
- Ward 19 Female (68.2%) remain below compliance impacted by long-term sickness and maternity leave. Staff able to attend training have either recently attended a July training date or are booked onto dates in August. Current compliance is 72.7% (as of 20/07/26).
- Melton (79.4%) and Lyndhurst (74.1) have dropped just below compliance with staff booked on courses in July and August.

Reducing Restrictive Practice Interventions (RRPI)

- All 17 wards are above the RRPI training compliance threshold.
- Rota planning and oversight from ward managers ensures adequate numbers of RRPI and CPR trained staff on each shift.

Fire Safety

- 14 wards are above fire safety training compliance threshold.
- Stanley (83.3%) remains below compliance in June. Staff have attended recent training sessions and current compliance is above threshold at 89.3% (as of 20/07/26).
- Ward 19 Female (77.3%) remain below compliance impacted by long-term sickness. Current performance is 82.6% (as of 20/07/26) with staff who are able to attend training booked on dates in August.
- Poplars (78.8%) dropped outside compliance in June. A bespoke training session has been arranged at the Poplars on 6th August, and staff outside compliance will be attending.

Bed Occupancy

- Beamshaw (115.5%) overoccupancy is reflective of their use of swing beds shared with Clark and over admissions into non-designated bedroom (e.g. quiet lounge) of service users whose risk couldn't be safely managed by alternatives to admission.
 - Melton (109.4%) overoccupancy reflects over admissions into non-designated bedroom (e.g. Extra Care Area) of service users whose risk couldn't be safely managed by alternatives to admission.
 - Stanley (107%) overoccupancy is reflective of their use of swing beds shared with Nostell and admissions into the bed of a service users nursed in Extra Care Area.
 - Where wards are overoccupancy, staffing levels are reviewed and where necessary increased to maintain wards safety.
 - Bed occupancy exceeding target is reflective of general increased demand for admissions, particularly across working age adults.
 - 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 calculations at Poplars is based on 15 beds, however they operate with a maximum capacity of 12 beds, agreed with commissioners several years ago.
 - 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.

Average Length of Stay (ALOS)

- Length of stay (LOS) is measured at the point of discharge. The discharge of service users with a significantly long length of stay in any given month will impact to increase the overall average length of stay for the ward.
- In June:
 - Melton ALOS was 337 days. This relates to 3 discharges – 2 of those had a LOS under 40 days, 1 service user was subject to MoJ restrictions and had a LOS of 977 days.
 - Enfield Down ALOS in June relates to 1 discharge – LOS for this service user was 432 days.
- The nature and function of Rehab and Recovery Units mean service users will have longer length of stays.
- Rehab and Recovery length of stays also include any acute/PICU ward stays.

Safer Staffing

- There has been no approved review of older adult staffing establishments since 2016. Overall safer staffing rates being above 100% on OPS wards reflects wards being staffed to maintain patient safety in relation to service users: at risk of falls and with frailty; escorts to the acute trust due to complex physical health; complex dementia diagnoses and associated increased levels of violence and aggression. This is particularly pertinent for Poplars who are an isolated unit and whose service user population is people diagnosed with dementia.
- The high overall safer staffing rates in June for Poplars (219.3%) reflects staffing increases for the reasons outlined above.
- Crofton (159.1%) safer staffing reflects staffing increases to support a small number of service users with complex needs requiring enhanced observation levels for a sustained period. The service is undertaking a deep dive into temporary staffing use on Crofton to increase our understanding and plan appropriate actions.

Clinically Ready for Discharge (CRFD)

- CRFD rates are significantly above threshold on:
 - Poplars CRFD is 19.5% and is reflective of a number of service users awaiting placements.
 - Ward 19 Male CRFD is 16.0% and is reflective of 2 service users, one who has been recently discharged. The other is awaiting placement.
- 10 other wards are above the threshold for CRFD with Walton above 10%. This is due to the number of service users with complex needs who are awaiting placement or suitable accommodation and also one service user awaiting MoJ permissions.
- Across all wards the multi-disciplinary team continue to collaborate to progress pathways as timely as possible.
- There is a weekly check and challenge meeting led by the Director of Service to ensure senior oversight and focus and timely external escalations.

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FIRM Risk assessments

- To understand the breaches, the inpatient SLT have recently reviewed and mapped the process for completing a risk assessment within 24hours of admission. As a result of this QI work, we have reviewed and agreed practice standards for documenting the review of FIRM risk assessments on admission. These locally agreed standards were implemented on 22nd June and have been shared into the trust wide risk assessment quality improvement work. It is anticipated that performance results should start to improve in July data and be above compliance threshold in August data.
- Overall compliance in June was 89.6% (16 breaches) for 24hr target and 93.5% (10 breaches) completed within 48hrs.
- During June, Elmdale, Ward 19 Female, and Crofton had 1 FIRM breach each. Clark and Ward 19 Male had 2 breaches. Nostell ,Ashdale, and Ward 18 have 3 breaches each.
- Several June breaches related to service users who had to wait MHA assessment or bed allocation. The FIRM risk assessment was completed at point of referral and remained valid and current at time of admission, albeit outside of the 24hr target.
- In line with the Risk Assessment and Risk Management policy, the team who assessed the service user as requiring admission have a responsibility to update the FIRM risk assessment to reflect the change in risk necessitating inpatient admission.
- Compliance monitoring dashboards support oversight and a deep dive will be conducted by the inpatient matron for each breach to identify learning and inform improvement. These will be reviewed at the weekly inpatient quality and performance meeting and shared with Quality and Governance Leads in community to ensure a collaborative approach to improvement.
- The inpatient team receive a handover of risk prior to admission and at the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed. A Staying Safe risk management care plan is also implemented within 24hrs of admission.

Physical violence (Patient on Patient)

- 22 incidents of patient-on-patient physical violence throughout June across multiple wards.
- 7 incidents on Ashdale and 5 incidents on Ward 18, related to a small number of service users and reflective of the risk profiles of individual service users.
- Service users are supported on an individual basis by staff teams and risks are managed through individual care planning. Appropriate safeguarding actions taken by ward teams, including liaison with trust safeguarding specialist advisors and reporting to the police.

Physical violence (Patient on Staff)

- 12 incidents on Clark; 10 incidents on Walton; 8 incidents on Ward 18 and Elmdale. Relate to a small number of service user with a risk profile of violence and aggression.
- 10 incidents on Poplars (16) relate to a small number of service users with behavioural and psychological symptoms of dementia and a risk profile of violence and aggression.
- Where service users are a known risk of violence and aggression, risk specific care plans are in place with input from trust RRP specialist advisors as needed.
- Staff involved in incidents are supported by ward leadership teams including both managerial and clinical supervision.

Restraint incidents

- High incidence on Clark (11), Walton (13), Ward 18 (14) and Elmdale (14) correlates with incidents of physical violence outlined above as well as being reflective of current patient population and the presentation and risk profile of service users.
- High incidence on Nostell (23) is reflective of current patient population and the presentation and risk profile of service users, including restraint to prevent self-harm.
- High incidence on Crofton (21) relate to a small number of service users where restraint has been used to manage risk of violence and aggression or administer intramuscular medication.
- Ward teams seek advice and support from RRPI specialist advisors as needed to inform individualised and person-centred care planning for those service users with a known risk of violence and aggression.

Prone restraint incidents

- 4 incidents of staff led prone restraint in June:
 - Nostell (1) Service user led. Incident of violence and aggression. SU placed self in prone – supine position increases distress/aggression.
 - Walton (1); Stanley (1); Elmdale (1) – All staff led to administer intramuscular medication. Prone position assessed as safest option due to level of aggression. All incidents reviewed by RRP Team specialist advisors and feedback provided to ward teams.
- Prone restraint as an emergency intervention is still taught within RRP training.
- The care group continue to work collaboratively with colleagues in Nursing, Quality, and Professions to support the Trusts ambition for zero staff led prone restraint.

Cancelled S17 Leave

- Beamshaw (1) and Nostell (1) - cancellations due to staffing.
- Clark (4) – 2 cancellations due to staff. 2 cancellations due to patients being unwell.
- Crofton (1) – Cancellation due to availability of accessible taxi.
- Poplars (1), Willow (1) and Enfield Down (2) - cancelled due to patients being unwell.

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Metrics	Strategic Objective	CQC Domain	Threshold	Beamshaw Suite			Clark Suite		
				Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	94.4%	88.2%	100.0%	100.0%	94.7%
Sickness	Best place to work and learn	Well led	5.0%	3.5%	4.8%	7.3%	0.7%	4.2%	4.7%
Supervision - Clinical	Best place to work and learn	Well led	80%	89.3%	100.0%	92.6%	89.3%	100.0%	63.0%
Supervision - Management	Best place to work and learn	Well led	80%	89.3%	100.0%	92.6%	78.6%	89.3%	66.7%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	96.6%	96.6%	92.9%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.9%	92.9%	96.2%	89.7%	93.1%	96.4%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	96.3%	92.9%	88.5%	96.6%	96.4%	96.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.6%	89.3%	88.5%	100.0%	100.0%	92.9%
Bed occupancy**	Best Quality	Safe	85%	93.7%	103.2%	115.5%	93.7%	103.2%	88.1%
Average Length of Stay	Best Quality	Safe	Trend Monitor	79	35	70	37	51	20
Safer staffing (Overall)	Best Quality	Safe	90%	108.3%	117.2%	110.9%	110.9%	114.2%	119.9%
Safer staffing (Registered)	Best Quality	Safe	80%	98.3%	97.3%	89.9%	100.8%	102.0%	99.6%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	16.3%	5.4%	5.7%	11.8%	13.9%	7.9%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	100.0%	90.0%	81.8%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	2	0	0	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	1	7	4	12
Restraint incidents	Best Quality	Safe	Trend Monitor	3	2	2	9	9	11
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/17)	0% (0/38)	3% (1/31)	0% (0/18)	10% (3/30)	14% (4/29)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	3	4	10	4	3	14

** Bed occupancy is combined with Clark Suite due to use of swing beds

** Bed occupancy is combined with Beamshaw Suite due to use of swing beds

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Metrics	Strategic Objective	CQC Domain	Threshold	Melton Suite			Nostell		
				Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	96.2%	100.0%	85.2%	100.0%	100.0%	75.0%
Sickness	Best place to work and learn	Well led	5.0%	11.8%	3.3%	3.8%	1.0%	1.7%	5.2%
Supervision - Clinical	Best place to work and learn	Well led	80%	97.0%	96.9%	87.5%	60.0%	79.3%	59.4%
Supervision - Management	Best place to work and learn	Well led	80%	97.0%	96.9%	87.5%	73.3%	93.1%	53.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.9%	93.8%	97.1%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.6%	84.4%	94.1%	96.4%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.5%	84.4%	79.4%	89.3%	96.6%	96.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	96.9%	100.0%	94.1%	89.3%	86.2%	85.7%
Bed occupancy	Best Quality	Safe	85%	97.2%	104.3%	109.4%	99.6%	98.8%	93.9%
Average Length of Stay	Best Quality	Safe	Trend Monitor	15	37	337	29	50	43
Safer staffing (Overall)	Best Quality	Safe	90%	111.2%	114.4%	112.0%	104.8%	117.1%	111.7%
Safer staffing (Registered)	Best Quality	Safe	80%	91.6%	95.0%	90.6%	122.2%	123.7%	126.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	15.1%	1.5%	0.0%	4.8%	8.2%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	84.6%	70.0%	75.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	1	4	6	6
Restraint incidents	Best Quality	Safe	Trend Monitor	5	2	6	27	17	23
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	1	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	1
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	N/A	0% (0/38)	0% (0/3)	0% (0/110)	0% (0/110)	1% (1/87)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	3	7	12	7	12	33

** Bed occupancy is combined with Stanley due to use of swing beds

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Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	Stanley May-26	Jun-26	Apr-26	Walton May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	90.9%	96.7%	96.8%	83.3%
Sickness	Best place to work and learn	Well led	5.0%	9.3%	8.7%	7.2%	4.6%	5.0%	16.3%
Supervision - Clinical	Best place to work and learn	Well led	80%	87.5%	87.5%	66.7%	87.8%	95.0%	74.4%
Supervision - Management	Best place to work and learn	Well led	80%	90.6%	81.3%	63.9%	87.8%	87.5%	76.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.0%	93.9%	97.2%	100.0%	97.5%	97.4%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	97.0%	93.9%	94.4%	97.5%	97.5%	92.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	93.9%	90.9%	86.1%	82.5%	85.0%	87.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.9%	84.8%	83.3%	95.0%	95.0%	92.3%
Bed occupancy**	Best Quality	Safe	85%	99.6%	98.8%	107.0%	94.3%	94.0%	96.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	58	42	50	159	22	42
Safer staffing (Overall)	Best Quality	Safe	90%	100.0%	108.2%	104.6%	124.0%	115.9%	123.1%
Safer staffing (Registered)	Best Quality	Safe	80%	96.5%	95.1%	93.9%	95.2%	88.1%	89.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	15.4%	14.7%	9.3%	29.3%	13.4%	14.4%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	2	0	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	4	3	4	5	10
Restraint incidents	Best Quality	Safe	Trend Monitor	6	6	10	15	27	13
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	2	0	1	1	1	1
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/165)	0% (0/131)	0% (0/226)	0% (0/165)	0% (0/99)	N/A
Unfilled Shifts	Best Quality	Safe	Trend Monitor	1	9	21	6	6	16

** Bed occupancy is combined with Nostell due to use of swing beds

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Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	Ashdale May-26	Jun-26	Apr-26	Ward 18 May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	91.7%	100.0%	91.7%	95.2%	87.0%	75.0%
Sickness	Best place to work and learn	Well led	5.0%	4.6%	4.0%	6.4%	3.4%	1.8%	3.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	78.8%	74.3%	76.5%	62.2%	60.6%	92.1%
Supervision - Management	Best place to work and learn	Well led	80%	75.8%	74.3%	73.5%	62.2%	66.7%	92.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	97.1%	94.6%	94.3%	86.5%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.2%	88.6%	86.5%	91.4%	89.2%	92.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.8%	82.4%	83.3%	80.0%	73.0%	68.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	94.1%	94.3%	91.9%	94.3%	81.1%	92.1%
Bed occupancy	Best Quality	Safe	85%	94.0%	98.1%	99.2%	98.3%	99.9%	100.4%
Average Length of Stay	Best Quality	Safe	Trend Monitor	53	52	59	20	24	32
Safer staffing (Overall)	Best Quality	Safe	90%	123.1%	117.2%	119.0%	114.4%	119.3%	112.6%
Safer staffing (Registered)	Best Quality	Safe	80%	103.1%	101.0%	106.4%	114.9%	110.2%	112.6%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	13.8%	11.1%	6.9%	0.3%	1.8%	0.9%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	57.1%	72.7%	81.3%	100.0%	100.0%	86.4%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	6	3	7	2	1	5
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	1	3	8	3	8
Restraint incidents	Best Quality	Safe	Trend Monitor	6	3	3	7	5	14
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/663)	0% (0/630)	0% (0/636)	0% (0/562)	0% (0/604)	0% (0/588)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	3	6	7	8	4	10

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Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	Elmdale May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	95.5%
Sickness	Best place to work and learn	Well led	5.0%	4.6%	3.5%	3.3%
Supervision - Clinical	Best place to work and learn	Well led	80%	94.1%	94.1%	91.7%
Supervision - Management	Best place to work and learn	Well led	80%	94.1%	94.1%	88.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	97.1%	97.2%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	93.5%	97.1%	86.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	96.7%	90.9%	82.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.3%	91.2%	97.2%
Bed occupancy	Best Quality	Safe	85%	89.7%	92.7%	94.4%
Average Length of Stay	Best Quality	Safe	Trend Monitor	37	51	52
Safer staffing (Overall)	Best Quality	Safe	90%	99.3%	108.9%	111.9%
Safer staffing (Registered)	Best Quality	Safe	80%	101.9%	101.0%	103.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	6.3%	7.6%	7.4%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	95.0%	100.0%	95.2%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	4	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	4	7	8
Restraint incidents	Best Quality	Safe	Trend Monitor	3	13	14
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	1
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/275)	0% (0/239)	0% (0/252)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	5	9	15

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Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	Crofton May-26	Jun-26	Apr-26	Poplars CUE May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	77.8%	78.9%	73.7%	93.3%	100.0%	89.3%
Sickness	Best place to work and learn	Well led	5.0%	9.4%	15.0%	8.4%	3.2%	8.3%	14.5%
Supervision - Clinical	Best place to work and learn	Well led	80%	76.9%	50.0%	87.0%	93.9%	88.2%	85.7%
Supervision - Management	Best place to work and learn	Well led	80%	73.1%	41.7%	69.6%	93.9%	85.3%	85.7%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.2%	100.0%	100.0%	97.0%	96.9%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	83.3%	100.0%	92.6%	84.4%	87.5%	81.8%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	79.2%	81.8%	80.0%	90.6%	93.5%	96.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	96.2%	95.8%	88.9%	84.8%	87.5%	78.8%
Bed occupancy	Best Quality	Safe	85%	76.5%	89.9%	100.8%	69.3%	64.7%	72.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	105	29	57	114	109	114
Safer staffing (Overall)	Best Quality	Safe	90%	169.8%	158.5%	159.1%	207.7%	210.6%	219.3%
Safer staffing (Registered)	Best Quality	Safe	80%	123.7%	110.4%	120.3%	108.6%	112.5%	110.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	6.4%	0.0%	0.0%	43.5%	27.9%	19.5%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	90.9%	N/A	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	2	0	1	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	0	4	13	16	10
Restraint incidents	Best Quality	Safe	Trend Monitor	7	2	21	27	17	12
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/5)	0% (0/23)	5% (1/20)	7% (1/14)	33% (2/6)	9% (1/11)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	10	29	22	31	55	68

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Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	Willow May-26	Jun-26	Apr-26	Beechdale May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	93.8%	94.1%	81.3%	100.0%	100.0%	83.3%
Sickness	Best place to work and learn	Well led	5.0%	7.0%	5.2%	2.5%	6.8%	3.9%	5.8%
Supervision - Clinical	Best place to work and learn	Well led	80%	83.3%	68.8%	88.2%	100.0%	100.0%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%	83.3%	68.8%	88.2%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	87.5%	93.8%	100.0%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	81.3%	81.0%	94.1%	95.7%	95.7%	95.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.5%	93.8%	82.4%	95.5%	95.5%	95.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	93.8%	100.0%	100.0%	95.7%	100.0%	95.7%
Bed occupancy	Best Quality	Safe	85%	77.7%	95.8%	94.3%	90.6%	98.0%	99.4%
Average Length of Stay	Best Quality	Safe	Trend Monitor	57	61	50	139	120	170
Safer staffing (Overall)	Best Quality	Safe	90%	112.9%	114.2%	121.7%	144.3%	136.1%	155.8%
Safer staffing (Registered)	Best Quality	Safe	80%	93.3%	80.3%	87.1%	101.7%	102.6%	103.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	8.4%	2.1%	5.0%	14.3%	10.7%	4.6%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	3	0	4	0	1	1
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	N/A	0% (0/23)	2% (1/67)	0% (0/17)	0% (0/32)	0% (0/27)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	4	7	18	3	5	7

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Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Ward 19 - Male			Ward 19 - Female		
				Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	93.8%	100.0%	100.0%	100.0%	94.4%
Sickness	Best place to work and learn	Well led	5.0%	4.2%	8.5%	4.0%	7.8%	6.4%	7.5%
Supervision - Clinical	Best place to work and learn	Well led	80%	95.7%	95.5%	95.8%	94.4%	94.7%	95.0%
Supervision - Management	Best place to work and learn	Well led	80%	95.7%	100.0%	100.0%	100.0%	100.0%	95.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	92.3%	88.0%	100.0%	100.0%	100.0%	95.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.5%	88.0%	87.5%	85.0%	85.7%	90.9%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	69.2%	72.0%	83.3%	65.0%	76.2%	68.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	76.9%	80.0%	95.8%	70.0%	71.4%	77.3%
Bed occupancy	Best Quality	Safe	85%	88.2%	101.3%	96.2%	85.3%	95.7%	94.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	76	96	109	96	73	82
Safer staffing (Overall)	Best Quality	Safe	90%	129.0%	132.1%	122.4%	119.6%	130.8%	152.3%
Safer staffing (Registered)	Best Quality	Safe	80%	88.3%	93.7%	90.9%	106.0%	106.6%	109.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	1.3%	2.7%	16.0%	11.6%	2.4%	9.7%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	71.4%	85.7%	100.0%	83.3%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	2	0	0	0	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	4	2	0	6	1	2
Restraint incidents	Best Quality	Safe	Trend Monitor	5	1	1	5	1	0
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/50)	0% (0/54)	0% (0/42)	0% (0/10)	0% (0/14)	0% (0/13)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	3	1	0	17	5	11

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Inpatients - Mental Health - Rehab

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	Enfield Down May-26	Jun-26	Apr-26	Lyndhurst May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	97.9%	100.0%	89.4%	92.3%	92.3%	80.0%
Sickness	Best place to work and learn	Well led	5.0%	4.2%	6.1%	3.2%	8.1%	7.6%	2.4%
Supervision - Clinical	Best place to work and learn	Well led	80%	89.1%	95.7%	97.8%	74.1%	69.2%	76.9%
Supervision - Management	Best place to work and learn	Well led	80%	87.0%	30.4%	97.8%	74.1%	57.7%	76.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	90.4%	94.1%	96.3%	92.3%	96.3%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	84.3%	84.6%	84.3%	88.9%	92.3%	81.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	95.7%	89.1%	87.0%	81.5%	84.6%	74.1%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	96.2%	96.2%	92.2%	92.6%	96.2%	92.6%
Bed occupancy	Best Quality	Safe	Trend Monitor	53.8%	56.4%	63.1%	56.0%	52.3%	51.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	18	307	432	69	1161	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	99.1%	98.0%	98.3%	101.6%	102.7%	98.5%
Safer staffing (Registered)	Best Quality	Safe	80%	97.6%	97.5%	99.2%	103.5%	101.2%	97.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	50.0%	N/A	N/A	N/A	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	1	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	1	0	0	0
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/102)	0% (0/104)	2% (2/121)	0% (0/22)	4% (1/25)	0% (0/30)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	4	0	0	1	0

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Inpatients - Forensic West Yorkshire - Medium Secure

Medium Secure

- A continued focus on high-quality appraisals remains a priority for the service, with focused intervention to ensure all staff have a quality appraisal. As the service moves into the new appraisal compliance window, some expected variation in compliance data has been observed. Positively, Bronte, Hepworth and Waterton remain at 100% compliance. Compliance levels on Appleton (80%), Johnson (80.8%), Chippendale (84.2%), and Priestley (87.5%) are lower but remain under review as teams continue to adapt to the revised appraisal cycle.
- Separation of supervision recording has highlighted inconsistencies in distinguishing management and clinical supervision. A targeted QI programme, led by Ward Managers, is underway to strengthen supervision structures, quality and recording. This includes clarifying supervision trees to ensure all staff receive appropriate management, clinical, and primary nursing support. Current focus is on embedding clear, consistent recording systems and improving capture of group supervision (e.g. reflective practice) to strengthen oversight. Overall, an improving trajectory is noted.
- Sickness absence continues to improve overall with five wards (Johnson, Priestley, Hepworth, Bronte and Appleton) within compliance. Chippendale (7.1%) and Waterton (18.3%) continue to experience high sickness absence. Targeted interventions remain in place, addressing both short- and long-term absence to sustain improvement. Waterton continues to report individual challenges with the number of staff requiring long-term sickness absence, with a notable proportion of staff requiring surgery. Due to the extended nature of these absences, this continues to present a challenge; however, improvement has been seen in short-term sickness absence, and work remains ongoing.
- There have been improvements in mandatory training, however hotspots remain in Information Governance (IG), on Appleton (88.9%), Chippendale (94.7%) and Waterton (94.4%). This is considered to be a seasonal issue, reflecting the number of staff requiring updates during this period and all Ward Managers have a plan in place to improve compliance. A further hotspot in relation to CPR has shown overall improvement; however, Hepworth (76.2%) and Priestley (77.8%) continue to require focused attention and monitoring. We do understand that the Challenges have been identified in releasing staff from shifts to attend CPR training. Staff have therefore been advised not to book onto sessions during shifts.
- Bed occupancy on Appleton remains low at 50.0%, reflecting a continued reduction in learning disability referrals to secure care. Occupancy in the women's service has seen a period of unusual variation, with Johnson Ward (medium secure) at 100%. On the male pathway, although overall occupancy appears reduced within the data, our capacity is within our admission wards and rehabilitation wards are at full capacity. This demonstrates a positive position for patient flow. Where there is reduced occupancy on Hepworth (79.8%), this is to support process for new admissions. The service has a waiting list for our male pathway.
- There were three prone restraints with the service. All these related to one service user, with individual complexities and risks. Prone restraint was due to medication and seclusion exit. All have been reviewed by RRPI and ongoing advice and support to reduce prone restraint where possible is in place. Incidents of restraint show broad consistency.
- The service continues to experience high levels of acuity, during June both Chippendale and Bronte were operating above establishment to meet clinical need. Staffing levels are reviewed daily through the morning meeting, supported by team leaders to ensure proactive deployment of resources and the reallocation of staff from the wider multi-disciplinary team where required. A focused piece of work, supported by the E-Rostering team, has helped to further embed SafeCare within the morning meeting and routine practice, contributing to improvements in the quality and accuracy of SafeCare data.
- The metric relating to completion of inpatient risk assessments within 24 hours has been reviewed by the service. Within forensic services, forensic risk assessments are completed prior to admission as part of the gatekeeping process, supporting safe and effective planning. A communication has been issued to ensure these assessments are reviewed and formally signed off again on admission. The service is 100% compliant in this review period and this will be continued to be monitored.
- The service reviews staffing levels daily using professional judgement alongside SafeCare data. Where challenges arise in providing Section 17 (S17) escorts, these are actively reviewed and prioritised to ensure urgent health and legal appointments are maintained. An increase in inpatient acuity, combined with a higher demand for staff escorts, has placed additional pressure on staffing capacity across the service. This will continue to be closely monitored.

Low Secure

- Sickness absence levels continue to be monitored closely, with Ward Managers working alongside the People Directorate and Occupational Health to support staff and improve attendance. Newhaven remains within compliance (4.9%). Current sickness absence rates for, Sandal (6.9%) and Thornhill (5.9%) remain above the compliance target, reflecting a combination of both short- and long-term sickness absence. A particular hotspot has been identified on Ryburn (28.4%). Given the small size of the service, sickness levels can be disproportionately affected by a small number of absences and there are currently several staff members on long term sickness absence.
 - Ward Managers, with support from the People Directorate, continue to actively review the position and implement appropriate support measures. Planned return to work arrangements are expected to contribute to further improvements in long term sickness absence levels over the coming months.
 - Mandatory training compliance remains positive across the service. Hotspots for this month are IG training, which is recognised as an annual pressure point, and remains at Newhaven (93.3%) and Thornhill (76.5%). CPR is an additional hotspot on Sandal (65.5%) and Thornhill (76.5%). The service has had challenges in the release of staff from shift for this ½ day training and have requested staff to not book this whilst on shift to support attendance. Targeted actions are in place to improve compliance.
 - A continued focus on high quality appraisals remains a priority for the service. Thornhill (96.7%) and Ryburn (100%) are within agreed performance standards. Current compliance stands at 74.2% for Newhaven and 83.8% for Sandal with a clear plan for an improving trajectory in place and lead by the Ward Manager. Work has taken place to address data quality issues, and the service remains committed to ensuring that all staff receive a timely and high-quality appraisal.
 - Separation of supervision recording has highlighted inconsistencies in distinguishing management and clinical supervision. A targeted quality improvement programme, led by Ward Managers, is underway to strengthen supervision structures, quality and recording. This includes clarifying supervision trees to ensure all staff receive appropriate management, clinical, and primary nursing support. Current focus is on embedding clear, consistent recording systems and improving capture of group supervision (e.g. reflective practice) to strengthen oversight. The impact of the actions implemented to date is evidenced by improving compliance On Newhaven. Progress on Ryburn has been slower than anticipated due to a period of leadership absence, which has affected the pace of improvement. To mitigate this, temporary leadership support has been identified and is being implemented to provide additional oversight and drive further improvement in compliance.
 - The metric relating to completion of inpatient risk assessments within 24 hours has been reviewed by the service. Within forensic services, forensic risk assessments are completed prior to admission as part of the gatekeeping process, supporting safe and effective planning. A communication has been issued to ensure these assessments are reviewed and formally signed off again on admission. The service is currently compliant.
 - The service continues to work closely with the provider collaborative to support effective use of bed occupancy across West Yorkshire. The Bretton Centre currently has good occupancy with processes in place to support admissions. Newhaven (81.3%) has noted unusual variation with some increased occupancy but overall continues to experience lower level of referrals and has no waiting list.
 - There were no prone restraint incidents, and Incidents of restraint show broad consistency.
 - Safer staffing levels are within the expected compliance range. Increased acuity on Sandal (183.9%) has resulted in additional staffing to ensure safe service delivery.
- The service reviews staffing levels daily using professional judgement alongside SafeCare data. Where challenges arise in providing Section 17 (S17) escorts, these are actively reviewed and prioritised to ensure urgent health and legal appointments are maintained. An increase in inpatient acuity, combined with a higher demand for staff escorts, has placed additional pressure on staffing capacity across the service. This will continue to be closely monitored.

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Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	Appleton May-26	Jun-26	Apr-26	Bronte May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	93.3%	93.3%	80.0%	95.0%	95.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	3.0%	5.3%	4.4%	0.9%	0.0%	0.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	66.7%	70.6%	83.3%	65.2%	95.7%	90.9%
Supervision - Management	Best place to work and learn	Well led	80%	53.5%	58.8%	66.7%	4.3%	13.0%	54.5%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	94.4%	88.9%	88.9%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	94.4%	100.0%	100.0%	95.5%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	88.9%	83.3%	83.3%	66.7%	68.2%	81.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	77.8%	88.9%	88.9%	90.5%	90.9%	85.7%
Bed occupancy	Best Quality	Safe	90%	50.0%	50.0%	50.0%	88.1%	88.5%	98.6%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	134.8%	125.0%	93.8%	98.2%	98.6%	122.8%
Safer staffing (Registered)	Best Quality	Safe	80%	96.1%	89.7%	91.6%	99.1%	98.0%	112.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	100.0%	N/A	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	0	0	0	1	4
Restraint incidents	Best Quality	Safe	Trend Monitor	6	2	2	2	1	11
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	3
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/4)	N/A	N/A	0% (0/6)	0% (0/8)	100% (6/6)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	2	8	1	0	0	5

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Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Chippendale			Hepworth		
				Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	94.4%	89.5%	84.2%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	5.3%	5.2%	7.1%	1.3%	1.2%	4.5%
Supervision - Clinical	Best place to work and learn	Well led	80%	90.0%	84.2%	78.9%	50.0%	75.0%	55.0%
Supervision - Management	Best place to work and learn	Well led	80%	90.0%	68.4%	42.1%	35.0%	40.0%	10.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	94.7%	94.7%	100.0%	95.0%	95.2%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	84.2%	100.0%	89.5%	75.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	85.0%	94.7%	84.2%	78.9%	85.0%	76.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.0%	94.7%	94.7%	84.2%	80.0%	95.2%
Bed occupancy	Best Quality	Safe	90%	91.7%	98.4%	96.1%	80.9%	83.9%	79.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	814	N/A	N/A	66
Safer staffing (Overall)	Best Quality	Safe	90%	99.0%	97.6%	122.1%	99.2%	95.3%	95.9%
Safer staffing (Registered)	Best Quality	Safe	80%	111.8%	107.5%	125.0%	86.1%	87.1%	89.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	N/A	66.7%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	1	1	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	1	0	2	1
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	8% (2/26)	13% (4/31)	10% (3/31)	40% (2/5)	0% (0/4)	50% (1/2)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	2	14	1	0	1

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Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	Johnson May-26	Jun-26	Apr-26	Priestley May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	96.2%	80.8%	76.5%	88.2%	87.5%
Sickness	Best place to work and learn	Well led	5.0%	2.6%	3.7%	2.7%	5.2%	5.1%	4.2%
Supervision - Clinical	Best place to work and learn	Well led	80%	96.7%	66.7%	62.5%	61.1%	66.7%	78.9%
Supervision - Management	Best place to work and learn	Well led	80%	50.0%	51.5%	65.6%	55.6%	55.6%	57.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	90.9%	90.6%	96.9%	100.0%	94.7%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	78.8%	90.6%	93.8%	94.4%	88.9%	94.4%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	75.8%	87.5%	87.5%	88.9%	83.3%	77.8%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.9%	90.6%	93.8%	89.5%	89.5%	89.5%
Bed occupancy	Best Quality	Safe	90%	100.0%	100.0%	100.0%	98.0%	94.1%	93.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	775	1389	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	131.0%	112.8%	103.9%	107.8%	134.7%	90.9%
Safer staffing (Registered)	Best Quality	Safe	80%	100.6%	96.8%	99.5%	101.5%	92.3%	88.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	1	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	1	1	0	0	0	0
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	6% (2/34)	12% (3/26)	13% (5/39)	21% (6/28)	0% (0/14)	52% (11/21)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	6	1	3	4	2	1

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Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	Waterton May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	93.3%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	7.6%	22.9%	18.3%
Supervision - Clinical	Best place to work and learn	Well led	80%	44.0%	40.0%	75.0%
Supervision - Management	Best place to work and learn	Well led	80%	24.0%	32.0%	62.5%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	94.4%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	91.3%	90.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	73.9%	85.0%	88.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	91.3%	90.0%	88.9%
Bed occupancy	Best Quality	Safe	90%	99.6%	97.6%	92.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	1359	N/A	1514
Safer staffing (Overall)	Best Quality	Safe	90%	107.9%	109.2%	97.8%
Safer staffing (Registered)	Best Quality	Safe	80%	96.3%	103.1%	99.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/72)	1% (1/80)	20% (5/25)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	1	3	5

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Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	Thornhill May-26	Jun-26	Apr-26	Sandal May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	81.5%	96.7%	96.7%	88.0%	91.3%	83.3%
Sickness	Best place to work and learn	Well led	5.0%	15.2%	7.5%	5.9%	7.0%	3.1%	6.9%
Supervision - Clinical	Best place to work and learn	Well led	80%	45.5%	47.1%	52.9%	36.4%	46.9%	48.5%
Supervision - Management	Best place to work and learn	Well led	80%	33.3%	38.2%	41.2%	21.2%	34.4%	33.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.8%	96.9%	94.1%	96.6%	96.4%	96.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.6%	96.9%	97.1%	89.7%	92.9%	93.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.4%	87.5%	76.5%	65.5%	67.9%	65.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	93.8%	100.0%	97.1%	89.7%	85.7%	93.1%
Bed occupancy	Best Quality	Safe	85%	94.7%	96.3%	96.0%	95.4%	91.3%	93.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	1900	N/A	1400	162	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	95.7%	97.5%	95.4%	138.1%	151.3%	183.9%
Safer staffing (Registered)	Best Quality	Safe	80%	102.1%	101.4%	100.3%	105.4%	105.0%	105.3%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	100.0%	100.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	0	0	4	2	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	1	0	2	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	2	0	0	7	0	0
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	7% (10/135)	20% (34/168)	32% (34/108)	8% (6/74)	5% (1/20)	10% (4/39)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	0	20	15	20

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Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	Ryburn May-26	Jun-26	Apr-26	Newhaven May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	90.9%	90.9%	100.0%	74.2%	74.2%	81.5%
Sickness	Best place to work and learn	Well led	5.0%	19.4%	17.6%	28.4%	1.0%	0.5%	4.9%
Supervision - Clinical	Best place to work and learn	Well led	80%	58.3%	23.1%	30.8%	67.7%	90.3%	92.3%
Supervision - Management	Best place to work and learn	Well led	80%	58.3%	30.8%	23.1%	83.9%	71.0%	88.5%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	94.1%	94.1%	93.3%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.9%	81.8%	90.0%	93.5%	91.2%	90.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.8%	90.9%	100.0%	87.1%	90.3%	92.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.9%	100.0%	100.0%	94.1%	94.1%	96.7%
Bed occupancy	Best Quality	Safe	85%	81.9%	85.7%	87.6%	75.0%	77.2%	81.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	96.3%	99.0%	97.4%	113.0%	114.8%	104.6%
Safer staffing (Registered)	Best Quality	Safe	80%	96.7%	99.5%	97.6%	102.7%	102.1%	102.5%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	N/A	100.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	2	0	2
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0	6	2	2
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	100% (1/1)	100% (2/2)	0% (0/4)	3% (1/39)	8% (3/37)	3% (1/32)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	1	3	2	4

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Inpatients - Non-Mental Health

• Appraisal rate (90%):

Appraisal compliance against new thresholds shows 100% compliance during June for band 8a and above (the ward breakdown below shows compliance against rolling 12 months).

• Supervision (80%):

Work continues to improve clinical and managerial supervision; both uptake and recording. Plan in place on both units to improve trajectory by undertaking clinical and managerial supervision during handovers and recording this daily. See also narrative on page 1 for wider Care Group; this also applies to both wards.

• Sickness (5%):

NRU – sickness for June has continued to increase and is outside compliance at 11.3%. The current position includes some instances of long term sickness.

SRU – Sickness for June has shown a further improvement and achieved compliance at 3.8%. The current position includes several instances of long term sickness.

Sickness on both units is being monitored and managed via Supporting Wellbeing (Sickness and Attendance Procedure). As noted last month, some staff were not due to return to work until mid-June, therefore this has impacted this month's figures.

• Information Governance (95%):

NRU compliancy has seen a good increased to compliance in June and is at 100%.

SRU has maintained compliance at 95.8% for June.

• CPR (80%):

NRU has seen a slight increase during June to 77.8%.

SRU has shown a good increase and is now achieving compliance at 80.9% for June.

Sickness on NRU continues to impact attendance this month as a number of staff who were booked on future sessions were unable to attend due to sickness absence. In addition, we had to cancel some attendances in order to ensure safe staffing levels on the ward. All staff who are out of date are re-booked to attend future dates of ILS and BLS.

In addition, Learning and Development colleagues are exploring the use of local venues to enable Barnsley staff to attend this training more easily and reduce the amount of travel time.

• Fire Safety Training (85%):

NRU – remains slightly below compliance but showing an increase to 84.2% for June.

Sickness has impacted attendance at face-to-face training both in terms of staff off sick and other colleagues who have been unable to leave ward due to ensuring sufficient cover. All staff out of date have been booked onto future sessions at the earliest opportunity.

• Safer Staffing - overall (90%):

NRU – within compliance – at 110.9%

SRU – below compliance – at 79.97% - this correlates with our reduced occupancy level during June which fell to 67.8%. This meant the unit could allow additional staff to take annual leave during the periods when we had less patients on the ward.

Safer staffing (registered 80%) is within compliance for both units.

To note: the establishment figures for both wards were reviewed in November 2025 and work continues to realign this on e-roster following further meetings in early 2026. Additional meetings took place during May and June and the recommendations to correct the roster fill rate for SRU will take effect from 28.9.26. Until this date, there may be ongoing instances where the figures do not show as compliant.

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Metrics	Strategic Objective	CQC Domain	Threshold	Neuro Rehabilitation Unit (NRU)			Stroke Rehabilitation Unit (SRU)		
				Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	85.7%	100.0%	97.1%	94.0%	97.1%	88.4%
Sickness	Best place to work and learn	Well led	5.0%	7.7%	8.9%	11.3%	6.5%	6.0%	3.8%
Supervision - Clinical	Best place to work and learn	Well led	80%	61.5%	55.3%	23.7%	55.7%	40.8%	42.9%
Supervision - Management	Best place to work and learn	Well led	80%	53.8%	50.0%	21.1%	48.6%	43.7%	10.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	92.7%	92.5%	100.0%	94.2%	95.6%	95.8%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	79.5%	76.3%	77.8%	69.2%	74.6%	80.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	80.5%	80.0%	84.2%	94.2%	89.7%	90.3%
Bed occupancy (Barnsley Commissioned beds only)	Best Quality	Safe	80%	95.3%	96.0%	97.8%	97.2%	91.1%	67.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	69	67	67	23	28	26
Safer staffing (Overall)	Best Quality	Safe	90%	100.4%	106.2%	110.9%	93.1%	87.0%	79.9%
Safer staffing (Registered)	Best Quality	Safe	80%	86.7%	86.3%	92.3%	93.7%	97.5%	93.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	5	12	2	30	58	18

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Inpatients - Mental Health - Learning Disability

Headlines

- Appraisal compliance has reduced slightly to 88.2% this month. All outstanding appraisals relate to a very small number of staff, with reviews now scheduled, including for those recently returning from sick leave. Clear processes remain in place to support transition to the new appraisal framework, with robust governance ensuring timely completion and sustained quality.
- There has been a slight increase in sickness absence (5.7%), which remains above the compliance target. This appears to be normal variation rather than a concerning trend. Proactive processes are in place with managers to support attendance, and the position will continue to be closely monitored.
- Supervision continues to meet expected compliance levels, with clinical supervision at 100% and management supervision at 97.2%. This reflects a strong culture of support, accountability, and effective clinical oversight across the service.
- Mandatory training remains within target, reflecting strong compliance and a continued focus on maintaining required standards across the service.
- Low occupancy is understood and aligned with wider Assessment Treatment Unit (ATU) workstream.
- Clinically ready for discharge (CRFD), has noted improvement albeit currently at 81.8% and understood and in relation to pathway challenges. The service continued to support system wider working to identify appropriate packages of care. As previous report, placements have been identified for service users but complex packages including build work results in delay.
- On staffing levels, we have undertaken the establishment review and are just working on finalisation and ensuring template reflects new agreed staffing.
- Due to current acuity and needs of individual service users, the service has required additional staffing in the overall staffing (121.6%) and registered staffing (161.1%). Following template changes this would more accurately reflect proposed staffing.
- There have been no prone restraints this period and restraint levels remain broadly consistent with usual service parameters and reflect the acuity of a small number of service users.
- Cancelled leave is routinely monitored across the service.

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	Horizon May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	77.8%	97.1%	88.2%
Sickness	Best place to work and learn	Well led	5.0%	4.7%	4.2%	5.7%
Supervision - Clinical	Best place to work and learn	Well led	80%	88.4%	97.3%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%	79.1%	94.6%	97.2%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.6%	100.0%	97.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.3%	95.1%	92.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	94.9%	92.3%	81.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.7%	95.1%	90.0%
Bed occupancy	Best Quality	Safe	N/A	50.0%	42.3%	45.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	524	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	133.7%	120.2%	121.6%
Safer staffing (Registered)	Best Quality	Safe	80%	167.9%	162.0%	161.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	100.0%	100.0%	81.8%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	11	12	6
Restraint incidents	Best Quality	Safe	Trend Monitor	8	8	5
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/196)	0% (0/166)	0% (0/176)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	30	16	36

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Inpatients - Forensic South Yorkshire

Low Secure Services

- Appraisals: Strong performance in Calder (90.5%) and Esk (90.5%), meeting the 90% target. Aire (64.3%), Don (69.6%) and Wentbridge (78.1%) remain below target despite gradual improvement.
- Supervision: Calder demonstrates strong compliance with both clinical and management supervision and Wentbridge has recovered above target. Aire and Don remain below the 80% target for both clinical and management supervision, while Esk's clinical supervision fell below target in June (72.7%).
- Bed Occupancy: Don is operating at near full occupancy (98.3%) and Calder achieved target occupancy (92.9%). Aire (87.2%), Wentbridge (87.5%) and Esk (78.1%) remain below the 90% target, with Esk showing a continued decline.
- Mandatory Training: Compliance is generally strong across all wards. The main exception is Don's Reducing Restrictive Practice training compliance (78.3%), which remains below target.
- Restrictive Practice: No prone restraint incidents were reported across any ward. Restraint use remains low overall, although Don recorded an increase in restraint incidents during June, while Esk reported low-level but consistent restraint use.
- Staffing: Safer staffing and registered staffing levels exceed target across all wards. However, high levels of unfilled shifts, particularly in Wentbridge, Don, Aire and Esk, indicate ongoing workforce pressures.
- Section 17 Leave: Wentbridge is a significant outlier, with leave cancellations increasing to 76% (29/38) in June and requiring urgent review.
- Patient Flow: Esk and Calder have exceptionally long lengths of stay, highlighting ongoing challenges with patient progression and discharge pathways.

Medium Secure Services (Foss and Skipton)

- Appraisals: Skipton (96.6%) continues to exceed the 90% target, while Foss (83.3%) remains below target and has declined over the quarter.
- Supervision: Both wards have improved significantly and are now exceeding the 80% target for both clinical and management supervision.
- Bed Occupancy: Skipton achieved target occupancy (91.7%), while Foss remains significantly below target (74.8%), indicating available capacity and flow challenges.
- Mandatory Training: Compliance is generally strong across both wards. The main concern is Information Governance compliance in Foss (92.3%), which is below target.
- Restrictive Practice: No prone restraint incidents were reported. However, Skipton experienced a significant increase in restraint incidents, rising to 19 in June, representing the most notable safety concern within Medium Secure Services.
- Staffing: Overall safer staffing remains above target. However, Skipton continues to operate below the registered staffing target (70.3%), and both wards report high numbers of unfilled shifts.
- Violence and Safety: No patient-on-patient violence was reported. Skipton recorded two patient-on-staff assaults in June, whereas Foss reported none throughout the quarter.
- Patient Flow and Workforce: Foss continues to experience high sickness (7.1%), a very long average length of stay (1,894 days) and increasing Section 17 leave cancellations (27%), indicating ongoing challenges with workforce resilience and patient progression.

Metrics	Strategic Objective	CQC Domain	Threshold	Medium Secure Services					
				Apr-26	Foss May-26	Jun-26	Apr-26	Skipton May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	86.4%	87.0%	83.3%	90.0%	96.7%	96.6%
Sickness	Best place to work and learn	Well led	5.0%	6.7%	7.2%	7.1%	3.6%	2.1%	4.1%
Supervision - Clinical	Best place to work and learn	Well led	80%	70.4%	96.3%	88.9%	77.1%	97.1%	93.9%
Supervision - Management	Best place to work and learn	Well led	80%	63.0%	88.9%	85.2%	74.3%	100.0%	87.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.8%	95.8%	92.3%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	87.5%	87.5%	84.6%	82.9%	85.3%	84.8%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	62.5%	87.5%	80.8%	71.4%	80.0%	82.8%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	75.0%	100.0%	92.3%	82.9%	94.1%	97.0%
Bed occupancy	Best Quality	Safe	90%	78.6%	78.6%	74.8%	83.3%	86.8%	91.7%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	N/A	1894	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	125.3%	119.3%	105.3%	99.7%	100.8%	103.7%
Safer staffing (Registered)	Best Quality	Safe	80%	104.1%	97.9%	104.6%	70.2%	68.8%	70.3%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	2	0	2
Restraint incidents	Best Quality	Safe	Trend Monitor	1	2	1	4	5	19
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	14% (6/44)	11% (4/35)	27% (10/37)	18% (7/38)	14% (4/29)	16% (6/37)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	16	20	23	31	23	34

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Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Esk			Wentbridge		
				Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	90.9%	90.9%	90.5%	53.1%	78.1%	78.1%
Sickness	Best place to work and learn	Well led	5.0%	5.4%	2.0%	3.9%	1.5%	1.0%	3.2%
Supervision - Clinical	Best place to work and learn	Well led	80%	83.3%	91.3%	72.7%	73.5%	97.1%	91.2%
Supervision - Management	Best place to work and learn	Well led	80%	41.7%	73.9%	81.8%	58.8%	94.1%	88.2%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.7%	100.0%	100.0%	100.0%	100.0%	97.1%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	82.6%	81.8%	81.8%	97.1%	97.1%	97.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.0%	85.7%	95.2%	91.2%	97.1%	97.1%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	73.9%	100.0%	100.0%	97.1%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	85.0%	79.0%	78.1%	87.5%	87.5%	87.5%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	1075	3080	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	99.0%	99.9%	102.2%	112.9%	119.3%	121.4%
Safer staffing (Registered)	Best Quality	Safe	80%	90.5%	96.7%	81.4%	95.9%	91.8%	94.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	2	0	0	0	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	0	0	0	0	3
Restraint incidents	Best Quality	Safe	Trend Monitor	1	1	1	0	0	0
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	15% (4/26)	19% (6/32)	18% (8/44)	0% (0/28)	8% (3/40)	76% (29/38)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	2	10	3	15	17	28

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Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services			Don		
				Apr-26	Aire May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	48.3%	59.3%	64.3%	56.5%	68.2%	69.6%
Sickness	Best place to work and learn	Well led	5.0%	2.2%	3.4%	5.2%	0.6%	1.1%	1.8%
Supervision - Clinical	Best place to work and learn	Well led	80%	77.4%	75.9%	73.3%	30.4%	69.6%	50.0%
Supervision - Management	Best place to work and learn	Well led	80%	29.0%	62.1%	60.0%	26.1%	69.6%	45.8%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	95.7%	95.5%	95.7%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	83.3%	89.3%	89.3%	78.3%	77.3%	78.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	83.3%	89.3%	92.9%	91.3%	86.4%	87.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	93.3%	100.0%	100.0%	91.3%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	75.6%	84.7%	87.2%	100.0%	99.7%	98.3%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	99.4%	96.7%	90.3%	102.0%	104.3%	106.4%
Safer staffing (Registered)	Best Quality	Safe	80%	91.3%	92.7%	90.9%	87.8%	90.8%	86.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	1	1
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0	0	0	2
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	9% (2/22)	14% (5/36)	5% (1/20)	11% (5/45)	12% (6/52)	12% (5/42)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	7	11	11	10	11	8

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Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Calder		
				Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	90.9%	90.9%	90.5%
Sickness	Best place to work and learn	Well led	5.0%	0.0%	1.5%	5.4%
Supervision - Clinical	Best place to work and learn	Well led	80%	100.0%	100.0%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%	86.4%	90.9%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	100.0%	95.5%	95.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.5%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	88.3%	89.7%	92.9%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	1818	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	96.1%	95.7%	91.6%
Safer staffing (Registered)	Best Quality	Safe	80%	86.7%	91.8%	90.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	1	0	0
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	4% (1/23)	16% (8/51)	2% (1/57)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	6	8	7

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Overall Financial Performance 2026/27

Executive Summary / Key Performance Indicators

Performance Indicator		Strategic Objective	CQC Domain	Year to Date	2026/27 Forecast	Narrative
NHS Oversight Framework - finance metric		Best Value	Well Led	1	1	The score of 1 means that the financial override is not applied against the Trust National Oversight Framework score for the finance metrics. This will be reviewed in line with any changes to the National Oversight Framework and the calculation of financial metrics.
1	Surplus / (Deficit)	Best Value	Well Led	(£1.8m)	£0m	The financial performance in June 2026 is a deficit of £526k which is £120k more than plan in month. The year to date position remains just ahead of plan (£8k) due to the performance in April and is also supported by one off items. This means that further actions are required to ensure that the breakeven target can be achieved.
2	Agency Spend	Best Value	Well Led	£0.4m	£2m	Agency spend is currently being maintained at a historically low level. Spend in June 2026 is £138k, within plan and is constricted to a limited number of medical posts. This is forecast to increase over the coming months due to pending staff retirements.
3	Bank Spend	Best Value	Well Led	£5.8m	£20.2m	Bank spend has increased in June 2026 to £1,937k and remains higher than plan. The increase is within unregistered nursing, primarily within inpatient areas, to support operational pressures. The forecast includes a reducing run rate and this continues to be triangulated with the Trust workforce plan and strategy. At June the forecast is that the bank target will be exceeded.
4	Financial sustainability and efficiencies	Best Value	Well Led	£2.3m	£17.7m	The Trust value for money programme is reported as ahead of plan at month 3. The largest contributors are the reduction in corporate costs and the maintained run rate reduction of spend on temporary staffing and out of area placements which commenced in 2025 / 26. The trajectory includes the identification, and delivery, of new schemes later in the year. These need to be recurrent in nature to ensure that the Trust medium term financial plan of breakeven is maintained.
5	Cash	Best Value	Well Led	£57.7m	£61.4m	The current cash position continues to be positive but, in line with national focus in this area, best practice continues to be reviewed to ensure that we have effective management of the Trust working capital position.
6	Capital Spend	Best Value	Well Led	£2.4m	£14.7m	As highlighted previously, in June 2026, the capital programme has switched from being ahead of plan to behind. The main change is the profile of the Older People Inpatient scheme which continues to be developed. The forecast remains in line with allocation, including a new allocation for community hubs, and schemes are progressing. Any revisions to timescales or forecasts will be agreed through Trust Board.
7	Better Payment Practice Code	Best Value	Well Led	98%		This performance is based upon a combined NHS / Non NHS value. The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.

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



South West Yorkshire
Partnership Teaching
NHS Foundation Trust



Finance Report

Month 3 (2026 / 27)



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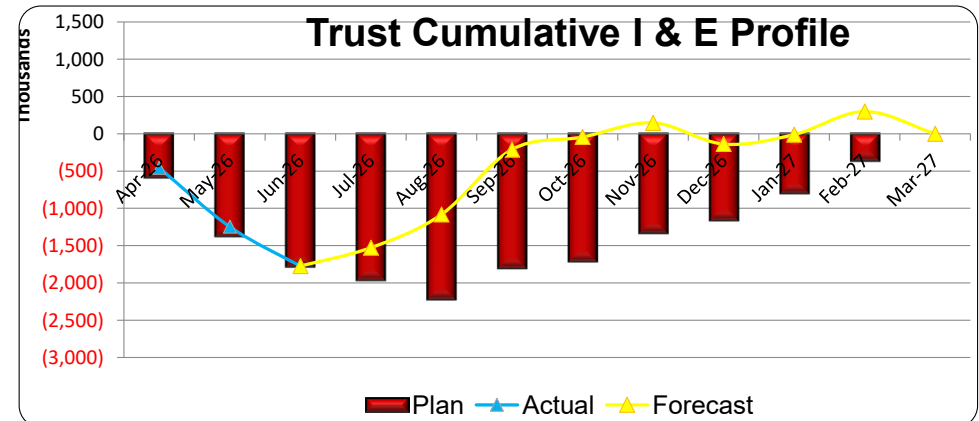
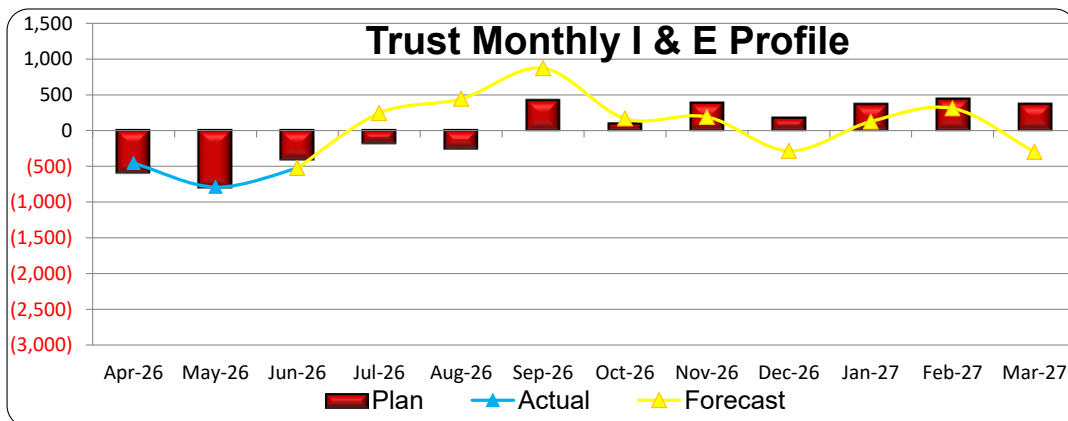
With **all of us** in mind.

1.0		Executive Summary / Key Performance Indicators		
Key Performance Indicator		Year to Date	Forecast 2026 / 27	Narrative
NOF 1	National Oversight Framework	1	1	The score of 1 means that the financial override is not applied against the Trust National Oversight Framework score. This will be reviewed in line with any changes to the National Oversight Framework and the calculation of financial metrics.
1	Surplus / (Deficit)	(£1.8m)	£0m	The financial performance in June 2026 is a deficit of £526k which is £120k more than plan in month. The year to date position remains just ahead of plan (£8k) due to the performance in April and is also supported by one off items. This means that further actions are required to ensure that the breakeven target can be achieved.
2	Agency Spend	£0.4m	£2m	Agency spend is currently being maintained at a historically low level. Spend in June 2026 is £138k, within plan and is constricted to a limited number of medical posts. This is forecast to increase over the coming months due to pending staff retirements.
3	Bank Spend	£5.8m	£20.2m	Bank spend has increased in June 2026 to £1,937k and remains higher than plan. The increase is within unregistered nursing, primarily within inpatient areas, to support operational pressures. The forecast includes a reducing run rate and this continues to be triangulated with the Trust workforce plan and strategy. At June the forecast is that the bank target will be exceeded.
4	Financial sustainability and efficiencies	£2.3m	£17.7m	The Trust value for money programme is reported as ahead of plan at month 3. The largest contributors are the reduction in corporate costs and the maintained run rate reduction of spend on temporary staffing and out of area placements which commenced in 2025 / 26. The trajectory includes the identification, and delivery, of new schemes later in the year. These need to be recurrent in nature to ensure that the Trust medium term financial plan of breakeven is maintained.
5	Cash	£57.7m	£61.4m	The current cash position continues to be positive but, in line with national focus in this area, best practice continues to be reviewed to ensure that we have effective management of the Trust working capital position.
6	Capital	£2.4m	£14.7m	As highlighted previously, in June 2026, the capital programme has switched from being ahead of plan to behind. The main change is the profile of the Older People Inpatient scheme which continues to be developed. The forecast remains in line with allocation, including a new allocation for community hubs, and schemes are progressing. Any revisions to timescales or forecasts will be agreed through Trust Board.
7	Better Payment Practice Code	98%		This performance is based upon a combined NHS / Non NHS value. The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.
Red		Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels		
Amber		Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels		
Green		In line, or greater than plan		

The table below presents the total consolidated financial position for South West Yorkshire Partnership Teaching NHS Foundation Trust. This incorporates its role as co-ordinating provider for a number of Mental Health Provider Collaboratives but excludes its linked charities which are consolidated into the Trust's group annual accounts. The impact of the Provider Collaboratives, and budgets held centrally, are 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					35,329	35,488	160	104,642	104,838	196	418,836	417,019	(1,817)
Other Operating Revenue					1,328	1,349	21	3,906	4,019	113	15,688	16,013	326
Total Revenue					36,657	36,837	181	108,548	108,857	309	434,524	433,033	(1,491)
Employee expenses	5,387	5,397	10	0.2%	(25,966)	(26,423)	(456)	(77,257)	(78,559)	(1,301)	(306,001)	(315,632)	(9,631)
Operating expenses exc. Employee expenses					(10,828)	(10,768)	60	(32,299)	(31,553)	747	(125,290)	(115,217)	10,073
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	5,387	5,397	10	0.2%	(36,794)	(37,191)	(397)	(109,557)	(110,112)	(555)	(431,291)	(430,849)	442
Operating Surplus / (Deficit)	5,387	5,397	10	0.2%	(138)	(354)	(216)	(1,009)	(1,255)	(246)	3,233	2,184	(1,049)
Finance expense					(57)	(59)	(2)	(168)	(178)	(10)	(673)	(672)	1
PDC Paid					(362)	(362)	0	(1,086)	(1,086)	0	(4,343)	(4,343)	(0)
Finance income					140	241	101	448	722	274	1,645	2,747	1,102
Surplus / (Deficit) - Total	5,387	5,397	10	0.2%	(417)	(534)	(117)	(1,815)	(1,797)	18	(138)	(84)	54
Adjusted Financial Performance													
Depn Peppercorn Leases (IFRS16)					11	8	(3)	34	24	(10)	138	84	(54)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - ICB performance measure	5,387	5,397	10	0.2%	(406)	(526)	(120)	(1,781)	(1,772)	8	(0)	(0)	(0)



Income & Expenditure Position 2026 / 27

**The consolidated Trust deficit in June 2026 is £526k.
This is £120k worse than plan.**

In line with national guidance the Trust submitted a risk assessed breakeven financial plan for 2026 / 27. Within this position there were identified risks and opportunities and these will be continually assessed as the year progresses. These are discussed monthly at the Trust Finance, Investment and Performance Committee.

NHS England - monthly submission

The actual financial performance reported here is consistent with the monthly return made to NHS England. The corresponding declaration is made within the return itself.

The submission is for the total consolidated financial position which operates as a single segment for the purpose of providing healthcare services. Within this report the financial information is split into core Trust, Provider Collaboratives and budgets held centrally. Financial performance is summarised in the table below.

	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
Description	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Trust (core)	5,364	5,376	11	0.2%	(531)	(533)	(2)	(2,545)	(1,707)	837	(4,315)	(12,926)	(8,611)
Provider Collaboratives	23	21	(2)	8.4%	42	(115)	(158)	29	(202)	(232)	20	(1,917)	(1,937)
Budgets held centrally	0	0	0	0.0%	83	123	39	735	137	(598)	4,295	14,843	10,548
Total - Consolidated position (ICB performance measure)	5,387	5,397	10	0.2%	(406)	(526)	(120)	(1,781)	(1,772)	8	(0)	(0)	(0)

Although the run rate has improved, the in month deficit reducing from £791k in May to £526k in June, this remains in deficit and continues to be higher than plan. This is both the core Trust and also the provider collaboratives. This is supported by some small non-recurrent benefits as shown against the budgets held centrally line and the timing of income. The year to date position is just ahead of plan.

Overall the Trust (core) run rate has remained relatively constant with June 2026 marginally below the average of £569k per month. As discussed later in this paper the main pressure remains on workforce (worked WTE and expenditure) which are greater than plan in month. Non pay expenditure has increased, but alongside the timing of income, continues to reduce the reported level of deficit.

The Adult Secure provider collaboratives (both South Yorkshire and West Yorkshire) continue to report operational and financial pressures with South Yorkshire reporting a £161k deficit in month.

Budgets held centrally remains for items that are not able to be coded through care groups. Actual expenditure remains limited, although there are c. £100k of non recurrent benefits reported in month, but the budget requires additional value for money schemes to be allocated against it. The forecast is significant improvement in order to achieve the breakeven target. The action plan, and forecast scenarios, is presented to the Trust Finance, Investment and Performance Committee.

This section focusses on the financial performance of South West Yorkshire Partnership Teaching NHS Foundation Trust. This excludes the financial impact of Provider Collaboratives and budgets held centrally which are presented separately. The movement between the total consolidated financial position and the table below is reconciled on the previous page for ease.

To confirm that the individual analysis within this report highlights the Trust only values unless explicitly stated otherwise.

Total Financial Position - Core Trust only

	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
Description / Heading	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Healthcare contracts					25,394	25,499	104	75,380	75,394	14	301,790	299,314	(2,476)
Other Operating Revenue					1,287	1,286	(1)	3,740	3,802	62	14,732	15,169	436
Total Revenue					26,681	26,784	103	79,120	79,196	76	316,522	314,482	(2,040)
Employee expenses	5,364	5,376	11	0.2%	(25,764)	(26,286)	(521)	(76,705)	(78,160)	(1,455)	(303,792)	(313,949)	(10,157)
Operating expenses exc. Employee expenses					(1,180)	(859)	321	(4,188)	(2,225)	1,962	(13,812)	(11,276)	2,536
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	5,364	5,376	11	0.2%	(26,944)	(27,145)	(201)	(80,893)	(80,385)	508	(317,604)	(325,225)	(7,621)
Operating Surplus / (Deficit)	5,364	5,376	11	0.2%	(263)	(361)	(97)	(1,773)	(1,189)	583	(1,082)	(10,742)	(9,660)
Finance expense					(57)	(59)	(2)	(168)	(178)	(10)	(673)	(672)	1
PDC Paid					(362)	(362)	0	(1,086)	(1,086)	0	(4,343)	(4,343)	(0)
Finance income					140	241	101	448	722	274	1,645	2,747	1,102
Surplus / (Deficit) - Total	5,364	5,376	11	0.2%	(543)	(541)	1	(2,579)	(1,731)	848	(4,453)	(13,010)	(8,557)
Depn Peppercorn Leases (IFRS16)					11	8	(3)	34	24	(10)	138	84	(54)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - ICB	5,364	5,376	11	0.2%	(531)	(533)	(2)	(2,545)	(1,707)	837	(4,315)	(12,926)	(8,611)

The Trust plan for 2026 / 27 is profiled with a deficit in the early part of the year and reducing as value for money schemes have an impact. The budget requirement for these schemes are held centrally until schemes are identified. At this stage the Trust (core) remains in a deficit position.

The key headlines, against these budget assumptions, are included below and illustrated within the bridge:

Workforce - Expenditure continues to exceed planned assumptions including the delivery of Value for Money schemes. Primarily mental health care group and Forensics.

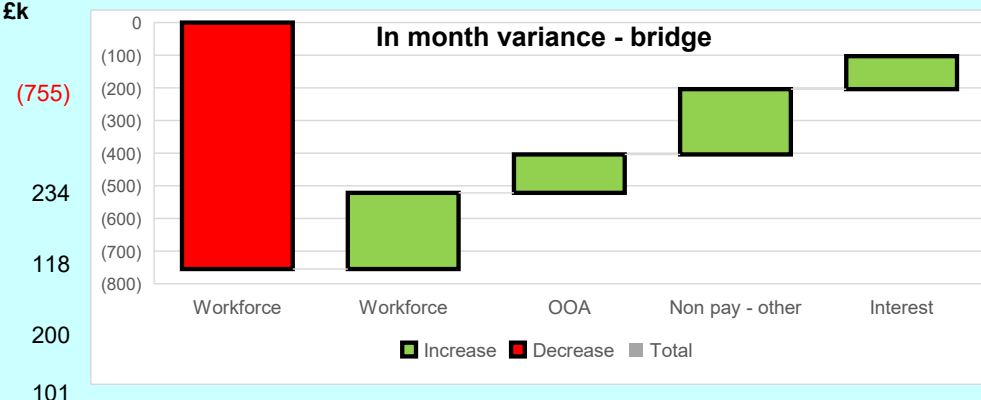
Workforce - continuation of utilisation of less staffing than plan. Support care group

Non pay - Out of area placements have continued, despite significant operational pressures, to be maintained less than planned.

Non pay - general reductions across the Trust

Finance income - due to cash position, and maintained interest rates, interest receivable is higher than planned

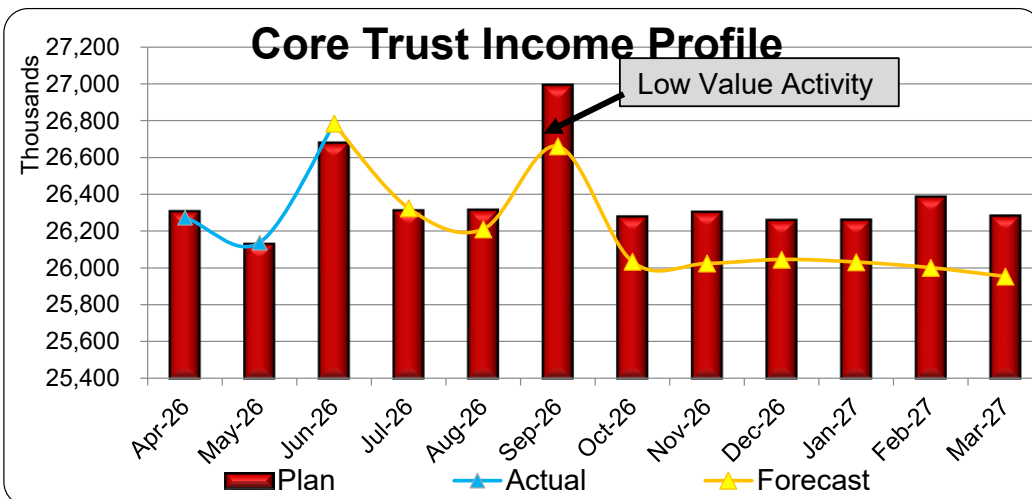
£k



The Trust receives income from its commissioners in order to deliver healthcare services to meet the defined needs of the local population. The majority of this funding is in the form of an Aligned Incentive Contract (AIC) with a set value agreed (fixed / block contract value). As such this provides income stability, and financial certainty, to enable the Trust to plan effectively. This is amended to take account of any tariff changes (set nationally) and for agreed changes in service provision (investment and / or disinvestment).

The table below categorises total income received by commissioner type.

	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
Description	£k	£k	£k	£k	£k	£k	£k	£k	£k
<i>Trust (core)</i>									
NHS Commissioners	23,817	23,808	(9)	70,812	70,785	(27)	283,610	283,332	(278)
Specialised Commissioning (NHS E)	656	693	36	1,989	2,062	73	7,148	6,157	(991)
Local Authorities	434	491	57	1,294	1,353	58	5,210	5,201	(9)
Partnerships	251	297	46	713	740	27	3,533	2,780	(753)
Other Healthcare income	125	78	(47)	356	241	(115)	1,423	1,009	(414)
Other non clinical income	1,393	1,412	19	3,941	4,000	59	15,538	15,943	405
Total - Trust core income	26,676	26,779	103	79,105	79,181	76	316,463	314,422	(2,041)
Provider Collaboratives	9,934	9,990	55	29,262	29,444	182	117,046	117,705	659
Budgets held centrally	41	63	22	167	217	50	955	845	(110)
Total - Consolidated income	36,652	36,833	181	108,533	108,842	309	434,465	432,973	(1,492)



Risks and opportunities

Although the majority of income is fixed in nature, and aligned with contracts and budgets, there are a limited number of variances.

These forecast variances are offset by corresponding reductions in pay and non pay.

* Additional roles reimbursement	£367k
* Yorkshire Smokefree - prescribing & activity	£22k
* Any qualified provider activity	£110k

Other income variances include:

* Income received for bed sales inc. Provider Collabs	£409k

Our workforce is our greatest asset; ensuring that we have the right staff, with the right skills available at the right place and time in order to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Provider 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.

	In month		Year to Date	Forecast	
Description	Worked WTE	£k	£k	Worked WTE	£k
Substantive	4,937	24,211	71,996	5,081	291,794
Bank & locum	432	1,937	5,758	352	20,176
Agency	6	138	407	8	1,979
Total	5,376	26,286	78,160	5,441	313,949
Budget	5,364	25,764	76,705	5,372	303,792
Over / (Under)	11	521	1,455	68	10,157

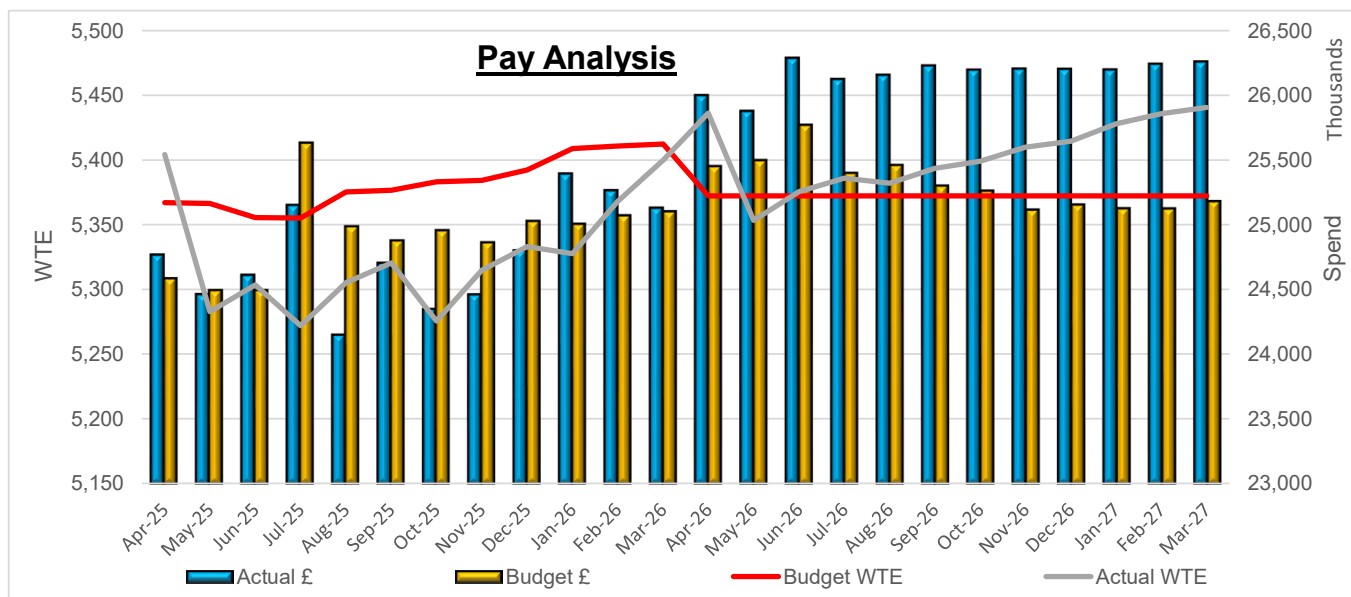
Movement since last month	
Worked WTE	£k
(8)	286
29	129
1	(6)
22	410
0	271
22	139

The table to the left, and graph below, show the breakdown of Trust pay expenditure.

Substantive worked WTE has continued to reduce month on month in small increments. The Trust workforce action plan will address this. Agency continues to be maintained at a low level. Bank staff, however, has continued to fluctuate month on month. This was a peak of 479 in April 2026 but reduced to 402 in May 2026. This has increased by 29 WTE in June.

Actual expenditure in June 2026 includes the medical staff pay award with arrears paid back to April 2026. This was higher than the original 2% planning assumption and budgets have been updated accordingly.

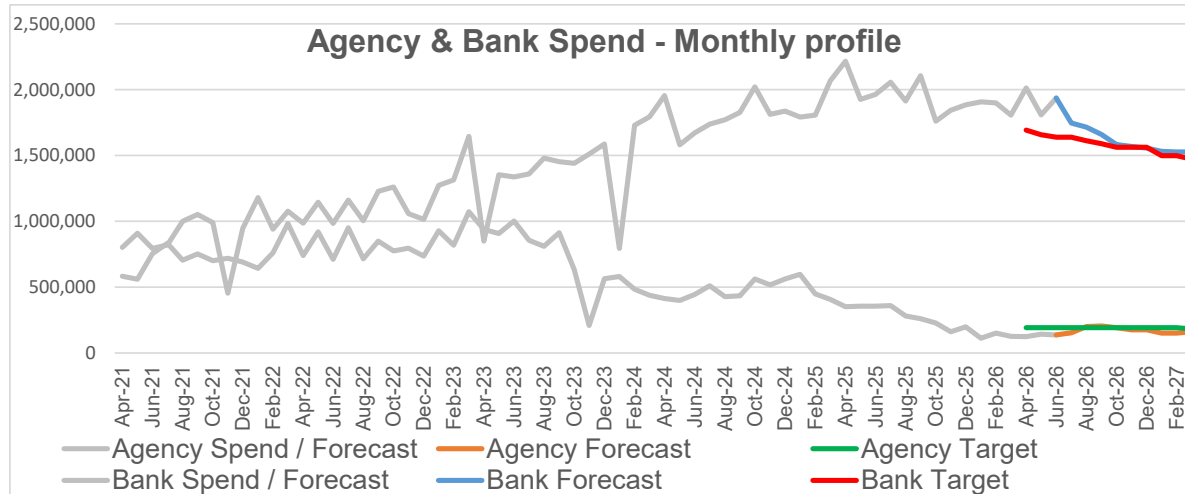
Pay budgets, which include the largest elements of the Trust Value for Money programme, are profiled to reduce whilst workforce is forecast to increase. This continues to be triangulated and the impact considered within the Trust forecast scenarios.



Trust spend in June 2026:
Agency £138k
Bank £1,937k

We continue to acknowledge that temporary staffing solutions continue to play an important role in the overall workforce strategy of the Trust. However this must fit within the overall context of ensuring the best possible use of resources and value for money whilst ensuring that operational pressures are effectively managed.

The focus has expanded from solely agency staff to total temporary staffing costs especially those which are paid a premium rate when compared to those paid under normal terms and conditions. This includes agency staff, Trust bank staff and also enhanced payments made to substantive Trust staff for additional hours.



Temporary Staff costs to date - by category			
Category	Agency £k	Bank £k	Total £k
Consultant	301	103	404
Other Medical	105	166	271
Reg Nursing	(0)	1,697	1,697
UnReg Nursing	0	3,504	3,504
Other Clinical	0	141	141
A & C	0	147	147
Other	0	0	0
Total	407	5,758	6,164
Lead Provider Collaborative		3	3
Budgets held centrally		0	0
Total	407	5,760	6,167

In line with national guidance the Trust financial plan for 2026 / 27 included spend reduction targets; c. 30% reduction in agency and 15% reduction in bank. Further reductions are required for future financial years. The target levels of expenditure per month are shown in the graph above.

Performance measurement of these targets is based upon total consolidated agency and bank expenditure and are reported as part of the Trust value for money programme and as overall key financial performance indicators (KPI). These are considered as absolute values and not in the context of other pay expenditure movements.

As shown above agency spend has been maintained at a low level and, in June 2026, the Trust has continued to only utilise medical staffing agency. Future pressures have been identified in this area especially relating to staffing retirements. The current forecast remains that the target can be achieved.

Bank spend has continued to fluctuate and has increased from May to June 2026. This is within the unregistered nursing category to support inpatient ward pressures. The current forecast trajectory has usage reducing but remaining above the target requirement.

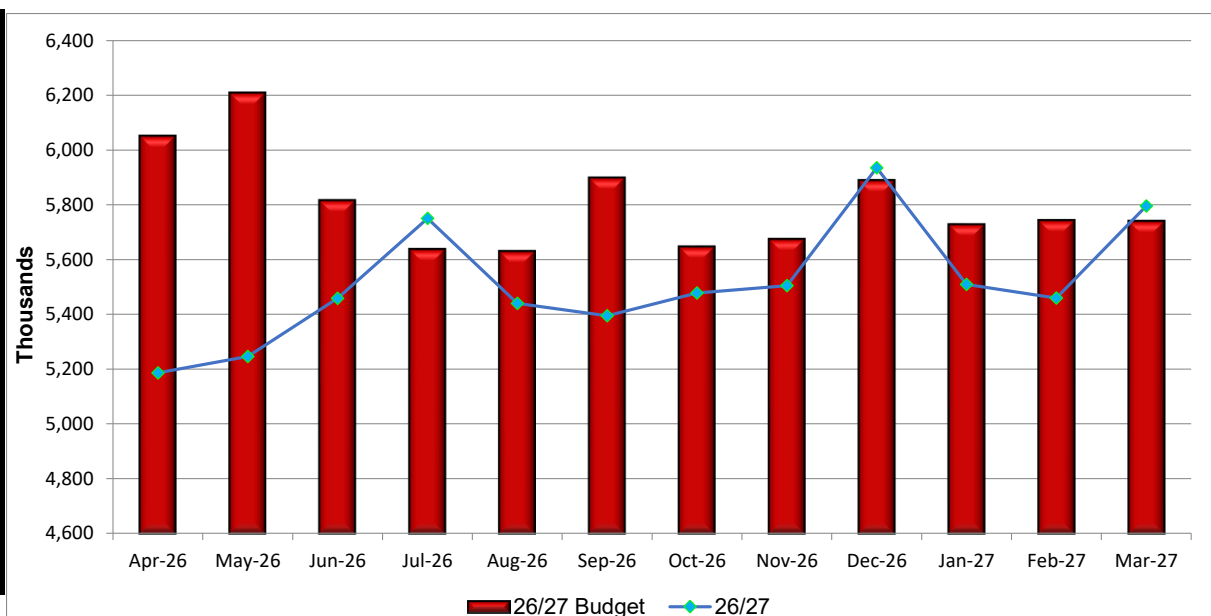
Action plans continue to be developed through the Trust temporary staffing group.

2.3 Non Pay Expenditure

Whilst pay expenditure is the majority of Trust costs, 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, To re-confirm that this presentation excludes non pay expenditure relating to the provider collaboratives and budgets held centrally.

Non pay spend	Apr-26 £k	May-26 £k	Jun-26 £k	Jul-26 £k	Aug-26 £k	Sep-26 £k	Oct-26 £k	Nov-26 £k	Dec-26 £k	Jan-27 £k	Feb-27 £k	Mar-27 £k	Total £k
2026 / 27	5,186	5,246	5,458	5,751	5,440	5,394	5,478	5,504	5,935	5,509	5,459	5,796	66,157
2025 / 26	4,754	4,656	4,507	4,812	4,475	4,802	5,002	4,795	4,511	4,633	5,023	5,833	57,805

Non Pay Category (per accounts)	Budget	Actual	Variance
	Year to date	Year to date	
	£k	£k	£k
Drugs	1,154	1,029	(125)
Establishment	2,988	2,295	(693)
Lease & Property Rental	2,208	2,186	(23)
Premises (inc. rates)	1,505	1,457	(48)
Utilities	814	688	(125)
Purchase of Healthcare	1,976	1,464	(512)
Travel & vehicles	1,531	1,482	(49)
Supplies & Services	2,228	2,119	(109)
Training & Education	337	128	(209)
Clinical Negligence & Insurance	362	358	(5)
Capital Charges Depn, PDC,	2,585	2,291	(294)
Other non pay	386	394	7
Total	18,075	15,891	(2,184)
Total Excl OOA and Drugs	14,945	13,398	(1,547)



Key Messages

Non pay expenditure, being less than plan, continues to support the overall Trust financial position but, as shown by the graph above, has been increasing in the first three months of the financial year.

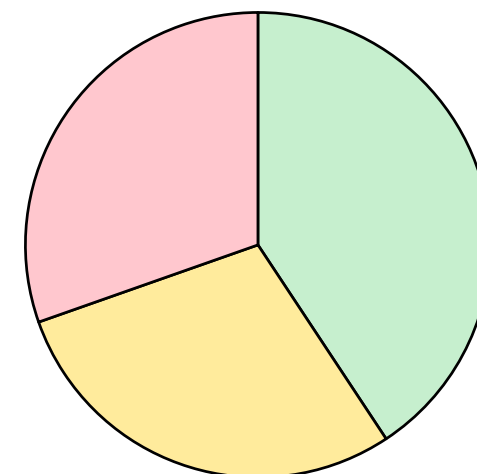
All categories continue to have spent less than plan for the year to date. The categories with the biggest increases in month are travel and transport, purchase of healthcare and premises costs. These have been partially offset by reductions in the establishment category.

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 2025 / 26 the value included in the plan was £17.7m. Additional mitigations will be required if the Trust run rate varies from 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.

Group	Key lines of enquiry	Year to Date				Forecast				
		Target	Achieved Recurrent	Achieved Non Recurrent	Variance	Revised Target	LOW	MEDIUM	HIGH	Variance
		£k	£k	£k	£k	£k	£k	£k	£k	£k
Pay	Workforce	0	176	21	197	3,689	197	1,643	5,370	3,521
	Temporary Staffing	1,333	1,042	0	(291)	4,412	1,042	2,945		(425)
	Corporate Pay	498	96	818	415	1,991	2,776			785
	Productivity	0	0	0	0	1,400				(1,400)
	Difficult Decisions	150	29	0	(121)	2,138	183			(1,955)
Non Pay	Non Pay	24	25	2	3	248	100			(148)
	Drugs optimisation	54	0	0	(54)	220	0	144		(76)
	Digital optimisation	9	75	3	69	35	310			275
	Out of Area placements	90	270	0	180	357	270	194		106
	Difficult Decisions	0	16	0	16	0	84			84
	Non pay - establishment	51	12	12	(27)	265	27	47		(191)
Other	Provider Collaboratives	540	540	0	0	2,160	2,160			0
	Bed Sales	0	0	0	0	0				0
	Income	192	29	17	(146)	760	46	137		(577)
	Misc income - overage	0	0	0	0	0				0
Total		2,941	2,309	873	241	17,675	7,194	5,110	5,370	(0)
Recurrent		2,752	2,309		(443)	16,925	4,618	5,110	0	(7,197)
Non Recurrent		189		873	684	750	2,576	0	5,370	7,197

Value for Money
Forecast Risk Rating

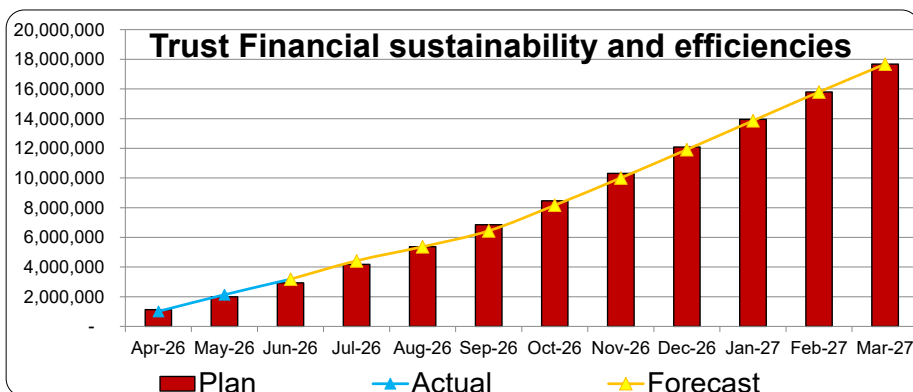


LOW MEDIUM HIGH

LOW On track for delivery: The scheme is on track, savings are being realised according to the plan, and there are no significant risks to the budget.

MEDIUM There are risks or minor delays in achieving savings. The scheme requires management attention but is generally considered resolvable. Cost overruns or timing of delivery risks.

HIGH The scheme is failing to meet its financial targets. It is likely to be significantly over budget or fail to deliver the required savings within the timescale agreed. Or the scheme is not yet scoped.



The phasing of the Trust Value for Money schemes is set roughly as £1m per month for the first half of the financial year, and £1.8m in the second half as schemes progress. At the end of quarter 1 £3,182k has been reported. This is £241k ahead of plan.

The largest driver of this relates to corporate pay savings. These have been reviewed in month and as such this has been updated to reflect the current recurrent / non-recurrent split. Work is continuing to maximise the recurrent value. The second largest relates to out of area placements which have been maintained at a lower level than for the same time period last year.

Based on current forecasts additional schemes and mitigations will need to be delivered to achieve the Trust financial targets. In the table above this is identified as high risk as well as ensuring that the medium risk schemes deliver.

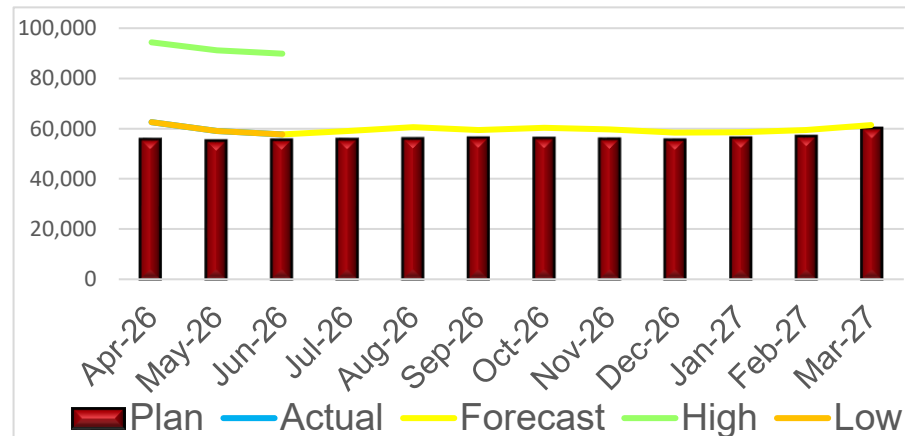
Whilst the focus is traditionally on the Trust income and expenditure position, the Statement of Financial Position (SOFP - balance sheet) presents a key snapshot of the Trusts overall financial health, stability and can provide important early warning flags of potential financial issues.

The balance sheet shows that the Trust owns (assets) and what it owes (liabilities).

Balance Sheet / Statement of Financial Position (SOFP)	Current £k	Note
Assets		
Non-Current (Fixed) Assets	191,102	Pg 13
Inventories & Work in Progress	209	
Trade receivables (Debtors)	1,499	
Accrued Income	4,102	Pg 14
Prepayments	5,982	
Cash and Cash Equivalents	57,696	
Total Assets	260,590	
Liabilities		
Payables (Creditors)	(17,216)	
Accruals	(18,470)	
Deferred Income	(1,751)	Pg 14
Provisions	(3,305)	
IFRS 16 / leases liabilities	(45,209)	
Total Liabilities	(85,951)	
Total Net Assets/(Liabilities)	174,639	
Taxpayers' Equity		
Public Dividend Capital	(79,119)	
Revaluation Reserve	(12,067)	
Other Reserves	(5,220)	
Income & Expenditure Reserve	(78,233)	
Total Taxpayers' Equity	(174,639)	

Non Current (Fixed assets): The value of Trust assets is impacted by additional capital purchases and disposals (page 13), reduced by the impact of depreciation and amortisation and annual revaluation exercises.

Cash: The Trust cash position is shown below. The graph shows the position at the end of each month and also the highest / lowest cash point during that month. This is monitored to highlight any risk or opportunity. Actual cash has reduced to £57.7m but remains ahead of plan.



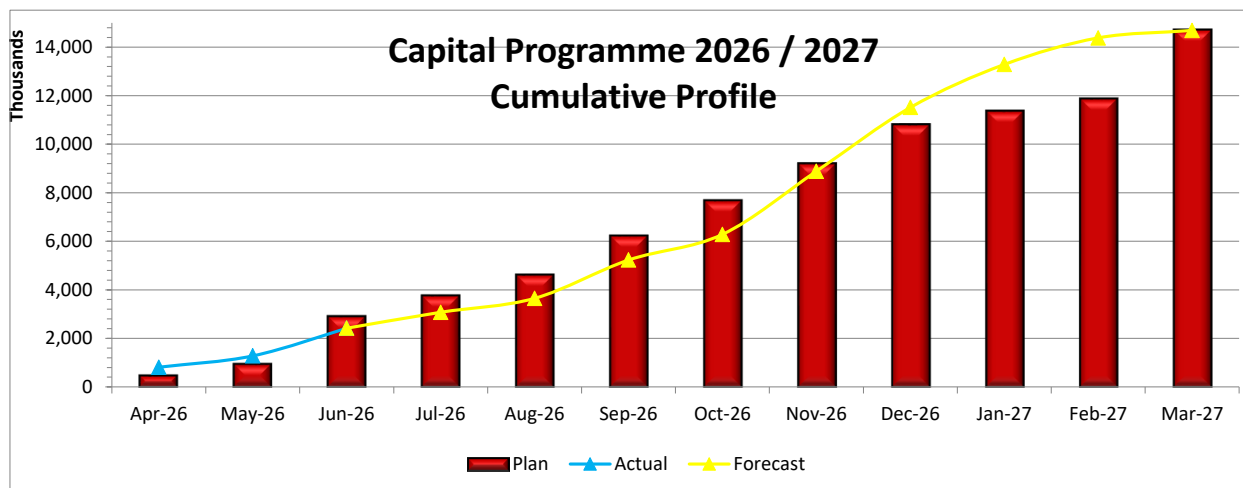
Overall the Trust balance sheet remains strong with assets greater than liabilities.

The taxpayers equity section, similar to shareholders equity, illustrates that Trust funding is entirely from public taxation.

4.1

Capital Programme 2026 / 27

Capital schemes	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Annual Budget £k	2026 / 27 Outturn £k	Variance £k
Major Capital Schemes						
Older People Transformation	1,305	217	(1,088)	5,428	5,428	0
IM & T - Digital Infrastructure	0	0	0	1,650	1,650	0
IM & T - Cyber Security	0	0	0	250	250	0
IM & T - Digital Care Records	48	0	(48)	200	200	0
IM & T - Digital Information Sharing	0	0	0	100	100	0
IM & T - Digital Insights	0	0	0	200	200	0
IM & T - Digitally Empowered Workforce	0	0	0	100	100	0
Net Zero Carbon	0	901	901	0	1,908	1,908
Other	0	(371)	(371)	0	(1,693)	(1,693)
Leases (IFRS 16)	1,497	1,664	167	3,011	2,795	(216)
TOTALS	2,850	2,411	(439)	10,939	10,939	(0)
Additional allocations						
Cheswold	60	7	(53)	3,000	3,000	0
Community hub	0	0	0	750	750	0
			0			0
TOTALS	2,910	2,418	(492)	14,689	14,689	(0)



Capital Expenditure 2026 / 27

The table, left, summarises the Trust capital programme for 2026 / 27. This is split between the Trust core capital allocation and additional allocations which have been secured. The core allocation includes leases (IFRS 16). The main scheme is the continuation of the Older People Inpatient Transformation project.

An additional allocation has been secured for both 2026 / 27 and 2027 / 28 in relation to improvements for Cheswold Park Hospital. In May 2026 the Trust also received confirmation of additional £750k funding to develop a community hub.

For April and May 2026 Trust spend was greater than plan due to the timing. This was planned for June 2026 and, as now included in the year to date position, we have reverted to being behind plan. This is primarily due to the plan profile for the older people scheme.

Work continues to finalise the pricing, and spend profile, for the main schemes and as such the plan and forecast currently reflects those included in the February 2026 plan submission. This will be updated as each is agreed.

The impact of profile changes if being considered on the multi-year Estates plan.

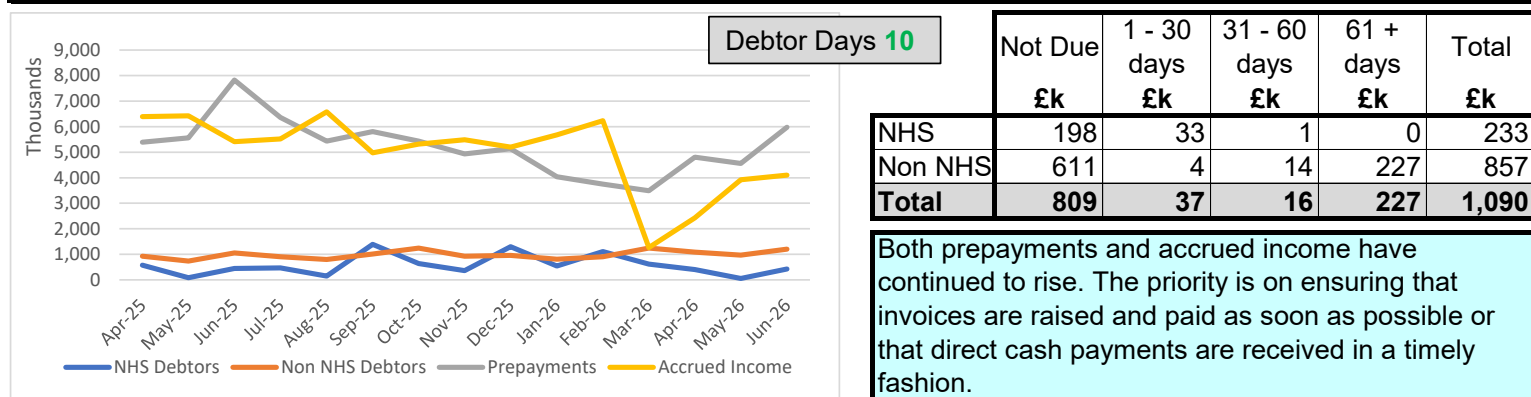
Agreed profiles will need to consider, and mitigate, the impact of the net zero carbon scheme which commenced in 2025 / 26

4.2

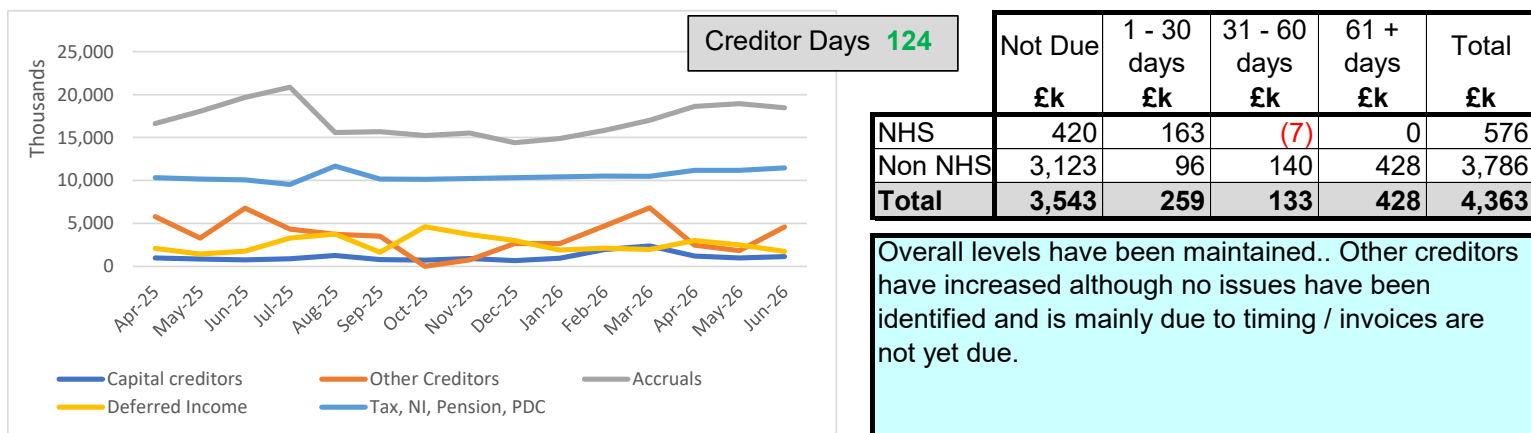
Balance sheet analysis

The presentation of this data, and supporting narrative, has been revised in order to enhance the awareness of potential future risk areas and the actions being taken to manage them.

Debtors: A debtor is an individual or company who owes money to the Trust for services provided. This directly impacts on cashflow. The action is to minimise these balances as far as possible and ensure that debts are recovered in a timely manner. Both the value and age is shown below.



Creditors: The risk flag is when creditors are increasing, both value and timing, meaning that we are not paying Trust suppliers in a timely manner. This will temporarily increase the cash position. This can be triangulated with Better Payment Practice Code (BPPC) performance which shows the percentage of suppliers paid within 30 days.



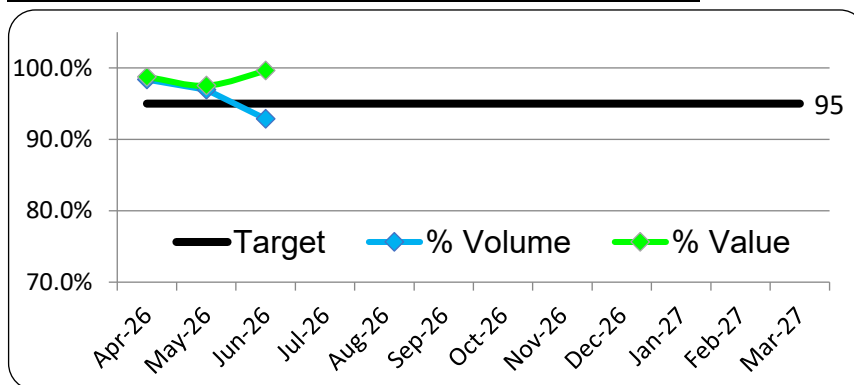
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Better Payment Practice Code

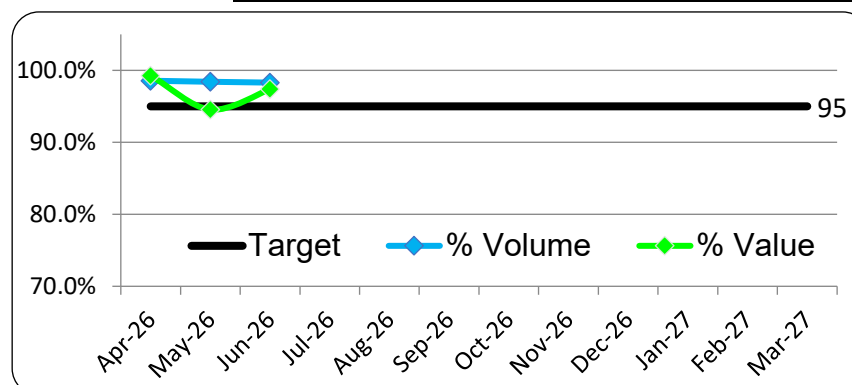
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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	93%	100%
Cumulative Year to Date	96%	99%



Non NHS	Number %	Value %
In Month	98%	97%
Cumulative Year to Date	98%	97%



5.1

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 (£)
08-Jun-26	Computer Licence	Trustwide	Trustmarque Solutions Ltd	2429279	1,417,491
05-Jun-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1007387	730,955
15-Jun-26	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	2000033591	704,131
23-Jun-26	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	206964	667,943
23-Jun-26	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	206968	667,943
02-Jun-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510011254	403,660
22-Jun-26	Purchase of Healthcare	AS Collaborative	Cygnnet Health Care Ltd	CYGWYS71	400,000
16-Jun-26	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000002393	351,604
22-Jun-26	Purchase of Healthcare	AS Collaborative	Cygnnet Health Care Ltd	CYGSYS48	240,000
04-Jun-26	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HONHSLS317	231,566
26-Jun-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898647	168,791
02-Jun-26	NHS Recharge	Kirklees	Mid Yorkshire Hospitals NHS Trust	1600040358	154,538
11-Jun-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34072299	147,577
08-Jun-26	Computer Licence	Trustwide	Trustmarque Solutions Ltd	2429277	146,105
02-Jun-26	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400004466	136,217
10-Jun-26	Purchase of Healthcare	AS Collaborative	Cygnnet Health Care Ltd	WYS069INV	132,775
17-Jun-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34072723	120,000
11-Jun-26	NHS Recharge	Barnsley	Barnsley Hospital NHS Foundation Trust	6029771	117,600
02-Jun-26	IT Services	Trustwide	Wavenet Ltd	1547745	106,816
02-Jun-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510011250	100,067
10-Jun-26	Purchase of Healthcare	AS Collaborative	Cygnnet Health Care Ltd	SYSEC049INV	99,895
07-Jun-26	Staff Recharge	Trustwide	Leeds & York Partnership NHS Foundation Trust	1007382	84,281
09-Jun-26	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trust	333010	73,682
05-Jun-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1007386	71,198
09-Jun-26	Drugs	Trustwide	Rowlands Pharmacy	1800006296	71,002
10-Jun-26	Purchase of Healthcare	AS Collaborative	Cygnnet Health Care Ltd	WYS069SN	67,544
18-Jun-26	Purchase of Healthcare	Kirklees	My Happy Mind Ltd	INV4022	66,110
04-Jun-26	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400004497	64,727
26-Jun-26	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trust	333135	64,670
11-Jun-26	Computer Licence	Barnsley	Pcmis Health Technologies Ltd	151508	61,168
04-Jun-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34071445	53,810

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
13-Jun-26	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000002388	51,249
23-Jun-26	IT Services	Trustwide	Wavenet Ltd	N021924	47,734
30-Jun-26	Lease Cars	Trustwide	Arval Uk Ltd	RI0015132633	47,642
11-Jun-26	Utilities	Trustwide	Edf Energy Customers Ltd	000028316386	42,984
04-Jun-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001566EPC	41,813
05-Jun-26	Purchase of Healthcare	Forensics	Humber Teaching NHS Foundation Trust	59898614	37,014
01-Jun-26	Rent	Kirklees	Bradbury Investments Ltd	19991	32,589
10-Jun-26	Purchase of Healthcare	Trustwide	Cygnnet Health Care Ltd	WKE0466573	32,094
05-Jun-26	Drugs	Doncaster	Speeds Healthcare Ltd	INV173305	27,147
23-Jun-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898624	26,143
23-Jun-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898625	26,143
23-Jun-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898626	26,143
23-Jun-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898627	26,143
19-Jun-26	Internal Audit	Trustwide	University Hospitals Of Derby & Burton NHS Foundation Trust	800049325	25,380

- * 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.
- * Value for Money / Cost Savings - The Trust priority of Value For Money is intrinsically linked to the ability to maintain financial sustainability. In addition to value for money this are also called savings, efficiencies, and Cost Improvement Programmes (CIP). In each case this is the identification of schemes to increase efficiency, reduce expenditure or increase income.
- * 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

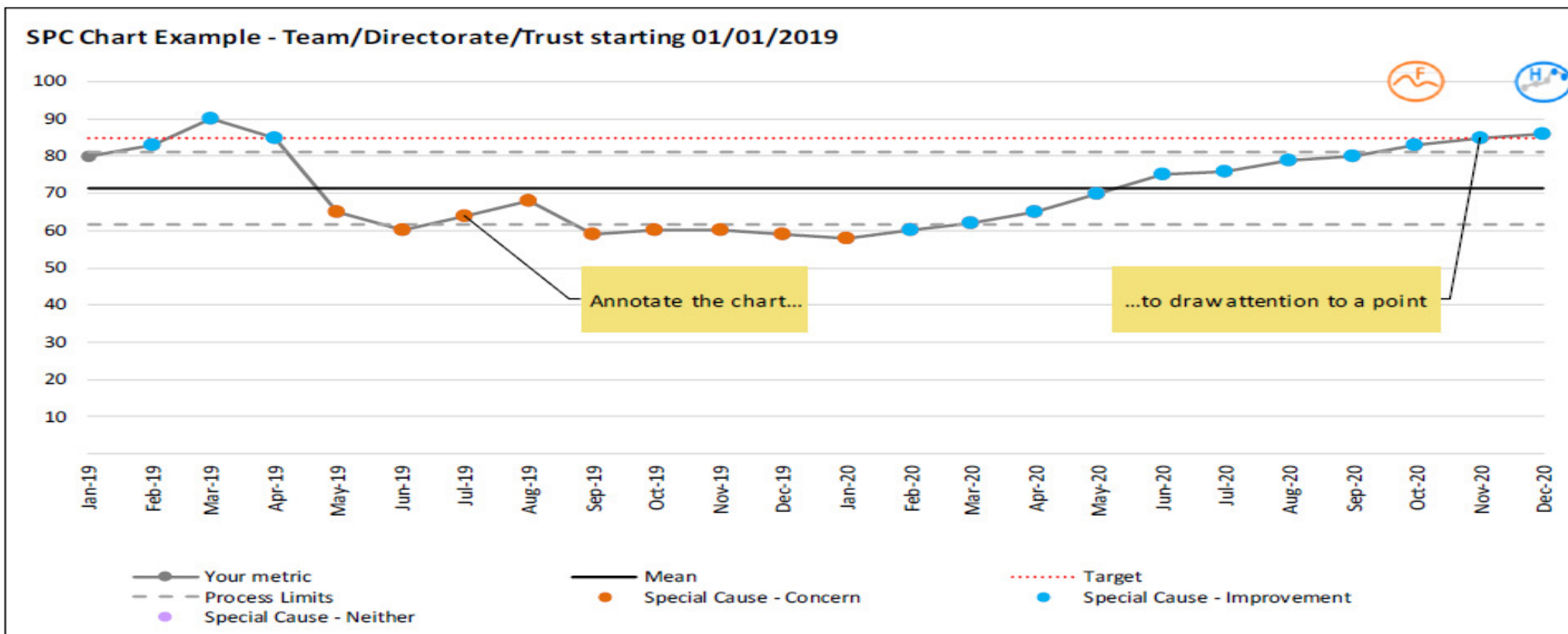
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data 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 significant 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 significant change in process. This process is not in control.

**Trust Board
28 July 2026
Agenda item 11.2**

Private/Public paper:	Public Paper		
Title:	Care Group Performance Dashboard: Barnsley Physical Health and Wellbeing		
Lead Director	Adele Fox - Chief Operating Officer		
Mission/values:	The report focuses on service delivery and as such aligns with the mission and values for the organisation. Improving performance in inpatients mental health services 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:	Live Our Values	✓	
	Be the best we can be:		
	• Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	Monitoring and managing performance in Barnsley Physical Health and Wellbeing services contributes to managing all the risks on the Board Assurance Framework and makes a specific contribution to actions to address the following risks: 1.1 Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience. 1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience.		

	2.1 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. 2.4 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes. 4.1 Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place. 5.1 Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively. 5.2 Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision. 6.1 Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care. 6.2 System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience.
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Barnsley Physical Health and Wellbeing services are a key component of care across South Yorkshire. Providing services that are accessible, safe and to a high quality is fundamental to achieving the aims of both of our integrated care systems.
Any background papers / previously considered by:	Care group performance is provided in an aggregated format within the integrated performance report provided to the Board meetings held in public. To provide more opportunity for understanding of specific groups a format has been developed which will result in each care group providing greater reporting with 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 review and preparation.
Executive summary:	Barnsley Physical Health and Wellbeing services have had a focus on performance and sustainability to improve the experience for both staff and service users. Senior Leadership across Barnsley Physical Health and Wellbeing services have oversight on quality of care, performance and improvements that may be required to enhance service user experience and support staff with training and development where required to meet the needs of our service users. Areas of note: Training Training and development across the care group remains in good performance range and appraisals across the care group are in date with good engagement. As in all mandatory training the care group has oversight of performance and supports proactive booking and attendance.

Sickness

There has been good oversight from leaders to improve attendance, and this is seen in the reduced sickness performance. The care group has been focusing on those people they can support to be in work and note they have several colleagues they need to support to remain off work due to long term illness. There has been an increase due to Long term sickness from elective surgery and serious illness and in Short term sickness from MSK and stress and anxiety. All have a clear supportive plan to return to work where possible.

Supervision

Supervision recording has resulted in the care group supervision performance dip, however this has a focus and will see an improving trajectory in the next two months., with weekly oversight meetings and support for managers to record supervision.

Turnover

Turnover is stable across the care group with people choosing to stay and work in the care group. Those that do leave have stated this has been due to promotion or career opportunities that cannot be offered in the Trust due to the lower turnover.

Finance

The care group generally performs well within the financial limits, they have used no agency and minimal bank cover. They have a close grip on the efficiencies and working endlessly to achieve the financial target applied, however this remains a challenge.

Access

Musculo Skeletal Service (MSK) are seeing a continued achievement against the national target of 92% for 18-week RTT (Referral to Treatment) –97.51% for May. The increase in demand is still a challenge however the service achieves its targets and continues to be innovative with how they provide access to people.

The UCR service offers a 24 hours 7 day service. The benefits to the 24/7 service provision are that hospital avoidance is continued during the night and the patients are maintained at home safely. UCR are seeing an increased number of people and 99.9% of these people have avoided a hospital admission.

UCR Service have continually achieve the 2-hour target with 81.6% performance for May which continues to be well above the 70% threshold.

Paediatric Audiology

This service has shown a continued increase and sustainable improvement in supporting children to have an audiology assessment. The 2026/27 Diagnostic Waiting Times and Activity Measure (DM01) threshold has been realigned with national expectation and Operational Planning / NHS interim trajectories – this target is currently set at 52.56% within 6 weeks. SWYPFT's Paediatric Audiology 6-week target for diagnostic procedures is currently showing compliance achievement of 99.12% against this target.

Important to note that this service is resourced by two staff therefore annual leave may have an impact on the performance.

	Safer staffing (registered 80%) is within compliance for both units. During May the Stroke Rehabilitation Unit (SRU) utilised an additional trained nurse and therefore reflected in the staff requirements. Both units remained safe during this month. The establishment numbers for the stroke unit were not reflective of the requirements; however, this has been rectified. Staff turnover on NRU and sickness as impacted on the unit, however there is a plan to address this and been included in future establishment review. Incidents Pressure ulcers and falls The increase in pressure ulcer incidents is related to an increase in caseload size and in the acuity of the patients on caseload in the district nursing teams. There is no statically significant trend, however one to have a watchful eye on for future trends oversight. Additionally pressure sores both prevalence and incidence show an increase of patients received onto caseloads from other services as well as some deterioration in pressure sores on exiting caseloads. The care group is reviewing the reporting of pressure ulcers to understand reporting and incidents further. Incidents relating to falls continue to fluctuate however, some early intelligence suggest some falls may be related to receiving patients earlier in their recovery and rehabilitation pathway therefore present as a higher risk. Work continues to be supported by the team and falls co-Ordinator Friend and family feedback from service users and their families continues to be above the threshold. The majority of the feedback is positive and all feedback is used to improve services and experience.
Recommendation:	Trust Board members are asked to: • RECEIVE and NOTE the report.

Barnsley Physical Health & Wellbeing Care Group



May 2026

With **all of us** in mind.

Barnsley Physical Health & Wellbeing (BPHWB)

Barnsley Physical Health and Wellbeing Care Group provides both adult and children/young people's physical health services which comprises of 54 individual service lines.

This includes the Stroke (SRU) and Neuro Rehabilitation (NRU) inpatient units at Kendray Hospital, Live Well Wakefield, Health Integration Teams in both Barnsley and Wakefield and Yorkshire Smokefree Services (both across the South West Yorkshire Partnership Teaching NHS Foundation Trust footprint and beyond).

The Care Group includes core Neighbourhood Team services such as District Nursing and Rehabilitation Services in addition to Specialist Nursing and Allied Health Professional (AHP) services.

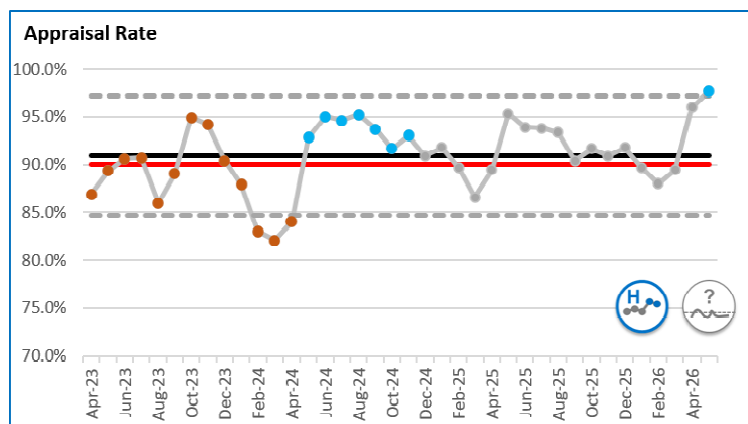
The Children and Young People's physical health services element comprises: Paediatric Audiology; Children's Therapy (Occupational Therapy & Physiotherapy); Children's Speech and Language Therapy; Paediatric Epilepsy; Child Health Information System and School Aged Immunisation Service.

The majority of our services are provided under the umbrella of the Integrated Neighbourhood Teams specification with reporting of associated key performance indicators. The Care Group continues to reflect the extent of partnership working within Barnsley Place and supports the aspiration of integration of neighbourhood health services in Barnsley in line with the new NHS 10 Year Plan.

The Care Group challenges are around increased patient flow in relation to complexity and acuity of care required in the community setting.

Workforce

Appraisals



Insights

The Care Group performance at the end of May stands at 97.7%, compared to a total Trust position of 93.5%.

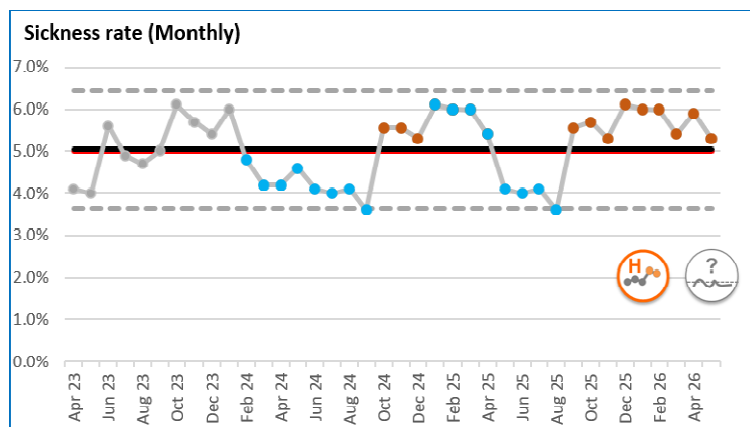
Appraisal reporting is transitioning from the requirement to have an appraisal in the last 365 days to being based on having an appraisal within the financial year with a completion date of the end of September. The first target is for Bands 8a and above to have a completed appraisal by 30 June.

Appraisal compliance and all workforce performance metrics are reviewed weekly at our weekly oversight meeting with Clinical Leads, Team Managers, and General Managers, helping us monitor progress and address any issues promptly. This approach gives us confidence that we can sustain our current level of performance.

Barnsley Physical Health & Wellbeing (BPHWB)

Workforce

Sickness



Insights

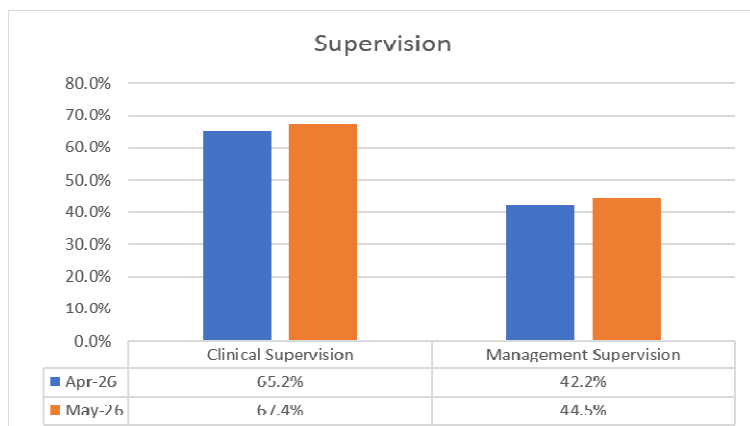
May 2026 sickness rate for the care group was 5.3% which is an improvement from 5.9% in April 2026, but remains over the 5.0% Trust target. Overall sickness rates have improved into Amber but remain slightly outside compliance for the month of May at 5.3%. We continue to have some instances of long-term sicknesses relating to serious illnesses & elective surgery, we have noted that as improvements have been made in elective waiting times our sickness relating to elective surgery has spiked, this is something out of our control as we have staff that have waited for various elective surgeries for some time.

The care group 12-month rolling figure is 5.28%. People Directorate colleagues are supporting the care group in reviewing long term sickness absence and triangulating with other data which may impact e.g. number of additional shifts, vacancies whilst excluding some reasons e.g. elective surgery and diagnosis of cancer.

We have done some significant work to understand the impacts of musculo skeletal issues as a cause for sickness within our care group and are supporting good health & safety practices including lifting and handling, back care and the use of equipment. The service areas most at risk of musculo skeletal issues are our two rehab inpatient wards and district nursing, this service works predominately in patient's own homes where adjustment and innovative solutions are required dealing with many and varied situations to provide optimum care and treatment.

We are also ensuring we use the resources available to us in respect of staff off work sick due to stress & anxiety, whether this be home or work related.

Supervision



Insights

Staff receiving supervision – following the introduction of the new separate 60-day targets for clinical and management supervision, the care group is undergoing a period of monitoring and reviewing the revised statistics and their impact on the achievement of compliance for this measure. Figures for May against the target of 80% are remaining largely consistent with a steady increase:

Clinical supervision – 67.4%

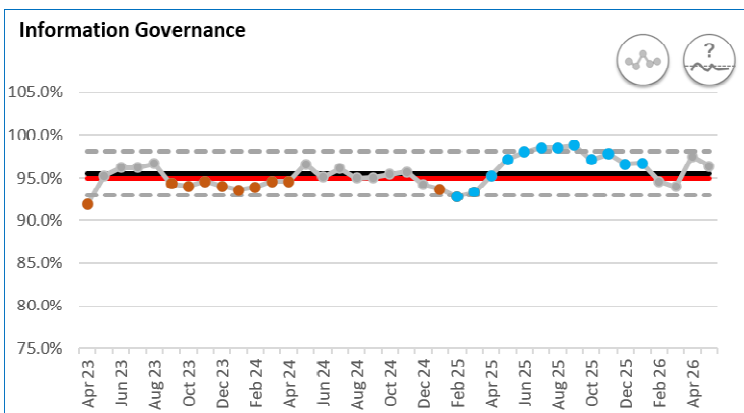
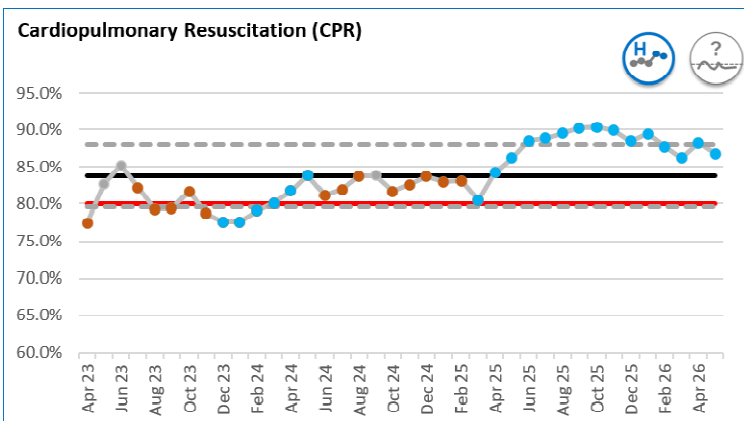
Management supervision – 44.5%

The care group has been working to improve both clinical and managerial supervision uptake and recording. This has included communicating clear expectations, and targeted work with teams to review the supervision dashboard and strengthen monitoring and oversight.

Posters and key information sheets have been developed, alongside clearer, relevant recording documentation for the care group, including direct links to the database to support recording. Engagement with team leads has also helped identify and address local barriers. These actions are expected to support a steady improvement in uptake and help embed a strong supervision culture.

Barnsley Physical Health & Wellbeing (BPHWB) Workforce

Mandatory Training



Insights

The May 2026 performance for cardiopulmonary resuscitation training stands at 86.8% with the Trustwide performance at 86.0%.

The care group has consistently achieved compliance. Focus continues on our occasional hot spot areas, noting the lag in recording CPR training statistics, and the fact that maternity leave cannot be excluded from training statistics.

Staff rostering ensures the availability of appropriately trained staff on inpatient wards at all times to maintain safety

CPR compliance performance reflects successful focus on critical training areas.

We are working with the professional directorate to ensure that there is a consistent offer from the resus training team held locally in Barnsley this will assist in maintaining our targets, reduced lost time to travelling and support reduced ravel costs , increasing sustainably. There is oversight to ensure people are booked on training to maintain mandatory standards.

The May 2026 performance for information governance training stands at 96.4% with the Trustwide performance at 93.9%.

Maintaining compliancy is paramount with a continued focussed effort on monitoring by managers.

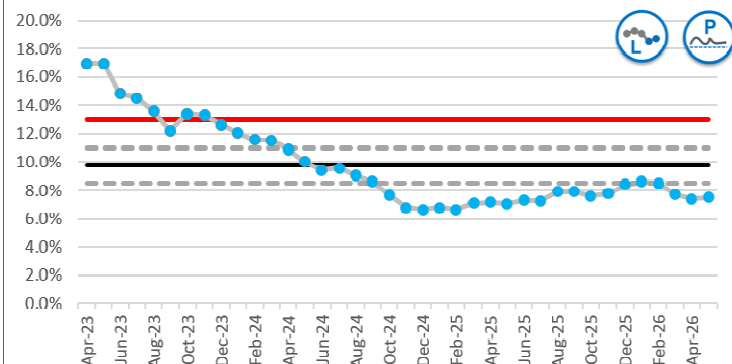
As in all mandatory training the care group has oversight of performance and supports proactive booking and attendance.

Barnsley Physical Health & Wellbeing (BPHWB)

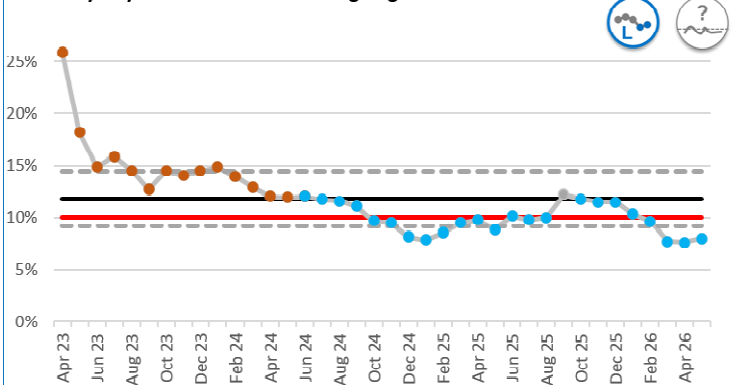
Workforce

Turnover

Staff Turnover



Barnsley Physical Health & Wellbeing Registered Staff Turnover



Insights

Staff turnover as at May 2026 is 7.5% and shows a stable, settled trend. This is a positive position with no spikes in data or areas of concern to address.

Overall Turnover

Turnover in Barnsley Physical Health remains steady at around 8–9%, with a short spike in late summer 2025.

Vacancies across the care group are generally low, with most nonclinical services stable and supported by active recruitment, temporary cover and a small number of posts held as vacancy factor. Staff mainly leave for career progression. Monthly leavers ranged from 3 to 10, and headcount remained stable between 916 and 929.

Turnover returned to its usual range from October onwards. Respondents reported a mix of factors influencing their decision, including workload and development opportunities. All respondents reported positive relationships with their managers and confirmed they had received adequate training.

Registered nurse turnover as at May 2026 is 8.0%, which is above the overall trust registered nurse turnover of 6.6%

Registered Nursing turnover ranged from 7.5% to 11.3% across the period. The highest point was in September 2025 when rolling leavers reached 30. Monthly leavers ranged from 0 to 5, and headcount remained between 259 and 269.

Turnover reduced steadily from autumn 2025 into early 2026.

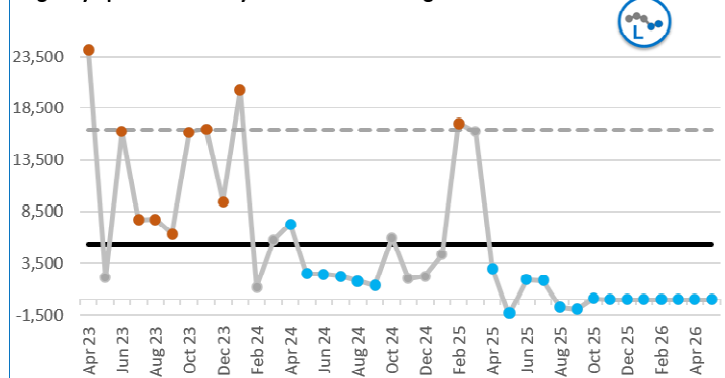
Leavers survey responses show that 60% of leavers were Band 5–6. These leavers cite limited internal progression routes, as physical health nurses face fewer upward or lateral opportunities within a mental health Trust competency. This creates a career ceiling at 2–5 years and contributes to predictable mid-career attrition and ongoing workforce pressure. The care group is strengthening retention through stay conversations, development planning and proactive workforce forecasting.

Barnsley Physical Health & Wellbeing (BPHWB)

Finance

Finance

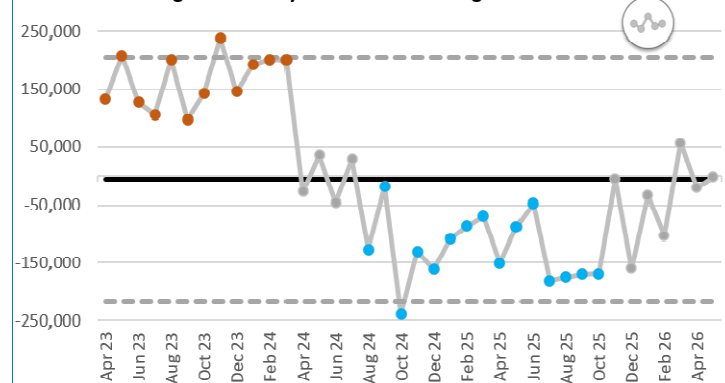
Agency Spend - Barnsley Health & Wellbeing



Insights

There has been no costs for Agency staff to the end of May and there are no costs forecast for the rest of the financial year.

Variance to Budget - Barnsley Health & Wellbeing



The Care Group is performing within planned budgets year to date, however this is not expected to continue with a forecast end of year deficit of £773k being reported in May, this is due to the 4% efficiency saving of £2.3m being applied Soley to direct budgets this financial year.

Plans for the delivery of the 4% efficiency target are yet to be fully realised within the forecast as they are still being worked on within the Care Group. The 4% efficiency savings are linked to the care groups plans around loss making services, some of which will contribute to an increase contribution to overheads but may not impact on direct costs, this will not show in relation to how the 4% has been applied to direct budgets, this is being explored by finance colleagues.

The area in the plan which is a high risk to delivery of reducing direct costs is the service area of Children's therapies, which equates to 800K of the savings required.

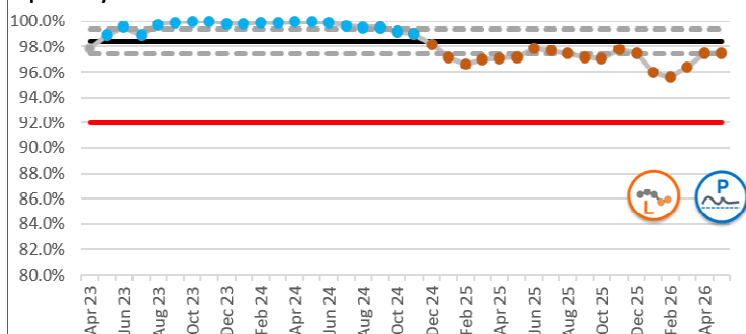
Non pay costs are forecast to be £214k underspent at the end of the year, some of these are linked to the VFM work that the Care Group is working on in BICES and MSK.

Barnsley Physical Health & Wellbeing (BPHWB)

Access

- Maximum time of 18 weeks from point of referral to treatment - incomplete pathway (MSK)

Max time of 18 weeks from point of referral to treatment - incomplete pathway Area



Insights

Musculoskeletal Service (MSK) are seeing a continued achievement against the national target of 92% for 18-week RTT (Referral to Treatment) – 97.51% for May.

The MSK service continues to build on the success of its first Community Appointment Day (CAD) held in Barnsley in September 2025, with a 2nd CAD day held in January 2026. These CADs provide an alternative to traditional clinic appointments by bringing assessment, personalised conversations and holistic support together in one community setting on the same day. Of the 105 patients attending, 57% were able to be treated and discharged on the day, giving their overall CAD experience a 96% satisfaction score.

The community appointment days (CAD) are using a 'what matters to you?' conversation, patients on the MSK waiting list receive personalised, holistic care, which is resulting in quicker access to treatment and support regarding their wider health needs.

Key outcomes:

- Reduced waiting times.
- Boosted self-management by equipping a high percentage of patients with the resources to manage their condition.
- Providing holistic support by connecting patients with wider community services such as social prescribing and local fitness programmes.

- 96% of patients rated their overall experience as very good or excellent.

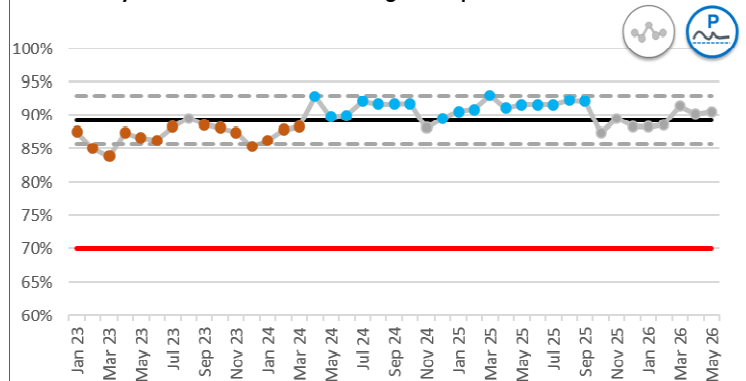
This feedback is specific to the CAD day and there is no comparator available.

Quarterly CAD are planned for the rest of the financial year.

This is an excellent achievement particularly considering continued demand for the service and also the forced venue changes due to the closure of Priory day centre. MSK Service and Estates colleagues have worked together and from January 2026, all group sessions

- Community health services two hour urgent response standard

Community health services two hour urgent response standard



Insights

Urgent Community Response Service 2-hour target has achieved 81.6% for May which continues to be well above the 70% threshold.

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 UCR service 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. The benefits to the 24/7 service provision are that hospital avoidance is continued during the night and the patients are maintained at home safely.

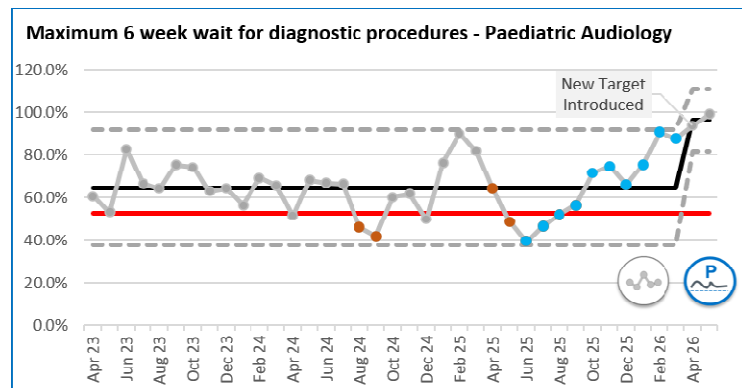
UCR are seeing an increased number of people. 99.9% of these people have avoided a hospital admission, our contribution to proactive care and supporting people to be cared for at home is well recognised by partners and contributes alongside many other services we provide to ensure good patient flow and improved outcomes for our population.

The Service now also supports virtual wards for respiratory and frailty both in hours and out of hours.

Barnsley Physical Health & Wellbeing (BPHWB)

Access

➤ Maximum 6-week wait for diagnostic procedures
(Paediatric Audiology only)



➤ Insights

The 2026/27 Diagnostic Waiting Times and Activity Measure (DM01) threshold has been realigned with national expectation and Operational Planning / NHS interim trajectories – this target is currently set at 52.56% within 6 weeks.

SWYPFT's Paediatric Audiology 6-week target for diagnostic procedures is currently showing compliance achievement of 99.12% against this target.

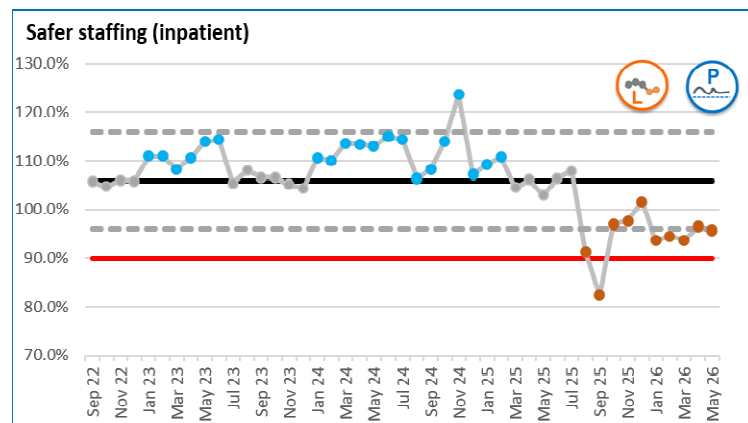
The total number on the waiting list as at 31.5.26 was 113 patients, with only 1 patient waiting over 6 weeks.

Significant work has taken place to ensure productivity is maximised now the team are fully staffed, however recognising that the service remain fragile in terms of annual leave and sickness as interim cover for these professional is not available.

Barnsley Physical Health & Wellbeing (BPHWB)

Quality and Safety

Safer Staffing



Insights

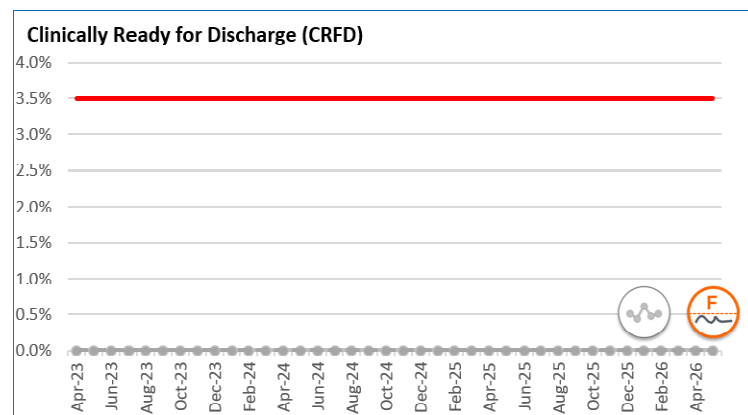
Safer staffing (registered 80%) is within compliance for both units.

During May we have been utilising an additional trained nurse on SRU and therefore reduced the untrained staff ratio. This is demonstrated in the overall figure, the reason for this was to support consistently high occupancy rates.

To note: the establishment figures for both wards were reviewed in November 2025 and work continues to realign this on e-roster following further meetings in February and March 2026. The establishment numbers for the stroke unit were not reflective of the requirements however this has been rectified. Staff turnover on NRU and sickness has impacted the unit however there is plan to address this and being included in the future establishment review.

An additional establishment review planned for 11.5.26 was cancelled. General Manager and Operational Manager met with Safer Staffing colleagues on 18.5.26 to discuss additional work required on SRU establishment. A further establishment review meeting has now taken place with some recommendations to go to EMT during July.

Clinically Ready for Discharge



Insights

The Care Group is fully compliant at 0%.

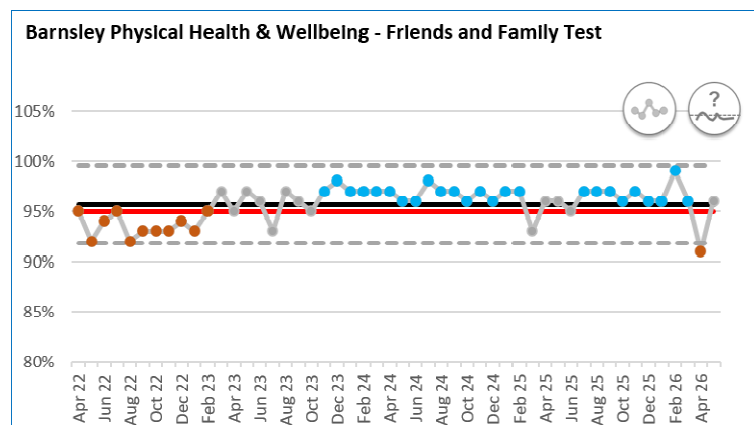
Sustained compliance on our 2 wards is due to most admissions/discharges being planned.

Anticipated discharge dates are set on admission and discussed at the weekly MDT, adjusting when clinically appropriate.

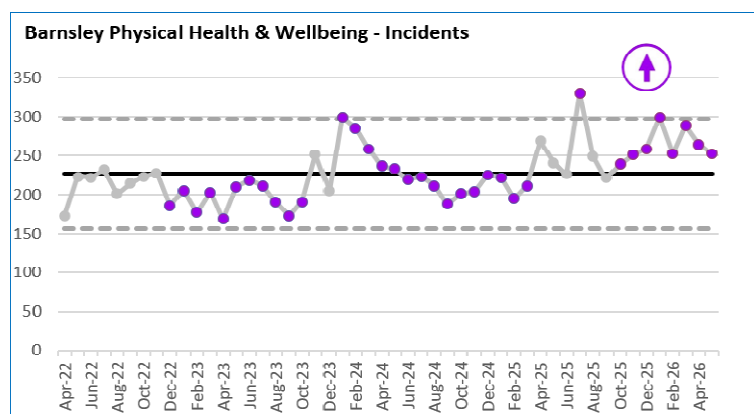
Barnsley Physical Health & Wellbeing (BPHWB)

Quality and Safety

Friends and Family Test



Incidents



Insights

Performance is very good with 96% of people saying they would recommend our services, this is back within compliance for the month of May, following the implementation of the Trust wide in-house system being from the 1st April. The total number of responses is still lower than previous years but has increased slightly during May.

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. Community teams use electronic links, QR codes, posters displayed in clinical areas and text messages to gather patient experience feedback.

Insights

The care group continues to have a positive reporting culture, and incidents are reviewed in line with PSIRF (Patient Safety Incident Response Framework). The care group work closely with the patient safety team and have continued to build relationships with partners in the local authority safeguarding team.

The care group has carried out the following learning responses since January 2026:

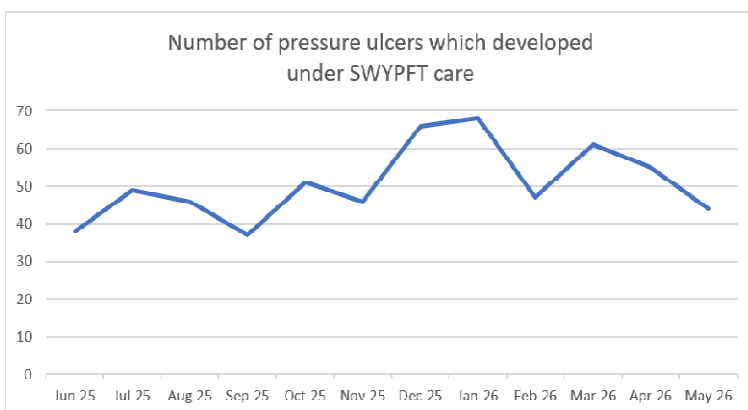
- Two After Action Reviews have been completed including action plans
- One Patient Safety Incident Investigation (PSII) has been completed and an action plan developed

The occurrence of any pressure ulcer continues to be recorded via the Datix system and make up the majority of reported incidents

Barnsley Physical Health & Wellbeing (BPHWB)

Quality and Safety

Number of pressure ulcers



Insights

All pressure ulcers are currently logged via the Datix incident reporting system. Pressure ulcers that have developed whilst a patient is on a caseload managed by SWYPFT are all reviewed and any areas for improvement are identified and managed in line with PSIRF.

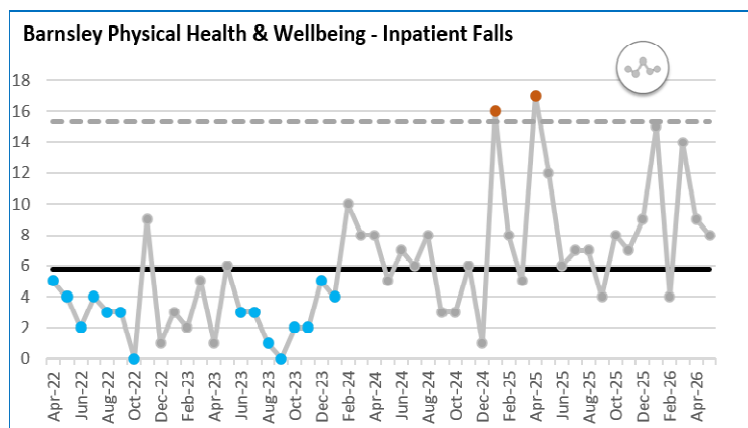
Discussions are underway to refine the definition of 'under SWYPFT' care with the potential to release time back to care. Community nurses do not provide 24 hour care to patients but offer advice on pressure prevention and any necessary treatment.

As part of the improvement work identified in the Patient Safety Incident Investigation (PSII) into pressure ulcer a new SystmOne template is in the pilot phase which will allow for the counting of pressure ulcers to be pulled from the clinical record rather than relying on the Datix system. These changes would result in a reduction of the data presented here.

It remains important to consider the development of pressure ulcers in the context of the health of the population in Barnsley with a high proportion being in the 'Core 20' population. 40% of our population in Barnsley live in the highest levels of deprivation, which is a key determinant related to health inequalities.

A review of data from December 2025 to March 2026 shows a pattern that may suggest the early stages of shift compared to April to November 2025, indicating the need for further monitoring of the trend. However the reporting is impacted by the definition of 'under SWYPFT care'.

Number of Falls (inpatients)



Insights

Patients undergoing neurological rehabilitation are at increased risk of falls due to the combined effects of mobility, balance and cognitive impairment, with risk often increasing as rehabilitation progresses and independence improves (National Clinical Guideline for Stroke, 2023).

All patients receive a comprehensive multifactorial falls assessment on admission, including completion of a Falls Risk Assessment Tool (FRAT), with regular review throughout their admission. Bone health assessments are undertaken where clinically indicated, and individualised falls prevention measures are implemented in line with patient need and Trust policy.

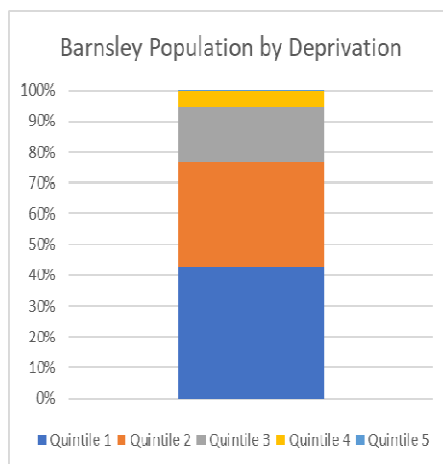
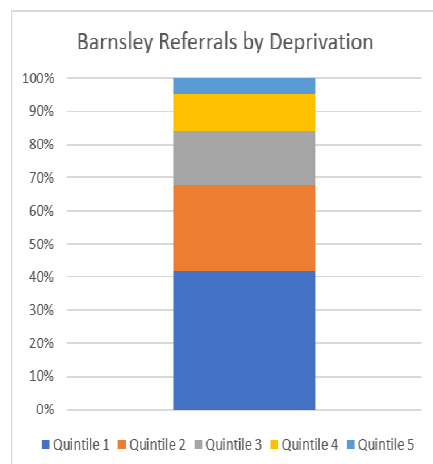
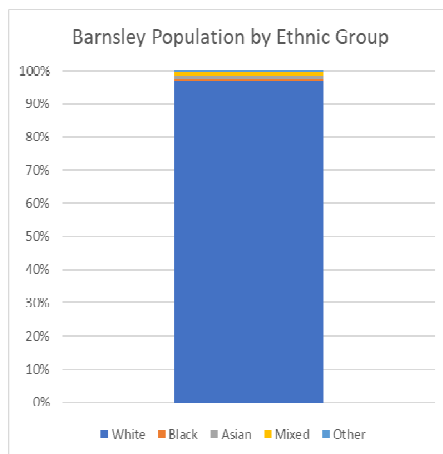
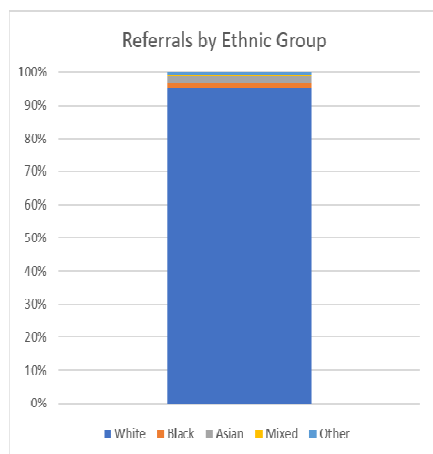
The multidisciplinary team works closely with the Trust Falls Co-ordinator to ensure appropriate risk mitigation is in place. Additional measures, including enhanced observation, bed and chair alarms, and regular safety huddles, are used where required. All falls are reported and reviewed through the Trust's incident reporting processes to support learning and continuous improvement.

Whilst some falls remain unavoidable within this complex patient group, maintaining safe staffing levels and robust risk management processes are key components of reducing falls and minimising harm. There is a piece of work to understand the increase in falls however early intelligence suggests this could be due to receiving patients earlier in their rehab and recovery process.

Barnsley Physical Health & Wellbeing (BPHWB)

Inequalities

Referrals



Insights

Based on year to date (YTD) Referrals (Jun 25 - May 26)

We have seen an increased representation across our ethnic minority groups in this report and the care group are drawing on expertise from Performance and Business Intelligence, in SWYPFT and at Place to explore the data further.

The Care Group has increased its number of service lines to 54 since the last report and from the transition in April 25 we have seen a reduction in the percentage of service users who have had their ethnicity data recorded to 80% as a result of this transferred data.

The complexity of over 54 different service lines is challenging as inequalities could present in individual service areas. However, work continues to encourage all services to embed the review of service user demographics into their everyday practice. This helps to ensure the accessibility of services to people across all protected characteristics, including ethnicity.

The care group continues to improve in the completion of equality impact assessments and ensure data quality through the recording of protected characteristics is optimised.

Based on year to date referrals (Jun 25 - May 26)

Understanding the impact that deprivation has on the service offer is again very complex and multi faceted. All service review work continues to be underpinned by the fundamental key drivers such as reducing health inequalities through application of literature and policy (CORE20Plus5 and Kings Fund).

Approximately 42% of referrals are from service users living in the 20% most deprived parts of the country which is similar to the population profile for Barnsley. The data also shows a disproportionately high number of referrals from our least deprived communities and requires continued analysis to understand whether this has been influenced by services which have transitioned into the Care Group since May 25 and whether this indicates a social gradient in service access.

System collaboration continues to provide insight into how we can maximise opportunities for improved public health outcomes when considering both clinical risk factors (co-morbidities), alongside socio-economic influences that may impact on these.

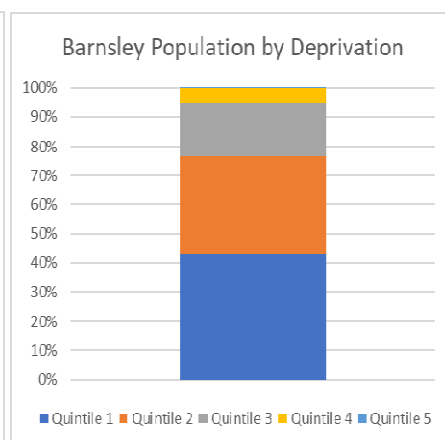
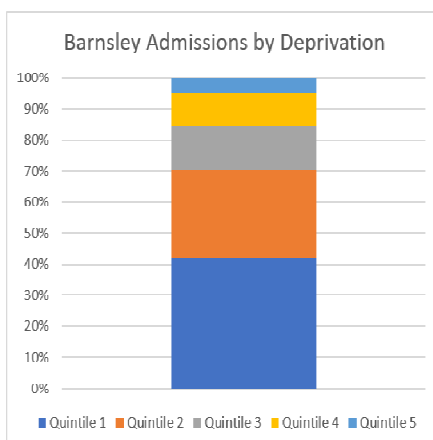
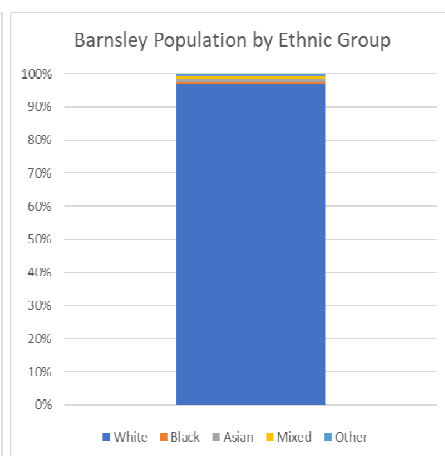
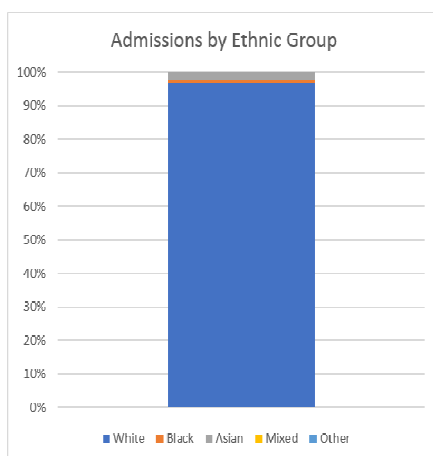
Local data is complemented by the use of National datasets e.g. Population & Person Insight (PaPI), to provide data driven approaches to proactive population health and care.

In late 2025 our Wound Care drop-in clinic launched. This is targeted at individuals experiencing homelessness / rough sleeping in the central neighbourhood. The clinic is running in conjunction with a weekly rough sleeper breakfast club. The pilot was initially supported by our Advanced Clinical Practitioners (ACPs) and Community Matrons but is now running as business as usual, being delivered by our Health Integration Team.

Barnsley Physical Health & Wellbeing (BPHWB)

Inequalities

Admissions



Insights

Based on YTD Admissions (Jun 25 - May 26)

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 for South Yorkshire & Bassetlaw ICB are shown below. This is the most up to date validated data.

We are unable to extrapolate specific numbers for patients seen by SWYPFT as this is recorded during admission to the Hyper Acute Stroke Unit (HASU) or Acute Stroke Unit (ASU.) However, when we have looked at local data in the past, the number of BAME admissions onto the Barnsley Integrated Community Stroke Team does reflect the population statistics for Barnsley.

Ethnicity	National (%)	SYB ICB (%)
White	81.7	88.5
Black	2.3	0.5
Asian	4	1.3
Mixed	0.6	0.4
Other	1.6	1.1
Not known/Not stated	9.7	7.4

In terms of NRU, 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

Based on YTD Admissions (Jun 25 - May 26)

This is consistent with population demographics and given the numbers are quite low, this can fluctuate from month to month.

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.

Statistical Process Control (SPC) Charts Explained

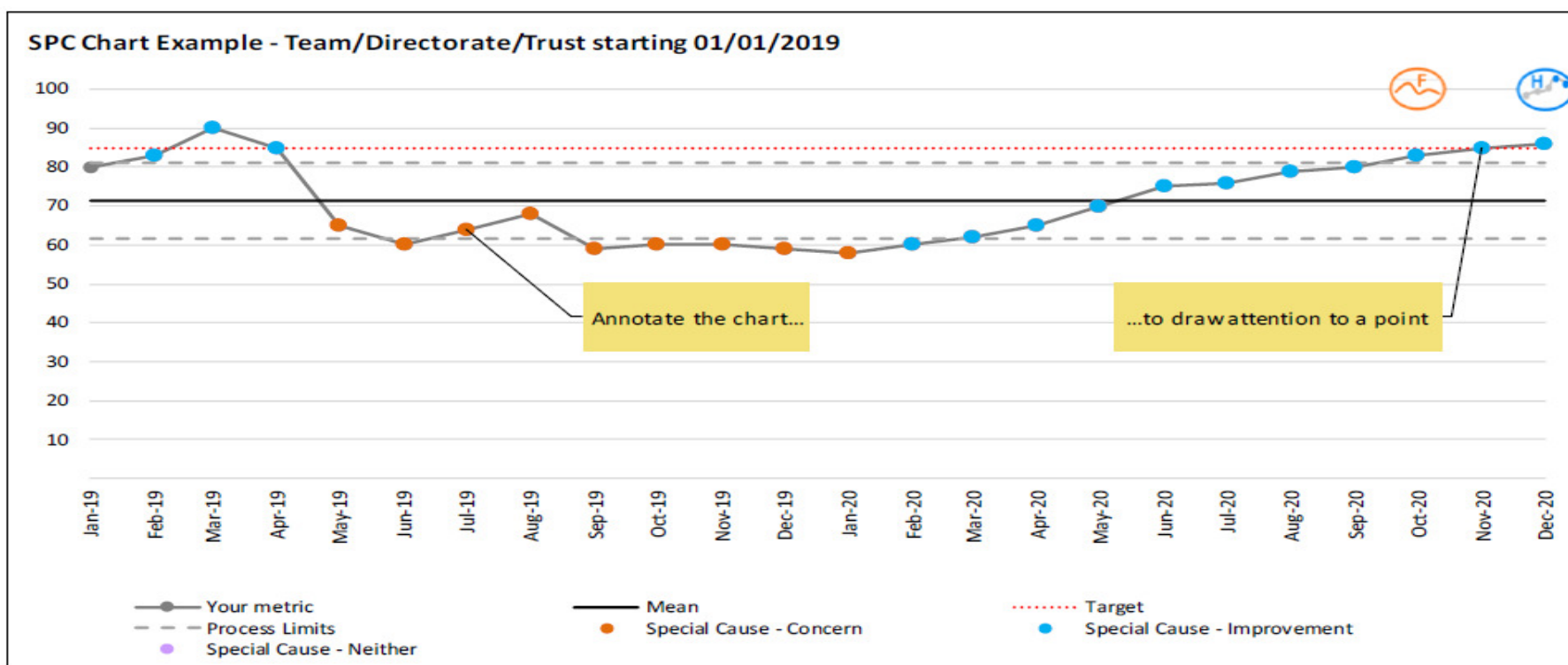
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data 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 (I) 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 significant 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 significant change in process. This process is not in control.

**Trust Board
28 July 2026
Agenda item 12.1**

Private/Public paper:	Public		
Title:	South Yorkshire Integrated Care System (SY ICS) Update including Mental Health, Learning Disability and Autism Provider Collaborative (MHLDA)		
Lead Director:	Mark Brooks - Chief Executive Dawn Lawson – Executive Director of Strategy, Inclusion and Change/ Deputy Chief Executive		
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 aims:	Live Our Values	✓	The Trust’s partnership working at system and Place supports it to be the ‘Best Partner’ and to achieve its ambitions.
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓	
	Be ambitious	✓	
BAF Risk(s):	4.1 Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place’ 4.2 Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust. 4.3 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 6.2 System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience.		

	6.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through Place- based partnership arrangements and provider collaboratives, and also developments and discussions in progress where relevant.
Any background papers / previously considered by:	The Trust Board receive regular updates on the progress and developments in the SY ICS, including the development of the provider collaborative. The last update was received by Trust Board on 30 th June 2026.
Executive summary:	The Trust is an active participant in the South Yorkshire Integrated Care System and this report provides a summary of key points from the main meetings and forums which have taken place in that system during the reporting period. Work continues with our partners in Barnsley to evolve and develop place-based partnership governance arrangements and neighbourhood health. 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 members are asked to: • NOTE the SY ICS and Barnsley Place updates.

**Trust Board
28 July 2026
Agenda item – 12.1
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.

Regarding partnership development in Barnsley, meetings are taking place with partners to develop a place provider partnership and determine its role and deliver against its agreed year one priorities given the changes that are taking place with the Integrated Care Board. The Trust is well represented in these discussions.

The paper summarises key developments from recent Integrated Care Board (ICB) and place-based meetings.

2. South Yorkshire Integrated Care Board

South Yorkshire Integrated Care Board

Member	Chief Executive
Items discussed	<u>Update from meeting held on 1 July 2026</u> Key agenda items included: • Story Telling: Every Birth, Every Journey – Listening to women and families’ experiences of maternity and neonatal care. • Chair’s Matters – it was agreed at the meeting that Lesley Dabell (non-executive director) will act as interim chair for the ICB until a new chair is appointed. • Chief Executive’s Report- key themes discussed included: ○ Integrated Care System Update- It was updated that from 1 July 2026, NHS South Yorkshire is adopting its new governance structure following the completion of the staff consultation into Organisation Change. The changes will see the organisation reduce to 483 whole time equivalents (wte) from 850 wte given the required 51% reduction in operating costs.

	○ Secretary of State and NHS Bill- it was updated that James Murray, MP, has been appointed as Secretary of State for Health and Social Care, replacing Wes Streeting, MP. The NHS Modernisation Bill was introduced to Parliament in May 2026 and should become law by the end of this financial year, with its implementation thereafter. This Bill includes the abolition of NHS England (NHSE) and will have a significant impact on the role of integrated care boards. ○ Financial Position Update- at Month 2 the ICB position is a deficit of £3.6m, which is £3.6m adverse to plan which relates solely to the Quarter 1 Deficit Support Funding (DSF) that has not yet been allocated to the ICB. Therefore, there are no material variances at this stage of the year. ○ Planning and Priorities for 2026/27 and National Oversight Framework- it was confirmed that NHS South Yorkshire submitted its strategic commissioning and commissioning intention plans to NHS England in May 2026. ○ Lord Mann report- a report including recommendations by Lord Mann has been accepted by the Government to tackle racism and antisemitism in the NHS. ○ Industrial Action- resident doctors called off industrial action due to take place in June 2026. ○ NHS South Yorkshire Board Changes and Health Commissioner- the recruitment of a new Chair/Health Commissioner is currently taking place to replace Pearse Butler, whose term ended at the end of June 2026. Roxanna Naylor has been appointed to the role of Chief Finance Officer following the retirement of Lee Outhwaite. ○ Neighbourhood Health Framework and National Neighbourhood Health Visit- the Department of Health and Social Care (DHSC) and NHSE published the Neighbourhood health framework on 17 March 2026 setting out plans to establish a Neighbourhood Health Service across England. Dr Fuller visited the new centre in Spittal Street, Sheffield, where a number of organisations are already operating a facility that Neighbourhood Health Centres could be modelled on. ○ Place updates- the Barnsley partnership achieved the highest possible rating from OFSTED for SEND services following a recent inspection. ● Board Assurance Framework & Risk Register- the Board reviewed key risks. ● Antimicrobial Resistance (AMR) Call to Action. ● Local Maternity and Neonatal System (LMNS) Equity and Equality Action Plan Update.

	• South Yorkshire – Delivering our Performance Objectives (IPR). • Updated Weight Management Eligibility Criteria. • Out of Area Placements: Intention to Achieve the Medium-Term Planning Framework) (MTPF) Commitment. • Strategic Commissioning Plan. • Transacting the Model ICB Change Programme. • ICB Running Cost Reductions Organisational Change Programme Update. • Corporate Assurance Report and ICB Governance Items. • NHS South Yorkshire Financial Delivery Report. • Month 2 Finance Report including Efficiency Programme Update. • 2025/26 ICB Annual Accounts and Annual Report. • Assurance Items (Committee Reports)- Minutes were received from: ICP, Place Committees, Assurance Committees.
Date of next meeting	Next meeting scheduled for 2 September 2026.
Further information:	https://southyorkshire.icb.nhs.uk/our-information/meetings-and-papers

3. South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative Board

Member	Chief Executive
Items discussed	There has been no further meeting of the South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative Board since the last report to Trust Board.
Date of next meeting	Next meeting scheduled for 9 th September 2026

4. South Yorkshire Eating Disorder Joint Committee (EDJC)

Member	Director of Strategy, Inclusion and Change/ Deputy Chief Executive
Items discussed	<u>Update from meeting on 13 July 2026</u> Key agenda items included: • Medical emergencies in eating disorder (MEED) update- The ICB leadership team and EDJC have recently agreed to fund developments in Medical Emergencies in Eating Disorders (MEED) services in South Yorkshire. Actions have commenced with an initial meeting about the adult pathway. • Children and Young People's (CYP) Eating Disorders ○ MEED.

	○ CYP Options for Integrated Service offer. ○ Avoidant/Restrictive Food Intake Disorder (ARFID)- a task and finish group to consider options of a consultation model has been established. • Physical health monitoring – update on implementation plan. • Integrated Service – adult service procurement update.
Date of next meeting	Next meeting scheduled for 10 th August 2026

5. Barnsley Place

Barnsley Provider Partnership (BPP)

Member	Chief Executive
Items discussed	There has been no further meeting of the Barnsley Provider Partnership since the last report to Trust Board. Arrangements have been made for chairing the partnership which will be on an annual rotational basis. The chief of executive for SWYPFT will chair the partnership for the first year.
Date of next meeting	Next meeting of Barnsley Place Partnership is scheduled for 30 th July 2026

Barnsley Community Health and Care Alliance

Member	Chief Executive, Chair, and Director of Strategy, Inclusion and Change/ Deputy Chief Executive
Items discussed	The planned meeting of the Barnsley Community Health and Care Alliance on 24 th June 2026 was cancelled.
Date of next meeting	Next meeting scheduled for 26 th August 2026

Barnsley Health and Wellbeing Board

Invited observer	Director of Strategy and Change/Deputy Chief Executive
Items discussed	There has been no further meeting of the Barnsley Health and Wellbeing Board since the last update to Trust Board.
Minutes	Papers and draft minutes (when available): https://barnsleymbc.moderngov.co.uk/ieListMeetings.aspx?Committeed=143
Date of next meeting	Next meeting scheduled for 23 rd July 2026

**Trust Board
28 July 2026
Agenda item 12.2**

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.		
Lead Director:	Mark Brooks - Chief Executive		
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 aims:	Live Our Values		The Trust's partnership working at system and Place supports being the 'Best Partner' and the Trust to achieve our ambitions.
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓	
	Be ambitious	✓	
BAF Risk(s):	4.1 Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place 4.2 Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust. 4.3 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 6.2 System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience. 6.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.		
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 and partner organisation objectives at national regional or local level.	
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. The last update was received by Trust Board on 30 June 2026.
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. 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. Meetings of Place Provider Partnerships in shadow form commenced April 2026 in Calderdale, Kirklees and Wakefield. The paper summarises key developments from recent ICB and place-based partnership meetings. Risk Appetite This update supports the risk appetite identified in the Trust's organisational risk register.
Recommendation:	Trust Board members are asked to: • 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. • NOTE the minutes of relevant partnership boards/committees.

**Trust Board
28 July 2026
Agenda item 12.2**

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.

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, in line with the delegations provided to it by the NHS West Yorkshire Integrated Care Board. The role of these committees has changed given the reorganisation of the ICB in 26/27 and there will only be one meeting per quarter for decision-making purposes.

Work continues in each of the Trust's three districts' partnerships to evolve and develop place-based provider partnership governance arrangements. The Trust has continued to work with partners in each of its places to support the development of place-based arrangements. Meetings of Place Provider Partnerships in shadow form commenced April 2026 in Calderdale, Kirklees and Wakefield.

This paper summarises key developments from recent ICB and place-based partnership meetings. A key focus of system discussions has been the organisational change in each of our ICBs, and the role ICBs play in the future as strategic commissioners.

Recruitment to the role of chief executive for the West Yorkshire ICB has taken place recently. Once the outcome of this process is known it will be communicated to Trust Board members.

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	<u>Update from meeting on 23rd June 2026</u> Key agenda items included: • Chief Executive's Update. • Medium Term Planning 2026/27 – 2028/29 Closedown Letter. • System Financial Plans 2026/27 – 2028/29. • System Financial Position month 2 2026/27. • Neighbourhood Health Centre Proposals. • Neighbourhood Health Visit. • Committee 'AAA' Report. • Receipt of the 'Palantir out of West Yorkshire NHS' petitions. • Performance Update. • Corporate Risk Register. • People's Voice at the Heart of Decision Making: The Experience and Involvement Advisory Board.Primary Care Mental Health Specification Approval (Leeds Place). • The ICB as a Strategic Commissioner. • Strategic Objectives and Development of the Board Assurance Framework. • Changes to the ICB Constitution. • Changes to the Financial Scheme of Delegation and Standing Financial Instructions. • Committee Terms of Reference and Workplans.
Date of next meeting	Next meeting scheduled for 22nd September 2026. An update from this meeting will be shared at the next Board meeting.
Further information:	<u>Integrated Care Board : West Yorkshire Health & Care Partnership</u>

West Yorkshire Health & Care Partnership Board

Member	Chief Executive
Items discussed	There has been no further meeting of the West Yorkshire Health & Care Partnership Board since the last update to Trust Board.
Date of next meeting	The next meeting date of the West Yorkshire Partnership Board is to be confirmed.
Further information:	Further information about the work of the Partnership Board is available at: https://www.wyhppartnership.co.uk/meetings/partnershipboard Meeting papers are available here: https://www.wyppartnership.co.uk/meetings/partnershipboard/papers

West Yorkshire Mental Health, Learning Disability and Autism Partnership Board

Members	Chief Operating Officer and Medical Director.
Items discussed	<u>Update from meeting on 16 July 2026</u> • Chair's update. • Learning disabilities and autism. • Assessment and Treatment Unit • Link- ED- Link- ED is a West Yorkshire-wide Tier 2 eating disorder service established in 2021 through the Community Mental Health Transformation programme. Originally developed as a consultation and advice service for Community Mental Health Teams (CMHTs), the model has evolved in response to stakeholder feedback and identified system need. An evaluation of the service was shared. • Mental Health Support Teams in schools. • Talking Therapies. • National Oversight • Framework and Plan Delivery. • Standard Operating Procedures: ○ Placing into and out of West Yorkshire ○ Repatriation & guidance • AAA reports and escalations.
Date of next meeting	Next meeting scheduled for 11 th August 2026.

Wakefield

The Trust continues to be a pro-active partner in the Wakefield District Health and Care Partnership (WDHCP) and associated work, leading in specific areas, for example, the Wakefield Mental Health Alliance. Since the last report to Board, the initial meeting of the Wakefield Place Provider Partnership has taken place.

Wakefield District Health and Care Partnership Committee

Member	Chief Executive
Items discussed	There has been no further meeting of the Wakefield District Health and Care Partnership Committee since the last update to Trust Board.
Date of next meeting	Next meeting scheduled for 11 August 2026
Further information	Meeting papers are available here: <u>Committee meetings - Wakefield District Health & Care Partnership (wakefelddistricthcp.co.uk)</u>

Wakefield Mental Health Alliance

Member	Deputy Director of Partnerships, Planning and Governance (Chair) Associate Director of Operations, Mental Health Care Group
Items discussed	At the time of writing this report, there has been no further meeting of the Wakefield Mental Health Alliance since the last update to Trust Board. In the context of changes to the role of ICBs, and organisation change, the Trust has reaffirmed its commitment to taking forward the work of the Wakefield Mental Health Alliance. The Deputy Director of Partnerships, Planning and Governance (SWYPFT) has taken on the role of Chair of the Alliance.
Date of next meeting	Next meeting scheduled for 22 nd July 2026

Wakefield Health and Wellbeing Board

Member	Chief Executive (deputy - Programme Director for Mental Health Transformation- Wakefield)
Items discussed	Update from meeting on 21 July 2026 Key agenda items included: • District Plan Outcomes Metrics with a Health and Wellbeing Focus. • JSNA (Joint Strategic Risk Assessment) Indicators of Health and Wellbeing aligned to the District Plan. • Interim Neighbourhood Health Plan. • Better Care Fund Update: ○ 2025-26 End of Year Submission. ○ Better Care Fund 2026-27 Plan Submission and Section 75 Partnership Agreement. • Overview and Scrutiny Committee Papers.
Date of next meeting	Next meeting scheduled for 15 September 2026.
Further information	Papers and draft minutes are available at: www.wakefield.gov.uk: Browse meetings - Health and Wellbeing Board

Calderdale

SWYPFT is a partner in delivering Calderdale Cares. We have continued to work with partners to develop a place-based approach.

Calderdale Cares Partnership Board

Member	Chief Executive
Items discussed	There has been no further meeting of the Calderdale Cares Partnership Board since the last report to Trust Board.
Date of next meeting	Next meeting scheduled for 13 th August 2026

Further information	Further information and meeting minutes can be found here: <u>Calderdale Cares Partnership Board Papers - Calderdale Cares Partnership</u>

Calderdale Cares Community Programme Board

Member	Associate Director of Operations, Adults and Older People Mental Health Care Group
Items discussed	There has been no further meeting of the Calderdale Cares Community Programme Board since the last meeting of Trust Board. Both the July and August meetings have been cancelled.
Date of next meeting	Next meeting to be confirmed.
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	Chief Nurse/Director of Quality and Professions
Items discussed	<u>Update from meeting on 20th July 2026</u> Key agenda items included: • Changes to the local Health and Care system and implications for Health and Wellbeing Board. • Starting Well. • Calderdale Strategic Neighbourhood Health Plan. • Public Health Annual Report 2025. • Health and Wellbeing Board Annual Report 2025-26.
Date of next meeting	Next meeting is scheduled for 14 th October 2026.
Further information	Papers and minutes are available at: https://calderdale.moderngov.co.uk/ieListMeetings.aspx?CId=148&Year=0

Kirklees

Kirklees ICB Committee

Member	Chief Executive
Items discussed	There has been no further meeting on the Kirklees ICB Committee since the last update to Trust Board.
Date of next meeting	Next meeting scheduled for 12 August 2026.
Further information	Further information and papers are available at: <u>Kirklees Integrated Care Board Committee - NHS Kirklees HCP</u>

Kirklees Health and Wellbeing Board

Invited Observer	Deputy Director of Partnerships, Planning and Governance
Items discussed	No meeting of the Kirklees Health and Wellbeing Board has been held since last report to Board. The meeting planned for 16 July 2026 was cancelled.
Date of next meeting	Next meeting scheduled for 24 September 2026
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

Kirklees Partnership Executive meeting

Member	Deputy Director of Partnerships, Planning and Governance
Items discussed	<u>Update from meeting on 9 July 2026</u> Key Agenda items included: • West Yorkshire Police update • Landscape of the Health Sector
Date of next meeting	Next meeting scheduled for 10 September 2026.

Kirklees Delivery Collaborative

Member	General Manager Adult Community and Recovery Services Kirklees and Calderdale
Items discussed	The meetings have currently been paused.
Date of next meeting	Next meeting to be confirmed.

Kirklees Mental Health Alliance

Member	Chief Executive with Associate Director of Operations, Mental Health Care Group as a member
Items discussed	There has been no further meeting of the Kirklees Mental Health Alliance since the last update to Board as the meeting of 27 March 2026 was cancelled. Discussions have taken place at Place Provider Partnership Board as to the oversight of key priorities, and meeting structures will be established.
Date of next meeting	Next meeting to be confirmed.

**Trust Board
28 July 2026
Agenda item 12.3**

Private/Public paper:	Public		
Title:	Specialised Provider Collaboratives and Alliances		
Lead Director:	Adrian Snarr (Director of Finance and Resources)		
Purpose/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 paper provides an update on 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.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	2.1 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. 2.4 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes. 4.1 Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place’ 4.3 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 6.1 Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place	The paper provides an update on the work of the Specialised Provider Collaboratives and their relationship to ICB, and Place based organisations. The paper provides an overview of the work being undertaken through the provider collaboratives, highlighting quality improvement initiatives including		

based partnerships and partner organisation objectives at national regional or local level.	service user involvement, pathway improvements and commissioning activity, leading to improved patient experience, partnerships. Reference is made to any pressure, capacity and demand within the provider collaboratives, noting the impact on out of area (OOA) placements, impact on waits to access care and the improvement work to address these areas. The paper also provides a financial update in relation to each provider collaborative highlighting any potential financial risk for the Trust.
Any background papers / previously considered by:	None.
Executive summary:	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. Where the Trust is the co-ordinating provider, the paper provides insights into the areas of improvement being undertaken. These include, in West Yorkshire and South Yorkshire, projects to address challenges in patient pathways and flow (out of area and clinically ready for discharge), health inequalities and work to improve our insights and sharing of patient experiences. Updates relating to environmental changes in services are also shared that impact on the access to services/patient experience and quality. Financial updates are provided for all Provider Collaboratives and the impact on the Trust through agreed risk shares.
Recommendation:	Trust Board members are asked to: • To RECEIVE the updates provided within the paper.

**Trust Board
Agenda item 12.3
28 July 2026**

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 1 October 2020, and the CAMHS and Adult Secure Collaboratives 1 October 2021 (with transitional support from NHSE/I until 31 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 1 October 2021, and the Adult Secure Provider Collaborative on 1 May 2022.

Although the South Yorkshire Integrated Care System does not include the Bassetlaw population, for the purpose of the Phase 1 services the Provider Collaboratives continue to include the Bassetlaw population and will link with Nottinghamshire Integrated Care System as required.

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. a summary of the key areas of activity includes:

- In response to the quality concerns at St Andrews Hospital, Northampton, the West Yorkshire (WY) Provider Collaborative (PC) has worked to identify placements for the two patients receiving care in St Andrews. One patient has now been discharged to a non-secure placement in Bradford, with the second patient awaiting transfer to a low secure service. A bed is available and a transition plan is underway. The PC anticipate this move will have happened by September 2026.
- The three Adult Secure Provider Collaboratives covering the Yorkshire and Humber region have initiated a series of workstreams to improve collaboration, patient pathways, experience and efficiencies. The WY Clinical Lead is leading a project exploring options for a regional SPA (single point of access) functions and improved coordination of secure beds across WY, South Yorkshire and Humber and North Yorkshire.
- The WY PC continue to experience the highest number of patients cared for in secure services since the PC went live, at 275 patients. This is due to demand, and recent slowing of discharges. The main pressure is on the medium secure male mental illness (MI) pathway. All male services are working between 90- 96% occupancy levels which highlights the challenges both with clinical demand and the potential impact on waits.
- The total numbers waiting for secure care has reduced in recent months.
- A full thematic review has been produced of waits, and this is due to be presented to the Wakefield Safeguarding Board. A task and finish group has commenced with all providers to address the recommendations noted in the review, with the aim to improve the assessment and admission processes and timescales. A presentation was also provided to the Wakefield Safeguarding Board Prisons Sub Group.
- The overall number of out of area (OOA) cases has increased to 57 which is the highest number since 2022. Whilst some cases are within their natural clinical flow, some are OOA purely due to lack of capacity in West Yorkshire. 24 men are currently OOA due to no bed availability within Newton Lodge (medium Secure).
- The PC has worked with colleagues in Rampton to establish a conference-style event facilitated in July, bringing together medium secure providers and high secure services to explore admission/discharge pathways and improve relationships.
- The PC continues to progress the wider improvement work to the women's pathways and community services, reducing variation in the service offer across West Yorkshire and improving pathways/service user experience.
- The PC Clinical Lead is part of a national project group led by NHSE to improve the use of and reporting of clinically ready for discharge (CRFD) in line with the definition. National variance is currently significant, and indications are that the definition is challenging to apply and may be revised by NHS England to offer specific forensic guidance.

The operational activity pressures continue to have a financial pressure on the West Yorkshire Adult Secure collaborative with expenditure on out of area placements and exceptional packages of care.

3.2 West Yorkshire Adult Eating Disorders Provider Collaborative

The 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.

As such the PC is reviewing the service offer, both in view of reduced income generation opportunities, and increased local referrals and complexity. An implementation plan is being developed.

The current forecast for 2026 / 27 is a surplus of £73k. Q1 finance and activity reports are due to be received by the PC Board this month. On commissioning activity, this forecasted position is likely to change due to an approved out of area admission.

3.3 West Yorkshire Children and Young People's Mental Health (Inpatient) Provider Collaborative

In line with the national developmental specifications, and inclusion of a service development improvement plan (SDIP) varied into Lead Provider contracts nationally, the PC are developing several priority workstreams to maximise viable alternatives to hospital admission, and/ or facilitated discharge, and further development of inpatient provision.

The current forecast for 2026 / 27 is a surplus of £1.8m. Q1 finance and activity reports are due to PC Board this month. On commissioning activity, this forecast will be maintained as high cost and complex care (EPCs) are reduced.

4. Phase 1 Provider Collaboratives - South Yorkshire

4.1 South Yorkshire Adult Secure Provider Collaborative

The Adult Secure Provider Collaborative Oversight Group receives monthly updates and continues to provide oversight of the Trust's commissioning responsibilities, this reports into the Trust's Commissioning Committee and key areas of focus have been as follows.

- There has been an increase in the SYB inpatient forensic population for the reporting period (+1) with 159 patients in inpatient treatment in total. This is 7 patients higher than planning estimated and one of the highest levels of occupancy seen since go live. Referrals continue to be dominated for the prison population and from Sheffield's PICU (psychiatric intensive care) ward. This trend is equally being observed in other parts of the region and across the Country and will form a key consideration in the planning for an expanded Community Forensic Service in South Yorkshire and Bassetlaw (SYB) in 2026/27.
- As at the end of June 2026, 17 patients were out of area (+2), 7 patients were within natural clinical flow (0 movement) and 2 are appropriate for repatriation (-1). Of the 2 patients appropriate for repatriation both will be prioritised for beds as they become available at Forest Lodge for low secure male services and at Wathwood for Medium Secure male services.
- Whilst it is positive that overall live length of stay has reduced within the last 12 months, since the Provider Collaborative's "go live" in October 2021, cumulative length of stay is showing an increasing trend. As previously reported, a Task & Finish group is working to review each individual patient and to understand what the challenges to discharge might be. This includes a review of demographics to understand health inequalities. This is being overseen by the SYB Provider Collaborative Clinical Director and the Adult Secure Clinical Lead. This will report to the Commissioning Committee in September 2026.
- 2026/27 Annual Quality Reviews have commenced with Cheswold Park Hospital's review taking place in April 2026, Amber Lodge in May 2026 and Cygnet Sheffield's

on 18th June 2026, Forest lodge is planned for July 2026. There were no immediate quality or patient safety concerns to escalate, and all providers remain in Routine Monitoring.

- Consideration is being taken on expansion of the Community Forensic Service within 2026/27 following funding being identified through growth monies. Following the event held with SYB Provider partners and regional colleagues in June 2026 a further event is planned for late July 2026 to hear proposals on how the expansion could be managed alongside existing services. This work will continue at pace with an agreed position deadline for end of August 2026 to ensure required governance for all parties involved can be completed in September 2026.
- The 'Enhanced Packages of Care working group' continues to both clinically and financially manage all Enhanced Packages of Care in place to ensure least restrictive care and reduce unnecessary spend. The work of this group has positively impacted the spend on enhanced packages of care and ensuring the least restrictive practices are used for our patients and continues to do so.
- Following a regional event held with West Yorkshire and Humber & North Yorkshire Provider Collaboratives and a follow up local event held with South Yorkshire and Bassetlaw providers, 4 priority workstream have been agreed upon, collaboratively led by the 3 Provider Collaboratives. These are as follows:-
 - SPA Task and Finish Group to explore existing strengths and opportunities across the local single points of Access with a view to focussing on patients from Yorkshire & Humber being considered for placement first within region. This will also strengthen collaboration and mutual aid for access assessment / assessment and patient placement for specific complexity/complex pathways.
 - Out of Area Patient Repatriation Group to review all out of area patients across Yorkshire and Humber with a focus on repatriation to local beds.
 - Understanding patient demography through a deep dive into data across the Yorkshire and Humber region to inform future commissioning and develop a region wide weekly SitRep.
 - Learning Disabilities and Autism pathway review to explore current provision and bed usage to identify opportunities for alternative commissioning arrangements, making best use of estate, skill and expertise.
- Negotiations are ongoing with Providers on 26/27 contract terms with 3 out of 5 now finalised and the remaining 2 being worked on at pace to secure final agreement.

The SYB Provider Collaborative is reporting a deficit position of £1.5m as at month 3 for 2026/27, this is primarily driven by;

- An increase in demand for inpatient services which has increased costs for both in areas providers and out of area providers with a forecast pressure of £1.9m which is a £900k increase on month 2. Work is ongoing to review estimated discharge dates to ensure accurate financial forecasting and the working group reviewing barriers to discharge continues through the length of stay task and finish group.
- There is also a £331k pressure which is a £234k increase on month 2 in relation to higher than national inflation multi-site provider uplifts that the SYB Provider Collaborative do not negotiate. This is being monitored and reported to NHS England regional team as an ongoing annual pressure which may increase.

5. Phase 2 Provider Collaboratives

5.1 Forensic CAMHS

Commissioning oversight of Yorkshire and Humber FCAMHS transferred to the West Yorkshire Specialised Provider Collaboratives Commissioning Hub from 1 January 2024.

To ensure all Yorkshire and Humber Specialised Provider Collaborative commissioners remain updated on the service, developments and quality activity, a Yorkshire and Humber Provider Collaborative Oversight Meeting has been established between the three Commissioning Hubs, chaired by West Yorkshire Commissioning Hub. The minutes and content are shared with SWYFT Commissioning Committee

Regular reporting and governance structures have been established, alongside quality oversight arrangements.

A Learning Disabilities and Autism business case has been developed and approved. This utilises the £90,000 funding from central NHS England funding and £103k from FCAMHS surplus investment fund.

5.2 Perinatal Mental Health (PMH)

The Collaborative went live on 1st October 2024, in shadow form, and live on 1st April 2025,

Commissioning oversight of Yorkshire and Humber (inpatient) PMH PC transferred to the West Yorkshire Specialised Provider Collaboratives Commissioning Hub from 1st April 2025

West Yorkshire ICB 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.

The Yorkshire and Humber PMH Provider Collaborative Board has been established. SWYPFT as a named partner, have representation at the board level, and as such will be in receipt of updated positions, partnership agreements and finance and activity reporting.

The PMH PC commissioning and quality activity will be shared at the established Yorkshire and Humber Oversight Group (*detailed above*)

A full business case for the provider collaborative has been shared with all partners; further work is being undertaken to progress the partnerships agreements to signature.

The PMH PC, in line with the national approach for this service line, operates within a “steady state” arrangement.

Q1 finance and activity reports are due to be received by the Provider Collaborative Board this month. On commissioning activity, the forecasted position will be maintained, as nationally the PMH PCs operate within a “steady state” arrangement, and no infrastructure costs are expected to be included in the PC envelope

Recommendation:

Trust Board is asked to:

Receive the Specialised NHS-Led Provider Collaboratives update.

**Trust Board
28 July 2026
Agenda item 13.1**

Private/Public paper:	Public		
Title:	Assessment against NHS Constitution		
Lead Director:	Dawn Lawson – Director of Strategy, Inclusion and Change		
Mission/values:	We put the person first and in the centre We know that families and carers matter We are respectful, honest, open and transparent We improve and aim to be outstanding We are relevant today and ready for tomorrow		
Purpose:	To provide assurance to Trust Board that the Trust meets the rights and pledges set out in the NHS Constitution in relation to patients and staff, and that it is mindful of the commitments in the NHS Constitution in delivering, planning and developing its services.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	All BAF risks		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	This assessment by the Board of Directors assesses the Trust against the NHS Constitution and provides evidence of the Trust’s effectiveness, efficiency and economy, as well as the quality of its healthcare delivery which supports its contribution to the objectives of the integrated care partnership (ICP) and integrated care board (ICB), and place-based partnerships.		

Any background papers / previously considered by:	Previous assessments have been submitted annually to the Trust Board. A full copy of the NHS Constitution can be found on the Department of Health website at: NHS Constitution for England - GOV.UK (www.gov.uk)
Executive summary:	The NHS Constitution was published in January 2009, following extensive public consultation. It established the principles and values for the NHS in England and set out rights to which patients, public and staff are entitled, pledges which the NHS is committed to achieving, together with responsibilities which the public, patients and staff owe to one another to ensure the NHS operates fairly and effectively. All NHS bodies, private and third-sector providers supplying NHS services are required, by law, to take account of the NHS Constitution in their decisions and actions. The NHS Constitution also applies to public health services, which are the responsibility of local authorities. The Government has committed to renewing the NHS Constitution every ten years with the full involvement of patients who use the NHS, the public who fund it and the staff who work in it. In July 2015, the Constitution was updated to reflect a limited number of changes. In January 2021 the NHS Constitution was updated to reflect the rules had changed regarding UK residents' access to healthcare in the European Union (EU), Norway, Iceland, Liechtenstein and Switzerland following the UK's exit from the EU. The Trust has undertaken its annual self-assessment as required and evidence against all rights and pledges has been updated to reflect current position, providing assurance we are meeting the rights and pledges of the NHS Constitution. This was discussed by EMT on 23 July 2026. Key updates since the previous review include: • R1- Further detail has been added in relation to how the Trust analyses data in relation to health inequalities. • R4- includes reference as to how data is used to inform service delivery. • R6- incorporates changes to the governance arrangements for equality, diversity and inclusion within the Trust. • R7- references improvement work that has been undertaken within paediatric audiology services in order to improve access which has resulted in performance in line with national targets. • R8- references the Trust's People Strategy. • R11- makes reference to quality walkarounds as an established quality improvement mechanism.

	• R12- references further roll out of electronic prescribing and medicines administration. • The staff section has been updated reflecting the People Strategy approved in December 2025. Board members should note that the NHS constitution is currently under national review, as a result of the 10 year plan, but at this stage timescales for release are unknown.
Recommendation:	Trust Board members are asked to: • APPROVE the paper, which demonstrates how the Trust is meeting the requirements of the NHS Constitution.

**The NHS Constitution – patients and the public
How the Trust meets its obligations
Trust Board 28 July 2026**

Heading	Compliance	Evidence	Lead
R1 You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.	Yes	Core services are commissioned by integrated care boards covering the places where the Trust delivers services namely, Barnsley, Calderdale, Kirklees and Wakefield. These are delivered free of charge to service users. In October 2021, the West Yorkshire Adult Secure Provider Collaborative went live, and SWYPFT entered into a Lead Provider Contract with NHS England. In May 2022, the South Yorkshire Adult Secure Provider Collaborative went live, and SWYPFT entered into a Lead Provider Contract with NHS England. The Trust, as Lead Provider (LP), has established sub-contract arrangements with providers within the region, known as “in-area” subcontracts. Where service users are placed in adult secure services with providers outside West Yorkshire, these are known as “out of area” subcontracts. For Adult Secure Provider Collaboratives, the Trust has in place a tripartite direct agreement that is signed by the provider, SWYPFT and NHSE. This confirms that the commissioning responsibility will transfer to NHSE in the exceptional circumstance that the Lead Provider should cease to be the Lead Provider. Adult secure contracts are due for renewal in April 2027 and the Trust is currently awaiting guidance from NHSE as to future contract requirements.	Director of Finance, Estates & Resources
R2 You have the right to access	Yes	The Trust has contracts in place for its services with	Chief Operating

Heading	Compliance	Evidence	Lead
NHS services. You will not be refused access on unreasonable grounds.		commissioners and endeavours to provide access to services within its available resources. The Trust's contracting processes, internal performance review and complaints processes would identify any instances where the Trust has not met or is perceived not to have met this right. The Trust has clear referral and acceptance criteria for all services.	Officer
R3 You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.	Yes	The Trust has contracts in place for its services with commissioners and endeavours to provide access to services within its available resources. The Trust's contracting processes, internal performance review and complaints processes would identify any instances where the Trust has not met or is perceived not to have met this right. All services have an equality impact assessment in place ensuring services are accessible and meet the needs of the communities the Trust serves.	Chief Operating Officer
R4 You have the right to expect your local NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary and, in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.	Yes	The Trust does assess the health needs of the local community in the development of its operational and strategic plans and, as part of the development of its priority programmes. The Trust works with commissioners, stakeholders, service users and carers, and local people to transform its services and develop new models and pathways of care that meet people's needs. The Trusts older peoples service transformation consultation process prior to the implementation of the work programme has been an example of this process. The Trust reviews data in relation to deprivation, health and inequalities in order to respond to need. As part of two integrated care systems the Trust works with partners in each place it provides services to understand the needs of local populations and design service provision accordingly. The Trust is a member of the local Health & Wellbeing Boards who have a statutory duty to assess the requirements of their communities. The Trust uses Joint Strategic Needs Assessment data available in each place to	Director of Strategy & Change

Heading	Compliance	Evidence	Lead
		inform and shape strategic and service change priorities. All services have an equality impact assessment in place ensuring services are accessible and meet the needs of the communities the Trust serves.	
R5 You have the right, in certain circumstances, to go to other European Economic Area countries or Switzerland for treatment which would be available to you through your NHS commissioner.	N/A	N/A to the Trust. This is determined by commissioners. This section of the NHS Constitution has now been amended to state: You have the right to authorisation for planned treatment in the EU under the UK EU Trade and Cooperation Agreement where you meet the relevant requirements. You also have the right to authorisation for planned treatment in the EU, Norway, Iceland, Lichtenstein or Switzerland if you are covered by the Withdrawal Agreement and you meet the relevant requirements.	N/A
R6 You have the right not to be unlawfully discriminated against in the provision of NHS services including on the grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.	Yes	The Trust complies with appropriate legislation relating to discrimination and has an Equality, Diversity and Inclusion Strategy in place with the prime aims of respecting and valuing difference and promoting a fairer organisation. This was developed with strong engagement from the Members' Council. The Trust has changed its governance structure in relation to equality diversity and inclusion during 2025/26. Following a thorough consultation process the decision was taken to step down the equality, inclusion and involvement committee in order to enhance equality and inclusion agenda as part of everything we do. The new All of us in mind group consists of a diverse group of people from across the organisation who can give their own views and also source and bring in views from different communities/groups. This group champions the EDI agenda. The EDI annual report is received by the People and Remuneration Committee (PRC). The Trust utilises all available equality data to ensure equity of access to services for the communities the Trust serves, including video consultations and treatment sessions, improved communication through use of social communication tools e.g., SystemOne messaging tool.	Chief Nurse and Director of Quality and Professions/ Chief Operating Officer/ Chief Medical Officer / Chief People Officer/ Director of Strategy Inclusion and Change

Heading	Compliance	Evidence	Lead
		In the quality section of the integrated performance report there is monthly health inequalities data. The organisational risk register includes risk 1689 - Risk that the Trust does not address health inequalities under its control in the provision of services potentially exacerbating existing health inequalities for our service users. This risk is overseen the quality and safety committee and is reviewed on a monthly basis. The Board Assurance Framework includes a discrimination risk - Measures are taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience. Progress against actions is monitored by EMT and Trust Board.	
R7 You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.	Yes	The Trust does provide some services subject to waiting times as outlined in the Handbook to the NHS Constitution which are reported monthly to the Trust Board under the national metrics in the Integrated Performance Report: - Patients waiting for a diagnostic test (paediatric audiology only) should have been waiting less than 6 weeks from referral. - A maximum 72 hour wait for follow-up after discharge from psychiatric in-patient care. - There is a right for patients to start consultant-led non-emergency treatment within a maximum of 18 weeks of a GP referral and for the NHS to take all reasonable steps to offer a range of alternatives if this is not possible. (Only applicable to Musculoskeletal (MSK) services in Barnsley) There are further waiting times which are not currently subject to the NHS Constitution that are monitored by the Board, Committees and Operating Management Group (led by the Chief Operating Officer). Neuro development waiting lists for children with Attention Deficit and Hyperactivity Disorder (ADHD) and Autistic Spectrum	Chief Nurse and Director of Quality and Professions/ Chief Operating Officer/ Chief Medical Officer

Heading	Compliance	Evidence	Lead
		Disorder (ASD) are still a concern. Children do not need to have a diagnosis in order to receive a CAMHS service and services will be provided to meet their presenting needs. Mental health support teams have been developed in all areas, working with families and taking into account the co-determinants of health. Due to challenges in timely access to paediatric audiology services, the Trust implemented a number of improvements, and access times are now within national target.	
P1 The NHS commits to provide convenient, easy access to services within the waiting times set out in the Handbook to the Constitution.	Yes	As part of its contractual requirement through the service specification with commissioners, the Trust is required to report on local waiting times in relation to improving access to psychological therapies (NHS Talking therapies) and psychological therapies, referral and treatment times in relation to the Barnsley Care Group musculoskeletal service (MSK). The Trust meets the required timescales. The Trust has a continued history of regularly meeting national targets for access to NHS Talking therapies, and when there is an issue in terms of meeting any local targets action plans are put in place to address. The Trust continues to ensure people experiencing a first episode of psychosis will start treatment within a NICE-recommended package of care with a specialist early intervention in psychosis service within 2 weeks of referral and this is routinely monitored through our performance management framework. Patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, will be able to be seen and receive treatment more quickly. The Trust's performance is monitored across all waiting time pledges.	Chief Nurse and Director of Quality and Professions/ Chief Operating Officer/ Chief Medical Officer

Heading	Compliance	Evidence	Lead
		One of our quality priorities is safe and responsive care, which includes service access for all. The Trust continues to provide services in a flexible and dynamic way including the use of digital options where appropriate. The Trust maintains face to face services dependant on patient need.	
• P2 The NHS commits to make decisions in a clear and transparent way so that patients and the public can understand how services are planned and delivered.	Yes	The Trust has undertaken significant work during 2025-26 to improve accessibility to information in line with the Accessible Information Standard (AIS). Work includes a revised accessible communications policy, improved feedback and complainants processes, new British sign language (BSL) contract and improvements to SystmOne vis the improving access to care priority programme. The Board meets in public and papers and minutes for public Trust Board meetings are published on the Trust's website. This supports patients and the public to understand key areas of work, and decisions made. Minutes from Board Committee meetings are included in the public Board papers. Board stories are received at every public meeting from staff, service users and carers. The Trust holds an Annual Members' Meeting and usually holds regular public events throughout the year. The Trust has a Members' Council in place comprising of elected public and staff governors, and appointed governors representing key stakeholders. Members' Council meetings are held in public, and papers and minutes are published on the Trust's website. The Trust's Equality, Diversity and Inclusion Strategy outlines its approach to involvement and engagement. Governors from our Members' Council were fully involved in the development of this strategy.	Chief Executive

Heading	Compliance	Evidence	Lead
		Service users and carers are involved in planning and designing Trust services. Where services changes impact on service users, staff and our communities, the Trust will engage and consult on proposed changes e.g. older peoples' transformation programme. Members' Council have a joint meeting with Trust Board every November to discuss forward planning. The Trust's services have individual service user groups. A description of the Trust's service offer is available on the Trust's website and in hard copy. The Trust utilises all available equality data to ensure equity of access to services for the communities the Trust serves, including video consultations and treatment sessions, improved communication through use of social communication tools e.g., SystmOne messaging tool.	
P3 The NHS commits to make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them.	Yes	The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care. The Formulation Informed Risk Management (FIRM) system has been implemented within the Trust as a framework for assessing and recording risk, and to ensure access to up-to-date risk information and management plans across all services supporting smooth transitions of care. Care planning continues to be a priority area for the Trust Quality Improvement programme. The Trust has improved systems and processes to ensure that all service users have a care plan in place and that they know who is responsible for their care. The Trust launched the new approach to care planning in January 2025, the new care plan is a person centred collaboratively written document which is strengths based, and recovery focussed. Service user and their carers' perceptions of the Trust are	Chief Nurse and Director of Quality and Professions/ Chief Operating Officer/ Chief Medical Officer

Heading	Compliance	Evidence	Lead
		regularly reviewed through national and local surveys. The Trust is committed to system wide improvement of services and interagency protocols through the Integrated Care Systems (ICSs) and local partnership arrangements. The Trust has transition arrangements in place between services to ensure that handovers are as smooth as possible.	
R8 You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.	Yes	The Trust has in place strong and robust processes for the employment, appraisal and re-validation of medical staff. Employment checks (references/DBS etc) take place for all staff employed by the Trust. The Trust ensures all appropriate staff are registered with the Health and Care Professions Council (HCPC). There can often be a need to utilise temporary staffing. When this is required the Trust endeavours to use bank staff where appropriate. In circumstances, where it has to use agency staff, these are from approved suppliers to ensure the quality, skills and experience of staffing is maintained. The Trust has continued to closely monitor its use of agency staff in 2025/26 . The Trust has an e-rostering system for all inpatient areas with agreed establishment levels for registered and non-registered staff. The Trust is registered with no conditions with the Care Quality Commission (CQC). The Trust is licensed by NHS England with no conditions and continues to comply with licencing requirements. The Trust is compliant with relevant National Institute for Health and Care Excellence (NICE) guidelines. The Trust has a robust system in place to undertake appropriate employment checks for its entire staff. The Trust has an ongoing Continuous Professional Development (CPD) approach. The People Strategy was approved by Trust Board on 2 December 2025. The Trusts Quality Assurance System (QAS) provides a framework that triangulates data, information and feedback to provide an oversight of quality and culture across Trust services.	Chief Nurse and Director of Quality and Professions / Chief People Officer / Chief Medical Officer

Heading	Compliance	Evidence	Lead
		It has three levels, routine monitoring, enhanced monitoring and intensive monitoring. Quality walkarounds are an established process in the Trust and a proven quality intervention that focusses on open and transparent communication and includes Trust governors and non-executive directors. Safer staffing reports are included within the monthly Integrated Performance Report and the Board receives a safer staffing and workforce report every six months. The Trust undertakes a robust workforce planning process each year linked to service and financial plans.	
R9 You have the right to be cared for in a clean, safe, secure and suitable environment.	Yes	The Trust has an Estates Strategy to support and meet the needs of services. Development of the Estates Strategy included a detailed six-facet survey of Trust estate. The Trusts ten-year estates strategy was approved by Trust Board in July 2023 and Trust Board receives bi-annual updates on progress. The Trust is compliant with Fire and Occupational Health & Safety (OHS) legislation. Patient-led assessments of the care environment (PLACE). assessments have been conducted during 2025/26 with outcomes presented to Trust Board in July 2026. The assessments have and continue to produce good results. Infection prevention and control (IPC) advisers and specialist advisers are in place with regular programme of audits in place. The infection, prevention and control board assurance framework is presented bi-annually to Trust Board. The Trust undertakes an annual Health and Safety Monitoring Audit. Trust Board approves an annual Health and Safety action plan, an annual safety services report and a premises assurance	Director of Finance, Estates and Resources

Heading	Compliance	Evidence	Lead
R10 You have the right to receive suitable and nutritious food and hydration to sustain good health and wellbeing.	Yes	model annual report The Trust's approach is based on the key areas included in the Department of Health Food Standards in relation to nutritional care, healthier eating for the whole hospital community and sustainable procurement of food and catering services. In all areas, the Trust works with its dieticians to create a balanced nutritional and healthy menu to cover the Trust's diverse patient base and also cooks to request for special diets. Nursing and medical staff are also aware of their role within the process. These processes are captured within the Trust's Food Hygiene Policy which was updated to include the latest guidelines including the latest guidance on allergens. Food provision is also included in the annual PLACE (patient led assessment of care environment) survey.	Director of Finance, Estates and Resources
R11 You have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of the healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.	Yes	The Trust publishes an annual Quality Account describing performance against key quality priorities and plan for improvement. The Trust's performance management processes include summary statistics on service activity data to enable comparisons of Trust outcomes with the 'what good looks like' and health needs assessment intelligence to support local decision-making to ensure continuous improvement. The Trust Board and its Committees receive performance and reports, as listed in the Trust Board work programme. Trust Board reports are publicly available on the Trust's website. Trust Board Committees provide assure, alert, advise (triple A) reports to Board which provide updates on key items and issues covered during meetings. The Trust has an ongoing change programme in place including engagement and involvement. Programmes of improvement are reviewed and prioritised on a regular basis.	Chief Nurse and Director of Quality and Professions

Heading	Compliance	Evidence	Lead
		Trust's own programme of visits to all in-patient locations (quality walkarounds) and a range of community teams registered with the Care Quality Commission (CQC) where compliance with essential standards is reviewed. In May 2023/24, the Trusts inpatient services were inspected by the CQC. Following receipt of the full CQC report the Chief Nurse, and Director of Quality and Professions provided an action plan to Trust Board. Regular updates on progress are provided to EMT, QSC and Trust Board. The Trust has a programme of PLACE visits undertaken annually, which are reported to Audit Committee and Trust Board.	
P4 The NHS commits to identify and share best practice in quality of care and treatments.	Yes	The Trust has a leadership and clinical management structure, including Care Group matrons whose role is to ensure best practice is being followed and effective clinical governance is maintained and developed. The Trust has quality improvement and patient safety strategies with implementation plans in place and formal systems in place to share good practice through the Quality Improvement Group. Accreditation for Trust services, such as electroconvulsive therapy (ECT), memory services in Barnsley, Calderdale, Kirklees and Wakefield, and secure services peer review undertaken annually. The Trust's Quality Assurance System (QAS) is a framework that triangulates data, information and feedback to provide an oversight of quality and culture across Trust services. It has three levels, routine monitoring, enhanced monitoring and intensive monitoring. Quality walkarounds are an established process in the Trust and	Executive Management Team

Heading	Compliance	Evidence	Lead
		a proven quality intervention that focusses on open and transparent communication and includes Trust governors and non-executive directors Clinical network for forensic services with providers as part of Allied Health Services Network members and the West Yorkshire Health & Care Partnership (WYHCP). Annual staff Excellence Awards which celebrate the difference that our staff and teams make to the lives of local people took place face to face in May 2026. The Trust has processes in place to learn from incidents and PSIRF (patient safety incident response framework) is fully embedded across the Trust. The leadership structure for operational leadership includes clinical networks which ensures the spread of best practice across pathways trust-wide, and the matron role in acute inpatient areas. The matron role leads on quality, best practice and standards of care. The Trust has an established Clinical Ethics Advisory Group (CEAG). The Trust is engaged with and has representation on South Yorkshire / West Yorkshire integrated care systems mental health work streams and partnership groups. CQC regulation leads monitor performance against CQC regulations.	
R12 You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if you doctor says they are clinically appropriate for you.	Yes	The Trust is compliant with relevant NICE guidelines. The Trust has a policy and procedures in place with timelines to implement NICE guidance. The Trust has a robust procedure in place for the approval and oversight of medical treatments within the Drug and Therapeutic sub-committee.	Chief Nurse and Director of Quality and Professions / Chief Medical Officer

Heading	Compliance	Evidence	Lead
		Quality and Safety Committee receives an annual report from the Drugs and Therapeutic Committee. Electronic Prescribing Medicines Administration (EPMA) digital system in place in place to support safe and efficient prescribing and administration.	
R13 You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain the decision to you.	N/A	N/A	
R14 You have the right to receive vaccinations that the Joint Committee on Vaccinations and Immunisation recommends that you should receive under an NHS-provided national immunisation programme.	Yes	The Trust is commissioned by NHS England to provide school age children (5-19) vaccination and immunisation programme including flu in Barnsley.	Chief Operating Officer
P5 The NHS commits to provide screening programmes as recommended by the UK National Screening Committee.	N/A	Where appropriate, all national screening programmes are in place and managed through the Screening Advisory Committee for South Yorkshire in respect of screening services provided by Barnsley Care Group.	Chief Operating Officer
R15 You have the right to be treated with dignity and respect, in accordance with your human rights.	Yes	Staff work to professional codes of conduct; Trust policies and the Trust launched a new approach to care planning in January 2025. The new care plan is a person centred collaboratively written document with a strength based and recovery focussed. The Trust's Equality, Diversity and Inclusion Strategy sets out how the Trust accords to an individual's human rights. Living our values continues to be a consistent message throughout the Trust. The Trust has values-based recruitment and induction	Chief Operating Officer / Chief Medical Officer / Chief Nurse and Director of Quality and Professions

Heading	Compliance	Evidence	Lead
		programme. The Trust has a strong pastoral care function to support service users and their carers, and staff. The Trust has a contractual duty of candour and has arrangements in place to ensure it meets the extended legal duties of candour introduced by the CQC. Regular reporting has been established at Care Group, Executive Management Team (EMT) and Board level.	
R16 You have the right to be protected from abuse and neglect, and care and treatment that is degrading.	Yes	The Trust has a robust policy and arrangements in place through its approaches to safeguarding vulnerable adults and children and is an active member of local safeguarding boards. There are clear processes in place for service users, families and carers to raise concerns via our dedicated Customer Services Team.	Chief Nurse and Director of Quality and Professions/ Chief Operating Officer/ Chief Medical Officer
R17 You have the right to accept or refuse treatment that is offered to you, and not be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests. (NB different rules apply for patients detained in hospital or on supervised community treatment under the Mental Health Act 1983.)	Yes	The Trust has a Consent Policy in place. The Trust has clear policies, procedures and guidance in place for the administration of the Mental Health Act (MHA), Mental Capacity Act (MCA) and for Deprivation of Liberty Standards. The Trust works in partnership with advocacy services provided by local authorities to provide support for service users and carers. The Trust's complaints processes would identify any instances where the Trust has not met or is perceived not to have met this right. The Trust has a training plan in place for Mental Health Act / Mental Capacity Act compliance and is meeting expected targets.	Chief Nurse and Director of Quality and Professions/ Chief Operating Officer/ Chief Medical Officer
R18 You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.	Yes	The Trust has medicine information leaflets including translation into other languages if required and utilises information available from NHS Choices. Service user information leaflets, which set out service user rights. Service users are given copies of their care plans. Service users and carers are part of developing Trust approach	Chief Nurse and Director of Quality and Professions/ Chief Operating Officer/ Chief Medical Officer

Heading	Compliance	Evidence	Lead
		to care planning. The Trust has undertaken significant work during 2025-26 to improve accessibility to information in line with the Accessible Information Standard (AIS). (see P2)	
R19 You have the right of access to your own health records and to have any factual inaccuracies corrected.	Yes	The Trust has a Data Security and Protection Policy, incorporating information sharing and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with requirements of Data Protection & Security Toolkit (DPST), CQC registration and NHSE's Licence conditions. The Trust has a senior information risk owner and Caldicott guardian in place and a published privacy notice.	Director of Finance, Estates and Resources/ Chief Nurse and Director of Quality and Professions
R20 You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure	Yes	Trust adheres to the Department of Health privacy and dignity guidance and has made an annual declaration of compliance to its regulator and to service users regarding elimination of mixed sex accommodation. The Trust has a Data Security and Protection Policy, incorporating information sharing and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Data Protection & Security Toolkit and Department of Health requirements to train staff in this area. When breaches do occur, they are thoroughly investigated with learning identified and notification to our commissioners or the Information Commissioner where appropriate.	Chief Nurse and Director of Quality and Professions/ Director of Finance, Estates and Resources
R21 You have the right to be informed about how your information is used.	Yes	The Trust has a Data Security and Protection Policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Data Protection & Security Toolkit and Department of Health requirements to train staff in this area.	Director of Finance, Estates and Resources/ Chief Nurse and Director of

Heading	Compliance	Evidence	Lead
			Quality and Professions
R22 You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered and, where you wishes cannot be followed, to be told the reasons, including the legal basis.	Yes	The Data Security and Protection Policy includes service user access. The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Data Protection & Security Toolkit and Department of Health requirements to train staff in this area.	Director of Finance, Estates and Resources/ Chief Nurse and Director of Quality and Professions
P6 The NHS commits to ensure those involved in your care and treatment have access to your health information so they can care for you safely and effectively.	Yes	The Trust has one main clinical information system (SystmOne) across its Care Groups. The Trust is also working with partners to ensure interoperability between systems, such as those used by local authorities, to make accessing information on care easier for staff working in integrated teams. Information sharing protocols are in place with partners as appropriate.	Director of Finance, Estates & Resources
P7 The NHS commits that, if you are admitted to hospital, you will not have to share sleeping accommodation with patients of the opposite sex, except where appropriate, in line with details set out in the Handbook to the NHS Constitution.	Yes	The Trust is able to make a declaration that it complies with the national standard in relation to Eliminating Mixed Sex Accommodation. The Trust also has a sexual safety policy in place that covers both patients and staff to protect them from sexual harassment.	Chief Nurse and Director of Quality and Professions
P8 The NHS commits to anonymise the information collected during the course of your treatment and use it to support research and improve care for others.	Yes	The Trust has a Data Security and Protection Policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Data Protection & Security Toolkit and Department of Health requirements to train staff in this area. When breaches do occur, they are thoroughly investigated with learning identified and notification to the Information Commissioners Office where appropriate. The Trust has robust governance arrangements in place to cover its research and development work.	Director of Finance, Estates and Resources Chief Medical Officer
P9 The NHS commits, where identifiable information is used, to	Yes	The Trust has a Data Security and Protection Policy and has systems and processes in place that give patients and service	Director of Finance,

Heading	Compliance	Evidence	Lead
give you the chance to object wherever possible.		users the right to object to the holding and sharing of their information.	Estates and Resources
P10 The NHS commits to inform you of research studies in which you may be eligible to participate.	Yes	The Trust has an in-house research and development department that manages, facilitates, and governs all research to ensure it reflects services and the geographical area the Trust serves. Support is available to staff, patients / service users and carers who would like to become more involved in research as well as those who are established researchers. Advice and information is available on NHS research approval, ethics, the research passport, letters of access, training and funding opportunities, patient / service user and carer involvement in research and dissemination.	Chief Medical Officer
P11 The NHS commits to share with you any letters sent between clinicians about your care.	Yes	All service users have access to their clinical records. The Trust has a Data Security and Protection Policy, incorporating information sharing and has systems and processes in place regarding access to and transfer of personally identifiable data. Service users are offered a copy of their care plan and are able to receive a copy of any correspondence between clinicians about them unless there is a specific risk identified to their physical and/or mental wellbeing.	Chief Nurse and Director of Quality and Professions/ Chief Operating Officer/ Chief Medical Officer / Director of Finance, Estates and Resources/
R23 You have the right to choose your GP practice and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.	N/A	N/A	N/A
R24 You have the right to express a preference for using a particular doctor within your GP practice and for the practice to try to comply.	N/A	N/A	N/A
R25 You have the right to	N/A	N/A	N/A

Heading	Compliance	Evidence	Lead
transparent, accessible and comparable data on the quality of local healthcare providers, and on outcomes, as compared to others nationally.		Under the NHS Oversight Framework, the public will have access to transparent, accessible and comparable data across NHS provider Trusts.	
R26 You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs.	N/A	N/A	N/A
P12 The NHS commits to inform you about the healthcare services available to you, locally and nationally.	Yes	Information is available on the Trust's website and in information leaflets. The Trust's service offer by district is available on its website, which provides individual service information on services offered and teams. The Trust has undertaken significant work during 2025-26 to improve accessibility to information in line with the Accessible Information Standard (AIS). (See P2)	Chief Nurse and Director of Quality and Professions/ Chief Operating Officer/ Chief Medical Officer
P13 The NHS commits to offer you easily accessible, reliable and relevant information in a form you can understand and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the quality of clinical services where there is robust and accurate information available.	Yes	Information available on the Trust's website, in information leaflets and the Trust's Quality Accounts. The Trust's service offer by Care Group is available on its website, which provides individual service information on services offered and teams. Information on mental health conditions is included on the Trust's website. Service user survey findings are displayed on wards and units. Feedback mechanisms are in place for service users and their carers, including 'real time' collection of customer experience feedback. Advocacy information is available on wards and in patient information. The Trust has undertaken significant work during 2025-26 to improve accessibility to information in line with the Accessible Information Standard (AIS). (See P2) Trust Board receives an	Chief Nurse and Director of Quality and Professions/ Chief Operating Officer/ Chief Medical Officer

Heading	Compliance	Evidence	Lead
		annual report in relation to patient experience.	
R27 You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end-of-life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate.	Yes	As above (see R18, P12, P13). The Trust offers and has available interpreter / translation services either face-to-face or by telephone. An agreed end-of-life care pathway involving all agencies involved in end-of-life care is in place. Care plans are co-produced wherever possible, allowing service users to be fully involved in planning their care and treatment. Compliance is monitored via the monthly Integrated Performance Report and the Quality and Safety Committee, and remedial steps taken wherever necessary.	Chief Operating Officer / Chief Nurse and Director of Quality and Professions
R28 You have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional, has caused, or could still cause, significant harm or death. You must be given the facts, an apology, and any reasonable support you need.	Yes	The Trust has a Duty of Candour policy in place supported by robust processes for complaints and redress. The Trust monitors compliance with the policy which is reviewed by the Quality and Safety Committee. .	Chief Nurse and Director of Quality and Professions
R29 You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in the decisions to be made affecting	Yes	Patients, services users and their carers can be involved in the Trust through the Members' Council, Trust membership and volunteering. The Trust has an Equality, Diversity and Inclusion Strategy in place. The Trust has an insight report which includes feedback from stakeholders, governors, patient's carers and services to help improve services. The Trust continues to engage with service users and carer groups to ensure all teams and wards will have the ability to	Chief Nurse and Director of Quality and Professions / Director of Strategy

Heading	Compliance	Evidence	Lead
the operation of those services.		involve, listen and respond to feedback from people who use Trust services at all levels of the organisation. Trust service users / carers on local partnership boards. Information provided to local HealthWatch.	
P14 The NHS commits to provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services.	Yes	As above (see P2, P3, R29).	Chief Nurse and Director of Quality and Professions
P15 The NHS commits to work in partnership with you, your family, carers and representatives.	Yes	As above (see P2, P3).	Chief Operating Officer / Chief Nurse and Director of Quality and Professions
P16 The NHS commits to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one.	Yes	Service users are offered a copy of their care plan. Care plans are co-produced with service users wherever possible. The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care.	Chief Operating Officer / Chief Nurse and Director of Quality and Professions / Chief Medical Officer
P17 The NHS commits to encourage and welcome feedback on your health and care experiences and use this to improve services.	Yes	The Trust welcomes feedback from service users and carers and actively encourages people to comment on its services. The Trust uses this information to inform service development and improvement. The Trust is working towards real time service user feedback through the Friends and Family service user test. Service user surveys are undertaken as part of our commitment to learn and improve across all of our Care Groups. Feedback facility on the Trust's website. Feedback is provided through the Customer Services Team, which is reported to Quality and Safety Committee quarterly Trust Board annually.	Chief Nurse and Director of Quality and Professions

Heading	Compliance	Evidence	Lead
R30 You have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated.	Yes	Customer Services Policy and Customer Service Team structure with annual reports to Trust Board (patient experience annual report). Performance measures in place. Complaints acknowledged within three working days and investigated appropriately.	Chief Nurse and Director of Quality and Professions
R31 You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent.	Yes	As above. The Trust encourages face to face meetings to discuss complaints as the first act of resolution. Formal complaints always involve the offer of a further face to face meeting.	Chief Nurse and Director of Quality and Professions
R32 You have the right to be kept informed of the progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.	Yes	Customer Services Policy and Customer Service Team structure. All responses are shared with complainants and personally signed by the Chief Executive including actions to be taken as a result. Identified learning is monitored by the Quality and Safety Committee.	Chief Nurse and Director of Quality and Professions
R33 You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman if you are not satisfied with the way your complaint has been dealt with by the NHS.	Yes	This is referenced in all correspondence around complaints. Everything possible is done to prevent this. During 2025/25, 19 cases were escalated to the PHSO, out of the 236 formal complaints closed by the Trust. This equates to 8% of all formal complaints closed. This is a small decrease compared to 2024/25 where 13% (21 cases) of complaints were escalated to the PHSO. The Trust has not yet received an outcome from the PHSO for 14 of the cases (74%) and we have been asked to provide further information for a number of these. There is one case where we have recently been asked to respond to the provisional views and recommendations report having initially responded 24 July 2025 to confirm that the Trust	Chief Nurse and Director of Quality and Professions

Heading	Compliance	Evidence	Lead
		had not been approached by the complainant to respond through stage one of the complaint process. The PHSO has returned an outcome for 5 cases (26%) and none of these involved recommendations/actions for the Trust to take. The Trust received 11 outcomes from the PHSO in 2025/26 and 55% of the original enquiries were first received prior to the current reporting period.	
R34 You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority.	Yes	Customer Services Policy and information on the Trust's website.	Chief Nurse and Director of Quality and Professions
R35 You have the right to compensation where you have been harmed by negligent treatment.	Yes	Claims Management Policy.	Chief Medical Officer
P18 The NHS commits to ensure you are treated with courtesy and you receive appropriate support throughout the handling of a complaint and the fact that you have complained will not adversely affect your future treatment.	Yes	Customer Services Policy and Customer Service Team structure.	Chief Nurse and Director of Quality and Professions
P19 The NHS commits to ensure that, when mistakes happen or if you are harmed while receiving	Yes	The Trust has robust processes in place to investigate and learn from its mistakes and to share lessons across services and districts. This is done via Blue light alerts, individual care group	Chief Nurse and Director of Quality and

Heading	Compliance	Evidence	Lead
health care, you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again.		governance meetings and monitored by the Quality and Safety Committee. Arrangements in place to ensure the Trust and its staff meet the Trust's Duty of Candour responsibilities. The Trust has implemented the new national framework PSIRF (patient safety incident response framework).	Professions
P20 The NHS commits to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services.	Yes	The Trust has robust processes in place to investigate and learn from its mistakes and to share lessons across services and districts. The Trust has implemented the new national framework PSIRF (patient safety incident response framework). Quality Improvement Group is in place to share learning between and across Care Groups. Learning lessons reports are reviewed by the Quality and Safety Committee. Post investigation meetings are held at a Care Group level.	Chief Nurse and Director of Quality and Professions / Chief Medical Officer

The NHS Constitution also sets out nine responsibilities of patients and the public.

- Please recognise that you can make a significant contribution to your own, and your family's, good health and well-being, and take some personal responsibility for it.
- Please register with a GP practice – the main point of access to NHS care as commissioned by NHS bodies.
- Please treat NHS staff and other patients with respect and recognise that violence or the causing nuisance or disturbance on NHS premises could result in prosecution. You should recognise that abusive and violent behaviour could result in you being refused access to NHS services.
- Please provide accurate information about your health, condition and status.
- Please keep appointments or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.
- Please follow the course of treatment which you have agreed and talk to your clinician if you find this difficult.
- Please participate in important public health programmes such as vaccination.
- Please ensure that those closest to you are aware of your wishes about organ donation.
- You should give feedback – both positive and negative – about your experience and the treatment and care you have received, including any adverse reactions you may have had. You can often provide feedback anonymously and giving feedback will not affect adversely your care or how you are treated. If a family member or someone you are a carer for is a patient and unable to provide feedback, you are encouraged to give feedback about their experiences on their behalf. Feedback will help to improve NHS services for all.

The NHS Constitution – staff
How the Trust meets its obligations

Heading	Compliance	Evidence	Lead
The rights are there to help ensure staff:			
have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives	Yes	The Trust's People Strategy is in place following approval by Trust Board in December 2025. includes workforce development, and staff engagement and wellbeing as key priority areas. People (formerly human resources) policies and procedures on annual leave, sickness absence, flexible working, carer leave, adoption rights and benefits, age retirement, equal opportunities in employment, job share, paternity leave, maternity leave, special leave, stress, etc. Harassment and Bullying Policy and Grievance Policy and Procedures are in place. Friends and Family Test for staff. Wellbeing survey / national staff survey. Occupational health policy and service in place including Musculoskeletal and staff counselling services. Values-based recruitment, induction and appraisal policies in place. Regular meetings with Staff side representatives, and inclusion of Staff side in key appointments to the Trust e.g., Chief Executive and Chair.	Chief People Officer
have a fair pay and contract framework	Yes	Trust pay structure based on Agenda for Change and dental and medical staff, and Trust follows guidance issued by National Pay Bodies as appropriate. People (HR) Policies and Procedures as above. Annual internal audit of compliance with national and local policies in place	Chief People Officer
can be involved and represented in the workplace	Yes	Social Partnership Agreement in place between the Trust and staff side organisations. Staff engagement strategy. Staff engagement events. Annual NHS staff survey. REACH, Staff Carers, Staff Side, Disability and LGBT+ staff Networks in place. Elected staff governors on the Members' Council. Substantive lead Freedom to Speak up Guardian in place.	Chief People Officer

Heading	Compliance	Evidence	Lead
		Regular staff network meetings with Equality, Inclusion and Involvement Committee.	
have healthy and safe working conditions and an environment free from harassment, bullying or violence	Yes	People (HR) policies and procedures. Staff survey. Health and Safety Policy. Health and Safety Steering Group. Health and Safety annual audit and work programme. Occupational health service. Risk assessments of workplace. Reducing Restrictive Practices and Interventions lead in place with supporting Reducing Restrictive Practices and Interventions Trust Action Group (RRPI TAG).	Chief People Officer/Director of Nursing, Quality and Professions.
are treated fairly, equally and free from discrimination	Yes	People (HR) policies and procedures. The Trust has changed its governance structure in relation to equality diversity and inclusion during 2025/26. Following a thorough consultation process the decision was taken to step down the equality, inclusion and involvement committee in order to enhance equality and inclusion agenda as part of everything we do. The new All of us in mind group consists of a diverse group of people from across the organisation who can give their own views and also source and bring in views from different communities/groups. This group champions the EDI agenda. Trust staff are required to undertake mandatory equality training. Equality networks, annual workforce equality impact assessment. Equality impact assessment of all policies and procedures REACH, Staff Carers, Staff Side, Disability and LGBT+ staff Networks established. WRES, WDES and EDS2 action plans agreed. Substantive lead Freedom to Speak up Guardian, and three additional guardians in place. The Trust has an oversight group in place called Race Forward, to identify and reduce racist abuse from service users and carers towards staff from BAME backgrounds, and ensure affected staff are appropriately supported.	Chief People Officer
can, in certain circumstances, take a complaint about their employer to an Employment Tribunal	Yes	Disciplinary and Grievance Policies and Procedures. Trust staff advised of their rights following disciplinary action. Substantive lead Freedom to Speak up Guardian in place.	Chief People Officer
can raise any concern with their	Yes	People (HR) Policies and Procedures.	Chief People

Heading	Compliance	Evidence	Lead
employer, whether it is about safety, malpractice or other risk, in the public interest.		Information given to staff and Trust welcome events include information for staff. Raising Concerns / Freedom to Speak Up (Whistleblowing) Policy agreed with Staff Side in Consultation and the Freedom to Speak Up Guardian Whistleblowing report taken to Quality and Safety Committee every six months. Freedom to speak up steering group in place. Raising concerns leaflet widely available. Posters on Freedom to Speak Up widely distributed. Intranet site for staff on raising concerns in place. Freedom to Speak Up Guardian have regular meetings with the Chief People Officer, Chief Nurse, Director of Quality and Professions and Senior Independent Director. Substantive lead Freedom to Speak up Guardian in place. Responsibility for Freedom to Speak up now sits with Corporate Governance. Recognised trade unions in place to support staff.	Officer

The NHS Constitution also sets out seven staff pledges, which, although not legally binding, represent a commitment by the NHS to provide high-quality working environments for staff.

- The NHS commits to provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.
- The NHS commits to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- The NHS commits to provide all staff with personal development, access to appropriate training for their jobs and line management support to enable them to fulfil their potential.
- The NHS commits to provide support and opportunities for staff to maintain their health, well-being and safety.
- The NHS commits to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
- The NHS commits to have a process for staff to raise an internal grievance.
- The NHS commits to support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice, or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998.

The NHS Constitution also sets out six existing legal duties that staff must observe. (This list is not meant to be exhaustive.)

- To accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role.
- To take reasonable care of health and safety at work for you, your team and others, and to co-operate with employers to ensure compliance with health and safety requirements.
- To act in accordance with the express and implied terms of your contract of employment.
- Not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.
- To protect the confidentiality of personal information that you hold unless to do so would put anyone at risk of significant harm.
- To be honest and truthful in applying for a job and in carrying out that job.

The Constitution also sets out how staff should play their part in ensuring the success of the NHS.

- You should aim to provide all patients with safe care, and to do all you can to protect patients from avoidable harm.
- You should follow all guidance, standards and codes relevant to your role, subject to any more specific requirements of your employers.
- You should aim to maintain the highest standards of care and service, treating every individual with compassion, dignity and respect, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole.
- You should aim to find alternative sources of care or assistance for patients, when you are unable to provide this (including for those patients who are not receiving basic care to meet their needs).
- You should aim to take up training and development opportunities provided over and above those legally required of your post.
- You should aim to play your part in sustainably improving services by working in partnership with patients, the public and communities.
- You should aim to raise any genuine concern you may have about a risk, malpractice or wrongdoing at work, (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff, or the organisation itself at the earliest reasonable opportunity.
- You should aim to involve patients, their families, carers or representatives fully in decisions about prevention, diagnosis and their individual care and treatment.
- You should aim to be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation.
- You should contribute to a climate where the truth can be heard and the reporting of, and learning from, errors is encouraged, and colleagues are supported where errors are made.
- You should aim to view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care.
- You should aim to take every appropriate opportunity to encourage and support patients and colleagues improve their health and wellbeing.
- You should aim to contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access and outcomes between differing groups or sections of society requiring health care.
- You should aim to inform patients about the use of their confidential information and to record their objections, consent or dissent.

- You should aim to provide access to a patient's information to other relevant professionals, always doing so securely, and only where there is a legal and appropriate basis to do so.

TRANSFORMATION, INNOVATION AND SUSTAINABILITY COMMITTEE

Terms of Reference

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 proactively address and mitigate risk.

The Transformation, Innovation and Sustainability Committee was established in April 2026. 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 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 Transformation, Innovation and Sustainability Committee's prime purpose is to provide oversight and direction for implementation of the Trust's strategy. More specifically this includes: oversight of the Trust's engagement and participation in external partnerships; oversight of our approach to innovation and to ensure we are maximising the opportunities in our digital and estates strategies, along with ensuring there is effective alignment with our research and development strategy.

It will gain assurance that that there are effective plans in place for the delivery of the Trust's priority programmes and that these are delivering the activity to enable the Trust's strategic goals to be achieved in line with plans. The Committee will maintain oversight of innovation priorities in light of the Trust Strategy. The Committee will provide assurance to the Board of Directors that appropriate and effective plans are in place for the Place Provider Partnerships for which the Trust is host provider or a partner. 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.

The Committee will provide strategic oversight and assurance regarding the delivery of the Trust's Social Responsibility and Sustainability (SRS) Strategy and Green Plan, ensuring that sustainability, social value and net zero objectives are embedded within transformation, innovation and service development programmes across the Trust.

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 two executive Directors.

Membership as at 1 April 2026

Chair – Non-Executive Director- Martin Neeson

Non-Executive Director – Gary Ellis

Non-Executive Director – Rokaiya Khan

Director of Strategy, Inclusion and Change/Deputy Chief Executive-
Dawn Lawson (lead executive)

Chief Medical Officer- Prof. Subha Thiyagesh

Attendees as required.

Deputy Director Strategy, Inclusion and Change- Sue Barton
Assistant Director of Corporate Governance – Izzy Worswick
Deputy Director of Estates – Kev Gelder
Chief Digital & Technology Officer – Paul Foster

Attendance

The Director of Strategy, Inclusion and Change/Deputy Chief Executive is in attendance (as lead Director) at meetings, and the Chief Medical Officer. The Chair of the Trust, 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 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 is 4 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 including the Digital Programme Group.

Duties

Transformation

- Gain assurance on the delivery of the Trust's strategy in line with the expectations of the Trust Board.
Oversee progress in relation to the Trust's strategic priority 'we are ambitious'
- Ensure that other enabling strategies are aligned with the Trust's overall strategy and reflect national Policy and local landscape.
- Oversee the development of annual priority programmes.
- Seek assurance that overall the Trust's priority programmes are being delivered in line with plans in order to provide the best services to our patients, carers communities. This will not replace the detailed oversight of priority areas given by relevant Committees.
- Receive annually the Trust's PESTLE and SWOT assessments, and in this context consider how the Trust makes the most of the opportunities we identify.

Partnerships

- Oversee the Trust's role in the development of Place Provider Partnerships, both as host and partner.

- Seek assurance that strategic partnership arrangements are in place and opportunities to the Trust are maximised in line with our strategic intentions to the best Partner.
- Review any significant risks or opportunities external changes will have on the Trust's strategic mission and advise the Board accordingly.

Innovation and sustainability

- Oversee implementation of evidence based innovation priorities in light of our Trust Strategic priorities, working alongside our communities, colleagues and partners.
- Oversee the development and implementation of our risk appetite and management process for innovation to ensure that we can innovate effectively with ambition but in a managed way
- Oversee delivery of the digital strategy, and digital transformation and artificial intelligence innovation programmes, ensuring that delivery plans are achieved with meaningful engagement with our communities, colleagues and partners.
- Provide high level oversight of our research and development activity.
- Oversee the development and delivery of the Trust estates strategy, including environmental sustainability alongside our system partners.

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 plans.

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.

Behaviours and Conduct

Trust values

Members will be expected to conduct business in line with the trust values and objectives.

Members of, and those attending, the committee shall behave in accordance with the trust's constitution, standing orders, and standards of business conduct policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

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 2027

**Transformation, Innovation and Sustainability Committee
Annual Work Programme
2026-27**

Agenda item/issue	July	Oct	Jan	Apr
Section 1 - Standing items				
Declarations of Interest	X	X	X	X
Minutes of previous meeting and action log		X	X	X
Actions from Trust Board		X	X	X
Consideration of items from the corporate/organisational risk register allocated to the Committee		X	X	X
Context report – national, regional & local		X	X	X
Section 2- Assurance from other groups				
Section 3 – Strategy & Policy				
Digital Strategy twice yearly update			X	
Trust Strategy Measurement (annual)	X			
Estates Strategy twice yearly update		X		X
Sustainability Strategy update (annual) including green plan	X			
Research and Development Strategy Update			X	
Pestle and Swot				X
Section 4- Place Provider Partnerships				
Place Provider Partnerships/ Neighbourhood Health	X	X	X	X
Section 5 – Innovation and Sustainability				
Sustainability updates			X	
Digital innovation		X		
AI and productivity initiatives				X
Section 6 – Transformation				

Strategic delivery of organisational objectives				X
Service re-design initiatives (as required)		X		
Older Peoples Service Transformation update			X	
Section 7 - Governance				
Committee annual report				X
Revised Committee membership & ToR as necessary	X			X
Annual review of Committee effectiveness				X
Section 8 – Standard Closing Items				
Agreement of Committee meeting dates and work programme for following year				X
Items to bring to the attention of Trust Board (to include impact of agenda items)	X	X	X	X
Work programme	X	X	X	X

**Trust Board
28 July 2026
Agenda item 14.1**

Private/Public paper:	Public		
Title:	Annual Review of Trust Strategy		
Lead Director:	Dawn Lawson, Deputy Chief Executive/Director of Strategy, Inclusion and Change		
Purpose/values:	The report is set out in line with the Trust strategy and therefore clearly demonstrates how the information provided aligns to the Trust purpose, values and strategic objectives.		
Purpose:	This report provides our first annual update of progress using our agreed strategic measurement framework for the first time. The purpose of this report is to: • Provide a summary of the progress we have made in the 12 months April 25 to March 26. • Acknowledge achievements in strategy deployment and delivery and therefore demonstrate how we are leading the organisation well, aligned to our agreed strategic direction. • Identify any issues that we might want to address going forward to make sure that we continue to lead well, do even better and are able to evidence this. This first annual report using the strategic measurement framework also provides an opportunity to test the framework so that we can continue to develop and improve it for future years.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	1.2,2.2,2.3,6.3		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation	This report clearly sets out our strategic intentions to be the best partner under strategic aim two – to be the best we can be. The evaluation provides a strategic assessment of how well we are doing in line with our strategic intentions.		

objectives at national regional or local level.	
Any background papers / previously considered by:	Considered at strategic Trust Board in May 2026.
Executive summary:	The report sets out how the strategic measurement framework has been developed and how it aligns to other key organisational documents. The measurement framework is designed to act as a compass and to provide information to Trust Board that we are leading well and moving forward, in line with the strategy so that we can: • Provide assurance on progress and direction. • Guide an intentional response and therefore drive and support improvement. • Guide our decision making on the areas where we would be 'even better if'. • Ensure that our measurement systems are strategically aligned so they all help to deliver on our strategic aims and lead well. The framework has been developed through consideration of a series of questions relating to: • Strategic alignment • Board leadership • Living our values • Ambitions • Performance • Annual reporting • Best we can be The report is structures using a Question, Answer, Conclusion approach. The conclusions of the report are that: • There has been significant progress and achievements in strategy deployment and delivery. It therefore demonstrates how we are leading the organisation well, aligned to our agreed strategic direction. There are some areas that we want to address going forward to make sure that we continue to lead well, do even better and are able to evidence this. The areas for focus are recognised within our Board Assurance Framework and form the core of our priorities for 2026/27.
Recommendation:	Trust Board members are asked to: • RECEIVE the progress update in line with our strategic intent and how this demonstrates that we are leading well noting the areas that we have identified where we would be 'even better if' and therefore our proposed areas for improvement. • RECEIVE and NOTE the use of the strategic measurement framework and provide feedback on its effectiveness and ideas for improvement for next year. • CONSIDER this framework throughout the year so that the annual review is the result of continued consideration of delivery of the strategy and not a one-off annual event.

How we lead well - A review of the first year of our Trust strategy

Strategic Measurement Framework

1.0 Introduction and purpose

On 1st October 2024, the Trust Board formally agreed the Trust strategy to take the Trust up to 2030. Full deployment of the strategy commenced on 1st April 2025. This report provides our first annual update of progress using our agreed strategic measurement framework for the first time. The strategic measurement framework used for this review has been developed over time through discussions in EMT and Trust Board it assesses how we lead the organisation in line with the strategy.

The purpose of this report is to:

- Provide a summary of the progress we have made in the 12 months April 25 to March 26
 - to acknowledge achievements in strategy deployment and delivery and therefore demonstrate how we are leading the organisation well, aligned to our agreed strategic direction.
 - to identify any issues that we might want to address going forward to make sure that we continue to lead well, do even better and are able to evidence this.
- Test the strategic measurement framework so that we can continue to develop and improve it for future years.

2.0 Strategic measurement framework

2.1 Development of the framework

A small group of staff have been working on the development of the framework, these are:

- Deputy Director of Strategy Inclusion and Change (Sue Barton)
- Head of Performance and Business Intelligence (Mel Wood)
- Intelligence Change Partner (Vic Humble)
- Head of Corporate Governance [Company Secretary] (Andy Lister)

The framework has been developed through research with external comparators and consideration of the evidence base. From this work we concluded that no other NHS Trusts had a strategic measurement framework in place and therefore our framework has been further developed through internal consideration and analysis.

The timeline for this work is:

- July 2025: Report into Private Board with discussion
- October 2025: Update into Executive Management Team (EMT) and then presented to FIP
- January 2026: Update into EMT and then presented to FIP
- May 2026: Update into EMT prior to discussion in strategic board
- June 2026: Update into EMT prior to June FIP and onto June Board

2.2 Linkages and alignment

We already report our operational performance into Board on a monthly basis through the Integrated Performance Report (IPR), our strategic risks through the Board Assurance Framework (BAF) and our organisational risks through the organisational risk register (ORR). Our framework acknowledges these elements of reporting and aims to co-ordinate and align them to provide one coherent picture which assists the Board in understanding our strategic delivery alongside our operational delivery on an annual basis and enables us to consider how well we are leading the organisation.

In order for us to maintain a coherent strategic vision and understand our delivery against it, it is important that we align key aspects of our operational performance, risk management and assurance framework. Getting the right connections between how the different elements connect together enables us to triangulate across the difference aspects to give us a full picture of assurance, and/or to

understand any gaps. It is also important to ensure that we are not 'blinded' by data or that we are duplicating data collection or analysis. Our approach outlines how we proposed to connect the different elements, together.

The Trust strategy is the key document that sets the direction of the Trust. Consequently, the strategic measurement framework has a strong relationship with the other key documents in the Trust but it is distinct. The key relationships are with the following:

- **The Board Assurance Framework (BAF)**

The purpose of the BAF is to provide a comprehensive method for the effective and focused management of the principal risks to achieving the delivery of our strategic objectives.

- **The Organisational Risk Register (ORR)**

The ORR sets out the key organisational risk to delivery of services. It links closely to the IPR which sets out our performance against key metrics.

- **Performance Management Framework and IPR**

The Trust Performance management framework sets out how performance is managed to ensure we consider our performance against all key performance indicators. It includes all areas of Trust business where our performance is externally measured as well as key performance indicators that we have decided within the Trust are important for us to monitor. Our performance is measured and reported into Trust Board and other key meetings on a monthly basis using the Integrated Performance Report (IPR). The performance management framework is being refreshed to consider recent changes in contractual requirements, the NHS Oversight Framework, the Provider capability assessment and national metrics etc.

A diagram that sets out the relationships between these key documents is included as *figure one* in Appendix A (*see attached*).

2.3 Purpose of our strategic measurement framework

Our Trust strategy sets the Trust direction up to 2030. Our measurement framework is designed to act as a compass and to provide information to Trust Board that we are leading well and moving forward, in line with the strategy. The aim of the framework is to provide a high-level indication that we are heading in the right direction in order to:

- Provide assurance to Trust Board on our progress and direction.
- Guide an intentional response and therefore drive and support improvement in line with our agreed strategic direction, enabling any changes to be made to ensure that we will continue to achieve our strategy.
- Guide our decision making on the areas where we would be 'even better if' and so we can take actions to make more progress and where our progress is in line with expectations.
- Ensure that our measurement systems are strategically aligned so they all help to deliver on our strategic aims and lead well.

It is therefore a high-level summary of information, built up from more detailed information which enables a judgement to be made to answer the following question.

Are we leading well and therefore moving forward in line with our strategy?

Please note this is not intended to provide a comprehensive assessment of every aspect of the Trust strategic delivery. It is a summary of a range of different information which the Board already receives and considers in order to make a judgment.

2.4 Principles

The following principles have been identified for the strategic measurement framework:

- Strategic, high level.
- As simple as we can design it.
- About progress, direction and leadership not operational performance.
- Based on data that we already have but with careful consideration of how information is presented/visualised to meet the purpose.
- Contains information presented in a different way and not a duplication of current measurement systems such as the IPR.
- Contains a triangulation of voice and numbers.
- Contains analysis of the data and intelligence to reach clear and actionable conclusions about what it is telling us about our general direction of travel.
- Enables us to make intentional decisions about where we focus our effort and our risk appetite.

2.5 Levels of reporting

Organisational reporting happens at a series of levels, each of which provides information for its readers at an appropriate level of detail to aid decision making. While the content of the reporting should provide consistent messaging, the inclusion of detailed information, including data, is tiered to prevent duplication. This is described in the graphic and table below.

Figure two: Graphic of the levels(tiers) of reporting

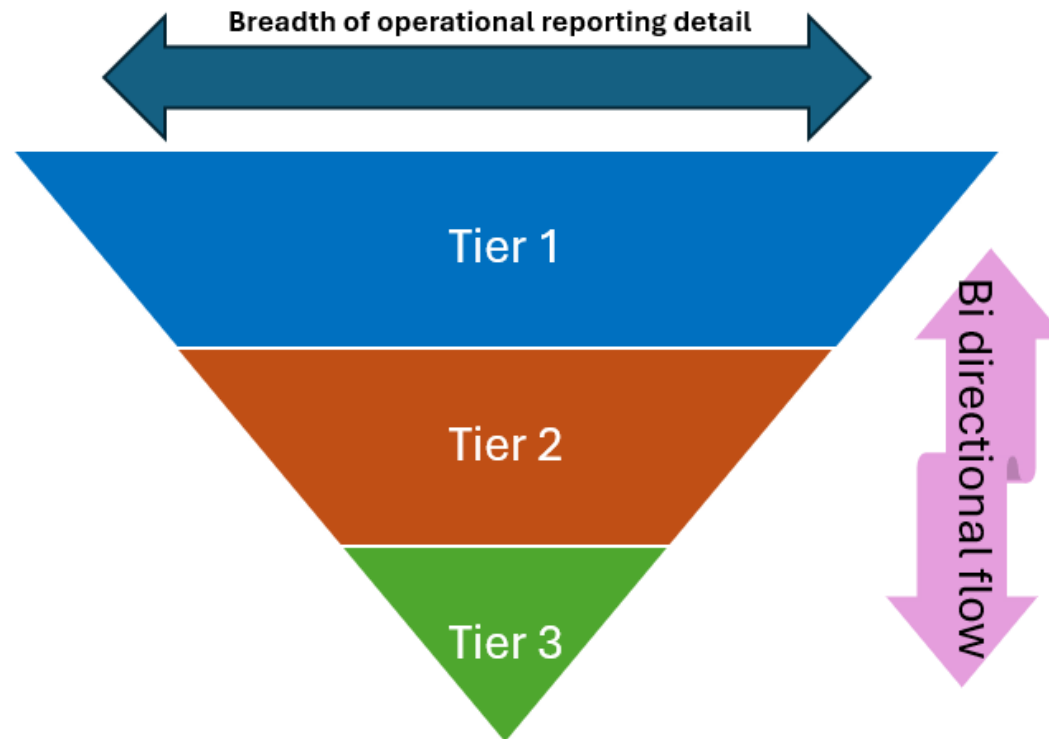


Table one: Details of the different tiers set out in figure two

	Audience	Characteristics	Examples	SWYPFT Example reports	Purpose
Tier 1	Individual Teams, Services, or specific programmes of work	Highly detailed and specific reports, focussing on immediate data points relevant to daily operational activity. Prepared frequently (in line with data publication) and include specific metrics on individual or team performance, productivity and efficiency, measures for improvement, impact and outcome measures along with balancing measures to prevent unintended consequences.	Daily, weekly or monthly data review (depending on the data being monitored). These reports assist frontline managers in monitoring team and / or programme delivery performance, identifying immediate issues and taking corrective action as needed.	Team Benchmarking Report Health Inequalities Improvement Report All reports at: https://swyt.sharepoint.com/sites/BIReporting	To ensure operational control and grip to ensure tasks are completed efficiently, on schedule and in line with quality and safety standards. They enable decision makers operating at this level to address issues quickly and maintain safe and effective operational and programme delivery.
Tier 2	OMG High level Governance / Steering Groups Care Groups	These include specific information on operational efficiency, departmental performance, budget adherence and project progress. These reports often contain metrics on productivity, cost management and resource utilisation and may feature detailed analysis and comparisons.	Departmental performance reports, budget variance reports, project progress reports and customer satisfaction reports. These allow performance monitoring, address issues and adjust processes to meet targets and improve efficiency.	Care Group Performance Reports Priority	Supports tactical decision making. Reports in this tier provide senior leaders with a thorough understanding of their areas of responsibility and enable them to manage resources effectively, optimise performance and align activities with overall organisational objectives.
Tier 3	Board Committees of the Board EMT	Summary orientated reports which are high-level and strategic in nature. They provide a broad overview without going into operational details. Reports are often concise, focussing on critical methods, trends and comparisons, and are reported by summaries or executive dashboards.	Strategic planning reports, financial summaries and / or performance reports. These reports help senior leaders assess overall business performance, identify opportunities and threats and make data (numbers and voice) driven decisions on resource allocation, investments and organisational direction.	IPR Trust Strategy Report EDI Report	To aid strategic decision making. These reports ensure that Executives and the Board are informed about the position of the organisation, long term trends and benchmarking comparisons with peers to be able to make impactful, forward thinking decisions.

Alignment to our strategic objectives is embedded and clear within each tier of reporting. This holistic reporting approach is then summarised as part of the measurement of the strategy.

2.6 Structure of the framework

Our strategic measurement framework tells us how well we are delivering against our Trust strategy, and specifically our three strategic aims. In order to measure this we might use items from our IPR but it also includes other items and considerations as set out in this paper.

The framework has been developed through consideration of a series of different questions. This is set out in figure three below:

We are asking ourselves a range of questions. The answers collectively form the foundations so we can consider the progress we have made in line with our strategy



Strategic alignment: Are we clear how our work aligns to deliver our strategy?	Board leadership: Can we evidence that our Board considers a range of items in line with our strategy?	Living our values: Can we evidence we are living our values (strategic aim one)?	Ambitious: Can we evidence what we are doing in line with our ambitions (strategic aim three)?	
Annual reporting: Does our Trust annual report demonstrate that we are delivering our three strategic aims?	Annual reporting: Do our specialist annual reports demonstrate that we are delivering our three strategic aims?	Performance: How well does our performance report demonstrate we are delivering our three strategic aims?	Best we can be: How well can we evidence we are being the best we can be (strategic aim two)?	

Figure three: Graphic of the questions within the strategic measurement

3.0 The results of our review

Our consideration of strategy measurement and our work so far identified that there are a range of things that we already do on a regular basis to measure the impact of our Trust strategy. This document therefore brings these areas together and considers the important question of ‘so what does this tell us about our leadership and progress?’

This section has been structured using a **Question, Answer, Conclusion** approach.

3.1 Strategic alignment

Question: How do we ensure that our strategy remains current and takes into account changes in context?

Answer: The Trust Board holds a regular strategic board meeting where consideration is given to changes in context and therefore potential impact on our strategy. Table two below sets out the topics that Board have considered in their strategic board meetings since August 2024.

Table two: Strategic Board agendas

Strategic Board meeting	Topics Covered
August 2024	• Trust Strategy Refresh • Trust Board Effectiveness Survey • Trust Board Committees governance, triangulation, terms of reference and workplans
December 2024	• Cheswold Park update
February 2025	• Board level trauma informed training • Darzi report/ 10-year plan/Trust role in neighbourhoods and place/PESTLE and SWOT analysis • Performance and Quality Assurance Model • Initial 2025/26 Trust Planning Submission • Strategy alignment
May 2025	• Board Appraisal Framework • MHA Bill update • Deployment plan for the Trust Strategy including Wakefield Alliance model overview
August 2025	• Our Trust in the strategic context of the new NHS
December 2025	• Trust Initial Planning Submission • Cheswold Park update
February 2026	• Care Quality Commission Well-Led update • Advanced Foundation Trust Status • Trust Priorities 2026-27 • Board Committees Structure
May 2026	• Trust strategy annual review structure proposal • SWOT and PESTLE • LEADING WELL - Shared Direction and Culture & Learning, Improvement and Innovation • Our approach to health inequalities

Conclusion: From the table above it is clear that the Board have considered a range of external factors and internal responses. Consideration of the detail of these discussions identifies the regular checking of strategic alignment and confirms that we are leading well and ensuring that our strategy remains current and can continue to be used as our true north.

3.2 Board leadership in strategy delivery

Question: What is the balance of items that the Trust Board considers? Does it cover all aspects of the strategy and address all BAF risks?

Answer: Andy Lister (Head of Corporate Governance - Company Secretary) has developed and tested an evaluation tool to assess the areas that Board considers and how these relate to the different strategic aims.

The tool analyses Board agendas and considers:

- BAF risk frequency of appearance in Trust Board front sheets
- Strategic aim frequency in Trust Board front sheets

A copy of the full report is attached at *Appendix B*.

Conclusion: In summary the evaluation tool demonstrates a spread and balance of items as part of Trust agendas thereby demonstrating that Board have the leadership and systems in place to receive assurance across the whole of the strategy.

3.3 Analysis of our annual report

Question one: What does our annual report for 2025/2026 say we have achieved in the last 12 months which demonstrates delivery against our strategy?

Answer: We have considered the key elements of the annual report and pulled out a summary of items to answer these questions with some simple analysis of what this is telling us in relationship to whether we are leading well in line with our strategy.

Strategic Aim 1: Live Our Values

Our annual report includes:

- High patient satisfaction (92–96%).
- Strong Freedom to Speak Up culture (69 cases raised and addressed).
- No Never Events and strong patient safety reporting culture.
- Duty of candour compliance (no breaches).
- New Equality, Diversity and Inclusion (EDI) strategy and development of staff networks.
- Staff engagement score 7.17 (above benchmark).

Conclusion in relation to strategic aim one: Our annual report demonstrates that our values are embedded through culture, safety, inclusion, and staff engagement.

Strategic Aim 2: Be the Best We Can Be

Our annual report includes:

2a. Best Quality

- Care Quality Commission (CQC) rating: Good overall.
- Patient Safety Incident Response Framework (PSIRF) implemented and embedded with improved learning and safety systems.
- 96% incidents low/no harm.
- Delivery of CQC action plans (all but one closed).
- Quality Assurance System in place.
- Continuous improvement culture.
- Information & Data:
 - 95% Information Governance compliance.
 - Strong data quality framework.
 - Robust reporting (Integrated Performance Report).

Annual report demonstrates: Continuous improvement and strong governance for quality.

2b. Best Place to Work & Learn

- People Strategy 2025–2028 launched.
- Workforce turnover reduced to 8.18%.
- Investment in leadership, Continuous Professional Development (CPD), apprenticeships.
- Strong staff survey performance above benchmark (7.17).

Annual report demonstrates: Improved retention, engagement, and workforce sustainability.

2c. Best Value

- £28.2m efficiency savings delivered.
- £2.2m surplus achieved.
- Reduced agency spend.
- Value for Money governance in place.

Annual report demonstrates: Financial discipline with quality safeguards.

2d. Best Partner

- Leadership of provider collaboratives.
- Active role across West & South Yorkshire Integrated Care Systems (ICSs).
- Integrated care and neighbourhood model development.
- Successful system collaboration (e.g., eating disorders, secure services).

Annual report demonstrates: Strong system leadership and partnership maturity.

Conclusion in relation to strategic aim two:

Our annual report includes strong examples under each of our best statements and therefore demonstrates progress towards being the best that we can be.

Strategic Aim 3: Be Ambitious

Our annual report includes:

- Reference to the fact that we have achieved Teaching Trust status.
- Examples of digital innovations such as apps, data, e-rostering and exploration of artificial intelligence.
- Our acquisition and integration of Cheswold Park Hospital.
- The expansion of services including CAMHS, neurodiversity, community pathways.
- Evidence of climate and sustainability leadership (Green Plan, net zero actions).

Conclusion in relation to strategic aim three:

Annual report demonstrates that we are a forward-looking organisation investing in future capability.

Overall conclusion in relation to what our annual report says we have achieved in the last 12 months which demonstrates delivery against our strategy

The Annual Report provides clear evidence of leading well and delivery against all three strategic aims. It demonstrates strong performance on quality, workforce, finance, and partnerships demonstrates that we are delivering 'the best we can be', while our inclusive culture and staff engagement reflect that we are living our values. Achievements such as Teaching Trust status, service expansion, and digital innovation show that we are also delivering on our ambitions for the future.

Question two: What does our annual report for 2025/2026 say we need to continue to work on in relation to delivery against our strategy?

Answer: We have considered the key elements of the annual report and pulled out the following elements that we would be 'even better if' and therefore are our areas for further improvement.

Strategic Aim 1: Live Our Values

- Inclusion and staff experience are improving but not yet consistently equitable across all groups.
- Freedom to Speak Up: Further work needed to ensure confidence and consistency in raising concerns.

Strategic Aim 2: Be the Best We Can Be

2a. Best Quality

- Not yet achieved consistent CQC ratings in 'Good' or 'Outstanding' across all services.
- Rising demand affecting access and quality. Pressure on capacity and risk of delayed care. Access is improving but not yet meeting demand consistently.

2b. Best Place to Work & Learn

- Not yet a fully stable, sustainable workforce. Workforce shortages persist in key professions with national shortages having an impact on recruitment, service delivery and reliance on temporary staff still present.
- Not all staff consistently receiving structured development/support.

2c. Best Value

- Financial sustainability improving but not yet secure long-term. Though surplus achieved, ongoing financial pressure with significant efficiency targets ongoing (£17.7m next year) and risk of cost pressures outpacing income.

2d. Best Partner

- Partnerships are strong, but the system is not fully stable risking service reductions or delays outside of Trust control.

Strategic Aim 3: Be Ambitious

- Digital ambitions are clear and progress has been made on digital transformation, but not yet fully realised at scale.
- Health inequalities, our work is at an early stage with some impact, good foundations and strong frameworks. However our outcomes are not yet fully evidenced.
- Sustainability journey ongoing with strong progress made in terms of the green plan, waste and energy. However net zero is still a long-term aim and targets not yet achieved.

Conclusion in relation to what our annual report says we need to continue to work on in relation to delivery against our strategy

Our annual report demonstrates strong progress against our strategic objectives. It also covers key areas where delivery is not yet complete, including achieving consistent CQC ratings across all services, addressing demand and workforce pressures, reducing inequalities in staff

experience and patient outcomes, and fully realising our ambitions in digital transformation and sustainability. These gaps are recognised within our Board Assurance Framework and form the core of our priorities for 2026/27.

3.4 Analysis of other annual reports received by Trust Board

Question: Are all our key agendas, as evidenced by our specialist area annual reports received by Board, demonstrating delivery of our strategy and progress against our strategic aims?

Answer:

We have considered the annual reports received by Trust Board over the last 12 months on specific topics. This is set out in table three below.

Table three Annual reports received by Board on specialist topics

Annual report	EMT	Committee	Board
Guardian of safe working hours	N/A	Quarterly Medical Education TAG meetings	30 September 2025
Ligature	7 October 2025	11 November 2025 - Quality and Safety Committee	November 2025 (2 December)
Medical appraisal/revalidation annual report	N/A	11 November 2025 - Quality and Safety Committee	November 2025 (2 December)
Freedom to speak up	22 October 2025	7 October 2025 - Audit Committee	28 October 2025
Medical education	N/A	11 November 2025 - Quality and Safety Committee	November 2025 (2 December)
Audit Committee annual report including committee annual reports and terms of reference	N/A	Audit Committee	28 April 2025
Equality and Diversity	9 December 2025	17 December 2025 Equality, Inclusion and Involvement Committee	27 January 2026
Patient Safety Oversight Annual report	27 May 2025	10 June 2025 Quality and Safety Committee	June 2025 (1 July 2025)
Health and safety annual report	20 May 2025	14 July 2025 - Audit Committee	29 July 2025
Patient Experience annual report	20 May 2025	10 June 2025	June 2025 (1 July 2025)
Sustainability annual report	27 May 2025	17 December 2025 Equality, Inclusion and Involvement Committee (out of alignment due to absence)	November 2025 (2 December)
Premises Assurance Model annual report	15 July 2025	N/A	29 July 2025
PLACE assessment annual report	1 April 2025	14 July 2025 - Audit Committee	29 July 2025
NHS staff survey results	24 March 2026	17 March 2026	31 March 2026

Consideration of the detail of these reports identifies that:

- the reports provide detailed information on the specific issue that they are covering.
- the extent to which the content, insight and analysis of these reports is clearly strategically aligned is variable.

Conclusion: It is not always easy to see how well these reports demonstrate the delivery of our strategy and progress our strategic aims. This means we are missing an opportunity for the Board to check how the different agendas help in our delivery of the Trust strategy and to use the insight and analysis on the particular topics as indicators of overall strategic progress. It is therefore proposed that we would develop a more standardised structure for reports in the future to address this.

3.5 Our integrated performance report (IPR)

Question: How does our IPR demonstrate achievement of our strategy?

Answer: Our IPR contains our performance measures and these have all been mapped to our strategic objectives. Consequently, we can present some 'doughnuts' that set out how our performance aligns to each area of the Trust strategy. This is set out below:



Figure four: Doughnuts of IPR reporting against strategic aims and objectives

Conclusion: Across all of our metrics as reported in the Trust IPR at end March 2026, we report a positive level of performance overall across all strategic objectives included within the report, with 81.6% meeting or exceeding their target. Detail relating to performance against individual strategic objectives can be seen in the sections below. As part of the Trusts monthly production of the IPR, there is detailed governance in place to review, address and action areas where performance is not being achieved and the monitoring of this is evidenced in the Trusts performance framework with exception narrative also added to the monthly IPR where appropriate. The Trust also achieved a segmentation score of 1 (highest) in the Quarters two, three and four of 2025/26 for the NHS Oversight framework and in quarter four we were ranked 3rd out of 61 peer Trusts for our performance against the metrics that were applicable to use. Both the IPR and the NHS Oversight framework results, provides

assurance that our performance is good across all our aims and therefore we are particularly delivering in line with our strategic aim two to be the best that we can be.

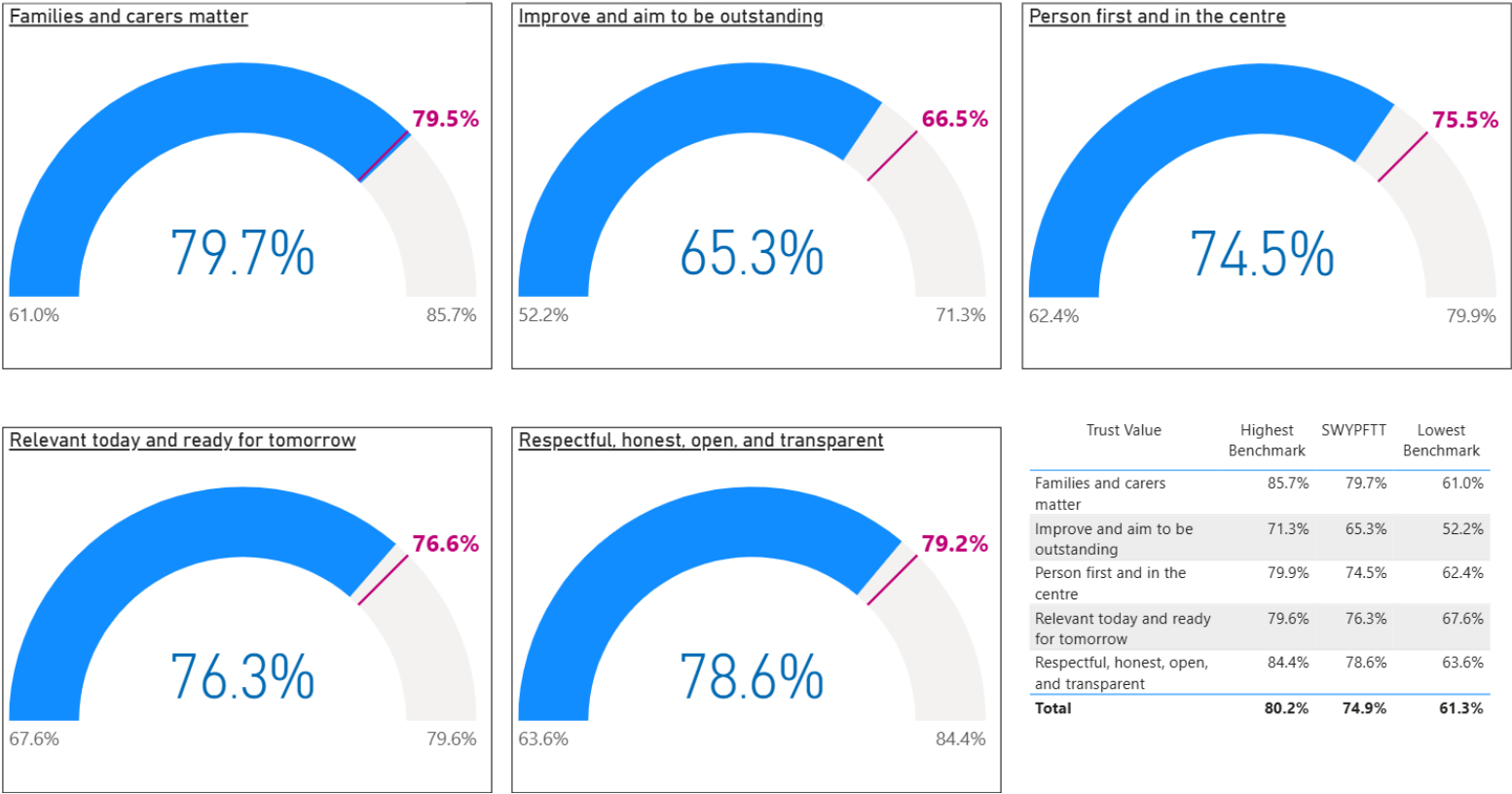
3.6 Strategic aim one: Living our values

Question: What is our staff survey telling us about the staff view of this?

Answer: We have developed barometers which present a curated set of results from the staff survey aligned to our Trust Values in a way which allows us to measure delivery against them. Visualising the data in this way helps us to see where we have made improvements and where there are opportunities for improvements as measured against our benchmarked peers. The target line indicates the value of the upper quartile of results mapped against benchmarked peers.

Living our Values

Figure five: Barometers of staff survey results for living our values



Conclusion: We perform well against our benchmarked peers across all our Trust Values. Examining this data over time it is possible to see consistency in the survey results, even where our benchmarked peers have experienced reduced performance.

An area of notable improvement is in our Value 'Families and Carers Matter' where we are in the upper quartile of results and maintained our own performance (2024: 79.4% and 2025: 79.7%) where both the performance of both the highest and lowest of our benchmarked peers reduced by 1-2%.

While opportunities to improve are visible in other areas, our ability to maintain performance across all areas is an important indicator of organisational stability when measured against its values.

Question: What are our other measures telling us about this?

Answer: Our Friends and Family Test results demonstrate that our service users feedback that they are happy with the quality of the care we provide. We also monitor the number of complaints and compliments we receive and while compliments data remains in normal variation, complaint data has experienced a statistically significant trend change (special cause variation high) since June 25.

Conclusion: Our Friends and Family data remain in normal variation indicating stability and consistency in this feedback. The statistically significant trend change in complaints received, continues to be analysed for themes.

Overall conclusion: There is strong evidence that we are living our values when we consider both the service user and staff data.

3.7 Strategic aim two: Best place to work and learn

Question: What is our staff survey telling us about the staff view of this?

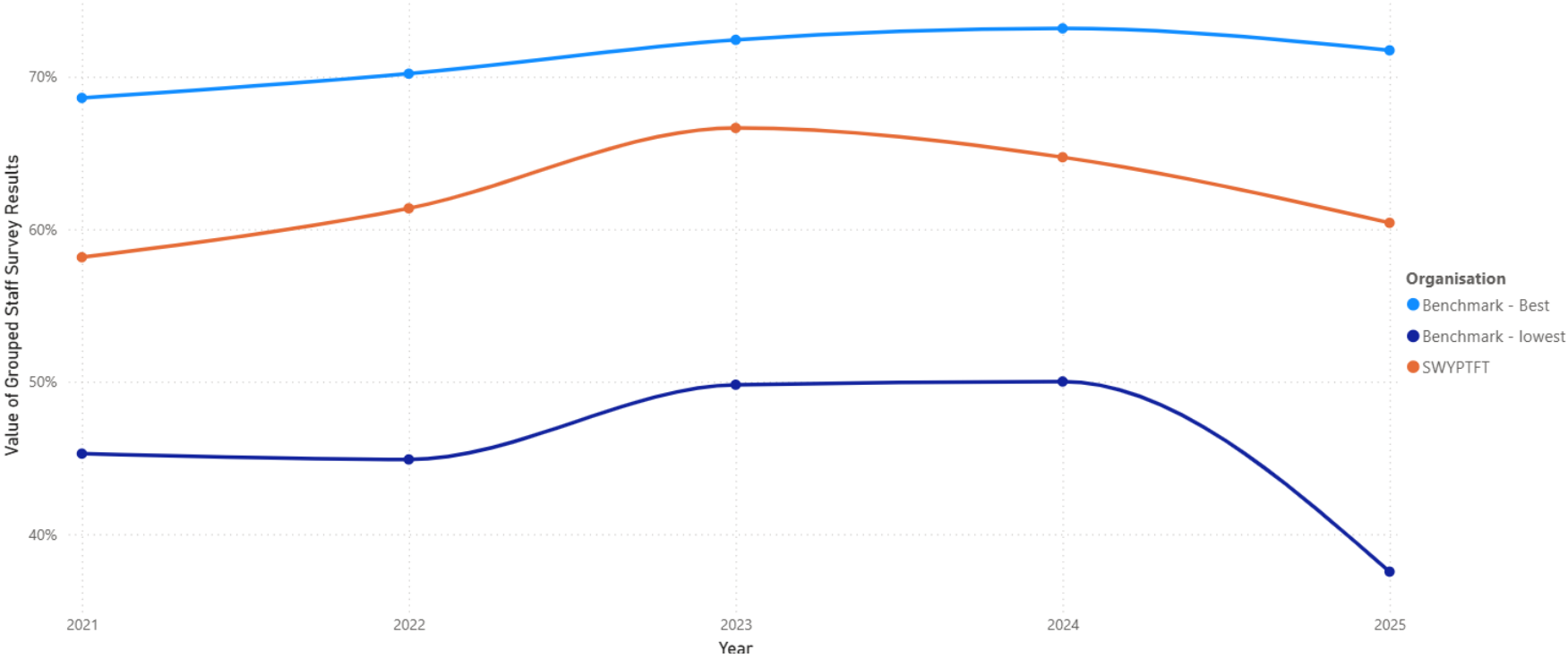
Answer: The information in figure six below sets out the staff survey results visually to demonstrate change over time and illustrate how we compare to other similar organisations.

Conclusion: There is strong evidence from our staff survey that our colleagues see this as a good place to work and learn. There are areas for improvement that are being actioned as part of the work in response to the survey which is being led by the People Directorate.

Figure six: Data from national staff survey on staff view of best place to work and learn

Measuring our alignment with our strategic aims

Staff survey responses - Best Place to Work and Learn



Question: What are our other measures telling us about this?

Answer:

Best place to work and learn

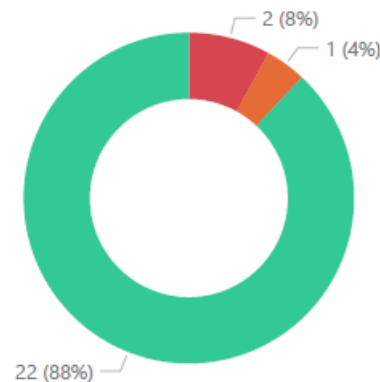


Figure seven: Doughnut of IPR reporting against best place to work and learn

Conclusion: The indicators mapped to Best Place to Work and Learn in our IPR indicate positive performance against their individual targets with 88% meeting or exceeding their target value. Our staff feedback through the 2025 staff survey mirrors benchmarked peers which all experienced a reduction in their scores. This indicates that while our performance metrics show positive performance, there is still work to be done to ensure staff feel that they are supported in their roles and have opportunities to learn in a way that supports their ability to do the best work they can.

3.8 strategic aim two: Best quality

Question: What do we know about the quality of the services we provide?

Answer: There are a range of items that provide an answer to this question

3.8.a The quality indicators that are in our IPR

Best quality

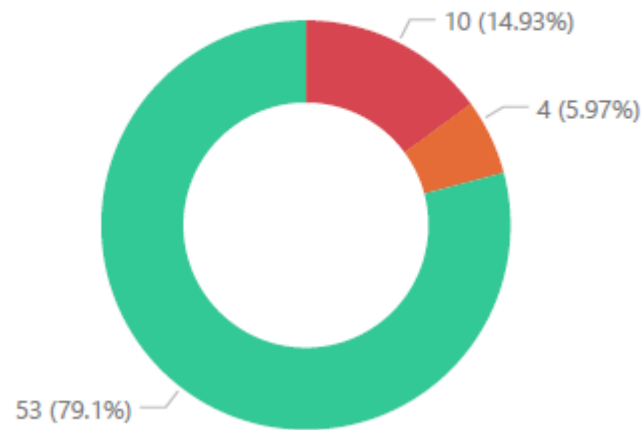


Figure eight: Doughnut of IPR reporting against best quality

3.8.b Our quality monitoring dashboard [Quality Monitoring Dashboard](#)

In 25/26 we developed a first version of our Quality Monitoring Dashboard. The dashboard allows us to triangulate our data through the review of performance, patients feedback and incident data. This provides us with a more holistic overview of our services and the care they are able to provide and helps to support the identification and understanding of improvement and areas of focus for our colleagues in Nursing Quality and Professions. The importance of this dashboard helps us to link through to our ability to know whether we are living our values as the increase in the number of complaints received can be analysed to understand the individual areas of concern and the outcome of those complaints (25/26 approximately 70% of complaints were not upheld).

The full potential and development of this dashboard remains ongoing to ensure it meets the needs of reviewers and allows us to ask questions and / or make decisions based on the information it is telling us.

Our proactive ability to develop these tools using the skills we have internally, also links to our Trust Values of 'Improve and Aim to be Outstanding' and 'Relevant for Today and Ready for Tomorrow'.

Conclusion:

Our measures demonstrate that we are providing good quality.

3.9 strategic aim two: Best use of resources

Question: Are we providing value for money?

Answer:

3.9 a The best use of resources indicators that are in our IPR

Best use of resources



3.9 b We have considered key pieces of information and intelligence in relation to finance

Table four:
Summary
financial
information
for 2025/26

Finance			
Metrics	Threshold 25/26	2024/25	2025/26
Surplus / (Deficit) against NHS England financial performance target	Breakeven	£0.2m	£2.2m
Agency spend managed within the overall workforce	£3m	£6.4m	£2.9m
Financial sustainability and efficiencies delivered over time (monthly)	£28.2m	£20.6m	£28.2m
Capital spend against plan	£17.1m	£7.5m	£14.8m

As measured against our financial performance of breakeven, the Trust, excluding linked charities, delivered a surplus of £2.2m (as per the NHS England measurement of financial performance). This is better than plan and represents a positive performance.

As part of its annual planning each year the Trust details its efficiency programme. Delivery is a key element of how we demonstrate on going value for money. In 2025/26 the level of efficiency delivered was £28.2m.

In 2025/26 we did not fully utilise our capital allocation which is why it is showing as red in table four. We are aware of the reasons for the delay.

Conclusion: Our measures indicate that we are performing well on our best value metrics and have delivered against our key financial metrics except in relation to the capital plan.

3.10 strategic aim two: Best partner

Question: Are we a good partner?

Answer:

To answer this question we have used insight from sources including West Yorkshire and South Yorkshire summary reports to Board, stakeholder engagement and direct feedback from partners:

3.10 a Our System Leadership Role

The Trust is a Lead/Coordinating Provider for:

- West Yorkshire Adult Secure services.
- Yorkshire & Humber Forensic CAMHS.
- West Yorkshire Maternal Mental Health.

The Trust provide active leadership across:

- West Yorkshire Health and Care Partnership.
- South Yorkshire and Bassetlaw Partnership Board.

This demonstrates:

- High level of trust from NHS England and system partners.
- Ability to lead complex, multi-organisational services.

3.10 b Effective Collaborative Working

The Trust is a partner in multiple collaboratives including:

- Adult Eating Disorders.
- Children and young people Mental Health.
- Perinatal Mental Health.

We are actively involved in key workstreams and projects with our partners, including:

- Neurodiversity.
- Complex rehabilitation.
- Care pathway redesign.
- Kirklees Involvement Network (KIN).
- Cancer Champions project.

This demonstrates:

- Strong integration across pathways and organisations.
- Commitment to joined-up care and shared outcomes.

3.10 c We attend a broad range of partnership forums as set out below.

Table five Meeting representation

Meeting representation

Place/Meeting	Rep 1	Rep 2	Frequency
Kirklees			
Place Provider Partnership Board	Mark Brooks (Chair)- member	Adrian Snarr- deputy	Monthly
Design Group	Mark Brooks (Chair)- member	Izzy Worswick- member	Monthly
Neighbourhood Health Oversight Group			
5 Delivery Groups, including mental health delivery group			
Health and Wellbeing Board	Izzy Worswick- attendee		Quarterly
Calderdale			
Provider Collaborative Board	Mark Brook- member	Izzy Worswick- member	Monthly
Development & Implementation Group-	Amanda Miller- member	Kelly Williams Carr- member	Monthly- alternate F2F and teams
Calderdale Cares Community Programme Board	Amanda Miller- member		Monthly
Health and Wellbeing Board	Caroline Johnson - attendee		Quarterly
Mental Health Alliance			
Wakefield			
PPP Board	Mark Brooks (member)	Izzy Worswick	Monthly
Design Group	Kelly Williams Carr		Monthly
Health and Wellbeing Board	Kelly Williams Carr		Quarterly
Mental Health Alliance	Izzy Worswick (chair)	Amanda Miller (attendee)	Monthly
Barnsley			
PPP Board	Dawn Lawson (member)	Mark Brooks (member)	Monthly
Health and Wellbeing Board	Dawn Lawson		Quarterly
CKW			
Sponsors Group	Mark Brooks (chair)		Monthly
CKW PPP Implementation Group	Izzy Worswick		
CKW Governance Group	Izzy Worswick		
CKW Due Diligence	Kelly Williams Carr		
CKW Shadow Arrangements			
Finance and contracting	Adrian Snarr		
OD	Christine Brereton		



**South West Yorkshire
Partnership Teaching**
NHS Foundation Trust

With **all of us** in mind.

3.10 d

We have the following **key achievements** that have been made through partnership working and in support of our partners.

- Our partnership working in Barnsley has had a positive impact on the mental health investment standard.
- Our work in partnership with acute hospitals to address 12-hour breaches has improved escalation leading to a reduction in bed delays.
- Our work with the police regarding responsibilities and handover in A&E and right care, right person has clarified roles and pathways.
- Our partnership work with the homeless in Barnsley has resulted in a much improved service for our patients with resulting improved outcomes.
- As part of our coordination of services at scale across South and West Yorkshire we have led improvements in Access, Quality and Service models (e.g. virtual wards, community pathways).

3.10 e The Trust Board have made several major, strategic decisions and undertaken significant work in partnership including:

- Our response to NHS England in relation to Cheswold Park Hospital.
- Success in achieving Teaching Trust status.

3.11 Partner feedback

We are aware that there are significant changes happening across our system which complicates obtaining feedback from our partners at the present time. However we wanted to ensure that we triangulated our data with direct feedback from some key partners. We therefore asked a short number of questions about their views on the Trust as a partner. We received four responses.

The questions and responses are presented in the table below.

Table six: Partner Feedback

1 On a scale of 1-4 (1 being the worst and 4 being the best we can be) how would you rate SWYTPFT as				
a) a visible partner in your Place	1	2	3 = 25%	4 = 75%
b) being capable and well led	1	2	3=25%	4= 75%
c) a good partner to work with	1	2	3	4 = 100%
d) a partner who has a shared understanding of challenges within the local system	1	2	3= 50%	4= 50%
e) having positive and collaborative relationships with partners in your place	1	2	3	4 = 100%
f) being transparent and open about performance?	1	2 = 25%	3 = 25%	4 = 50%

2) What does the Trust do well?

- Responsive and equally passionate about MHLDA, share ideas, insights and intelligence. Attend the programme board regularly and contribute to, lead different elements of the work/programme. We have good open transparent relationships in our collaborative executive group – peer support is readily provided and appreciated.
- SWYPFT is viewed as a high-performing well-led organisation. Good to work with and straightforward in approach, this approach is led from the Board downwards.
- Engages with system partners to support development of system strategies. Strong operational engagement of day-to-day communication and management of system pressures.
- Wakefield perspective Out of Area, CAMHS services and adult ASD waiting times are where SWYPFT are doing well in Wakefield place to support patients

3) Where can we improve?

- I have marked a couple of the areas down as possible areas for improvement (or to be even better!) as I would struggle to articulate any level of detail the challenges SWYPFT face from a performance/sustainability perspective other than superficially (for note - I haven't marked this one down on the transparency point). I appreciate this is because acutes often get the airtime but it would be good to understand these better.
- Communication for adults waiting in ADHD assessment process. ADHD transition planning between C&YP assessed with ADHD and SWYPFT adults ADHD team are not working currently. This is impacting on the medication requests for young adults and this is currently not being resolved by SWYPFT

Any other comments:

- Very strong NOF assessment rating for Quarter 4 2025/26 and likely same for Q1 2026/26 highlights how well SWYPFT as an organisation is performing across WY ICS and it is strongest MH Trust we have in terms of partnership working, ethos, leadership of SWYPFT management team.

Conclusion:

The Trust demonstrates that it is a strong and effective partner, with a leading role across local and regional systems, including acting as Lead Provider for multiple specialised collaboratives. Evidence shows high levels of trust, collaboration, and delivery at scale. Our feedback from partners, whilst only a small number, support this view.

Our partnership arrangements are strong but still evolving and influenced by wider system pressures and changes.

In the development of this new report it has become evident that we do not currently have a regular report into the organisation that sets out our plans and progress in terms of being a Best Partner. This is the only one of our four best statements where this is the case and we think that we

would be 'even better if' we had this report. It is therefore proposed that this is considered as an area of development going forward. This report would come to EMT and report into the Transformation, Innovation and Sustainability committee.

3.12 strategic aim three: We will be ambitious

Question: Are we being ambitious?



Answer:

Successful delivery of strategic aim three is built on a foundation of achieving strategic aims one and two with all four of our best statements being extremely relevant. Because of this, our progress against this strategic aim will inevitably be slower in the early years of our strategy whilst

we build these foundations. Our answer in relation to strategic aim three at this point is therefore a summation of all the work presented in this report.

In particular the following areas are highlighted:

- Our evidence in relation to strategic aim one – living our values.
- Our partnership work on the development of neighbourhoods and community-based services.
- Our developments in forensic services such as the acquisition of Cheswold Park Hospital.
- Our work on health inequalities – both within the organisation and in partnership.

In addition, the board identified that this area of work was more emergent and agreed a strategic aim three milestone plan. A progress report is attached at *Appendix C*.

In summary this demonstrates:

- We have developed and delivered an external communication plan to proactively promote the good practice examples that we have under each of our strategic ambitions.
- Identified and targeted opportunities to attend national and regional events which are in line with our strategic ambitions.
- Used excellence award nominations to identify areas to apply for awards, recognition and accreditation.
- Built on our success in the Wakefield Alliance and actively played a leadership role in the developments of integrated neighbourhood working.
- Actively supported each of our four places whilst the system changes have been happening.
- Ensured our work on integrated neighbourhood working is recognised and shared.
- Actively worked with our partners to understand the health inequalities of each place and our role in helping to address these.
- Commenced sharing of information on our learning and improvements at Cheswold Park.
- Developed agreed model of care and pathways with partners across South Yorkshire.
- Set specific objectives for research and development (R & D) activity, including publications in the trust in line with our strategic ambitions.

Conclusion: We have built firm foundations in line with our strategic ambitions. These are in line with our work under strategic aims one and two. We have delivered our plan for strategic aim three and will build on this further over the lifetime of the strategy. The development of a new committee covering transformation, innovation and sustainability will assist in the future delivery of strategic aim three.

4.0 Overall conclusion and recommendations

This document set out how we have carried out the first annual review of the delivery of the Trust strategy. In line with the purpose of this report we have:

- Provided a summary of the progress we have made in the 12 months April 25 to March 26.

This identifies the significant progress and achievements in strategy deployment and delivery. It therefore demonstrates how we are leading the organisation well, aligned to our agreed strategic direction.

We have also identified areas that we want to address going forward to make sure that we continue to lead well, do even better and are able to evidence this. The areas for focus are recognised within our Board Assurance Framework and form the core of our priorities for 2026/27. We have also recognised that we can improve the structure of some of our reporting so it is easier to see how our specialist agendas are strategically aligned and that we need to strengthen our partnership reporting into Board.

- Tested the strategic measurement framework so that we can continue to develop and improve it for future years.

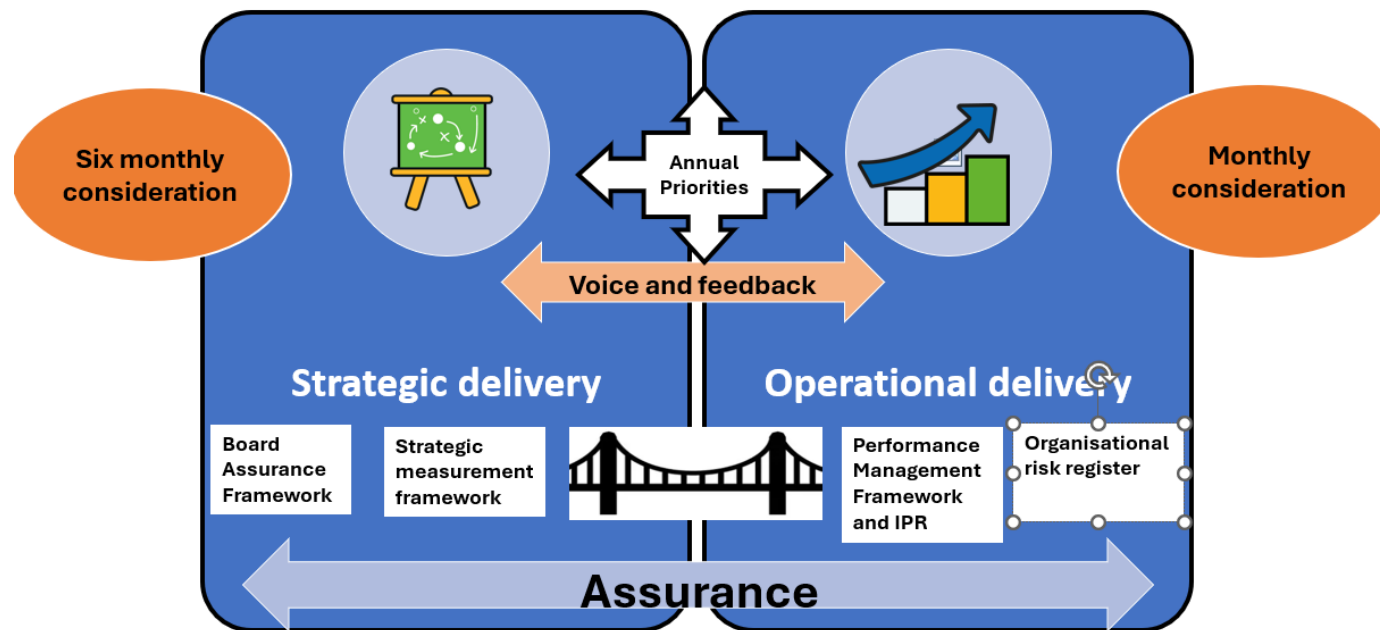
Trust Board members are asked to:

- **RECEIVE** the progress update in line with our strategic intent and how this demonstrates that we are leading well noting the areas that we have identified where we would be 'even better if' and therefore our proposed areas for improvement.
- **RECEIVE** and **NOTE** the use of the strategic measurement framework and provide feedback on its effectiveness and ideas for improvement for next year.
- **CONSIDER** this framework throughout the year so that the annual review is the result of continued consideration of delivery of the strategy and not a one-off annual event.

Diagram of relationships between different key Trust documents

The diagram below shows the relationship between these different key documents.

Figure one: *How the Trust Board listens, hears and receives assurance on the delivery of our strategy and our performance*

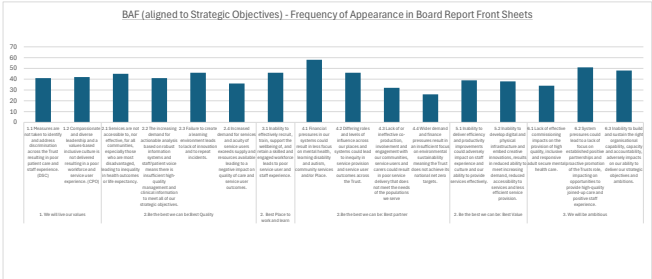


If we describe the strategic measurement framework as the compass for the organisation, we can describe the performance management framework as the sat nav and the IPR as the engine management system

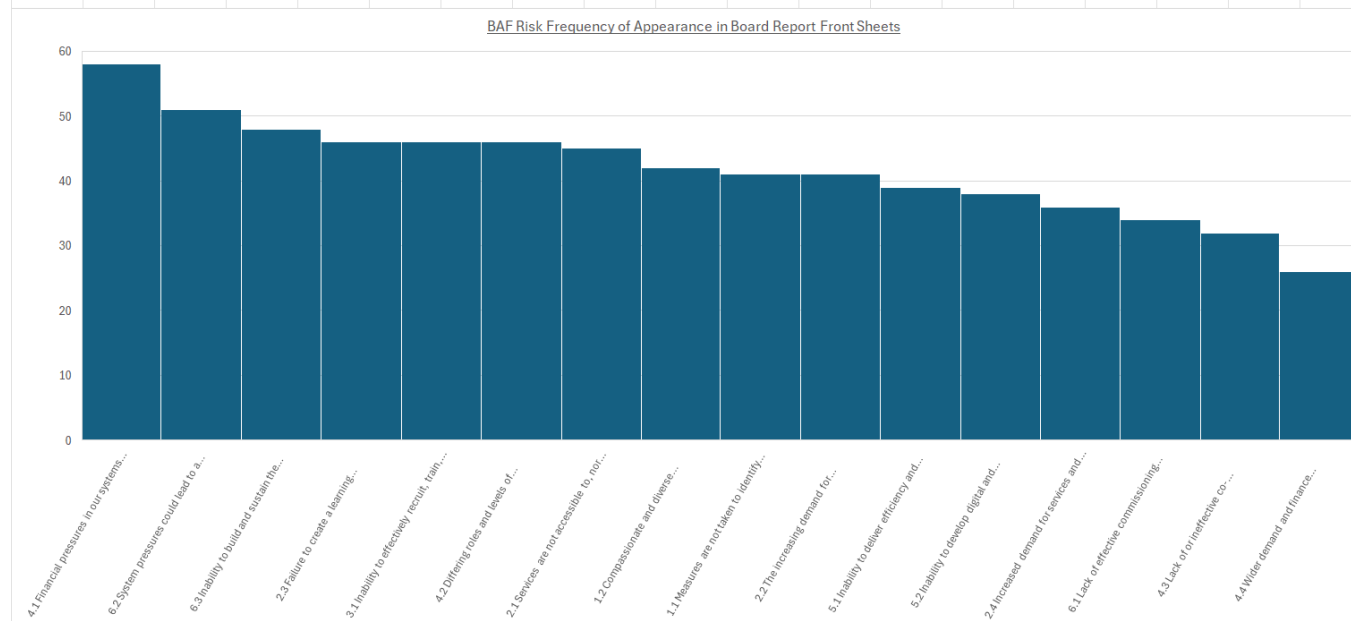
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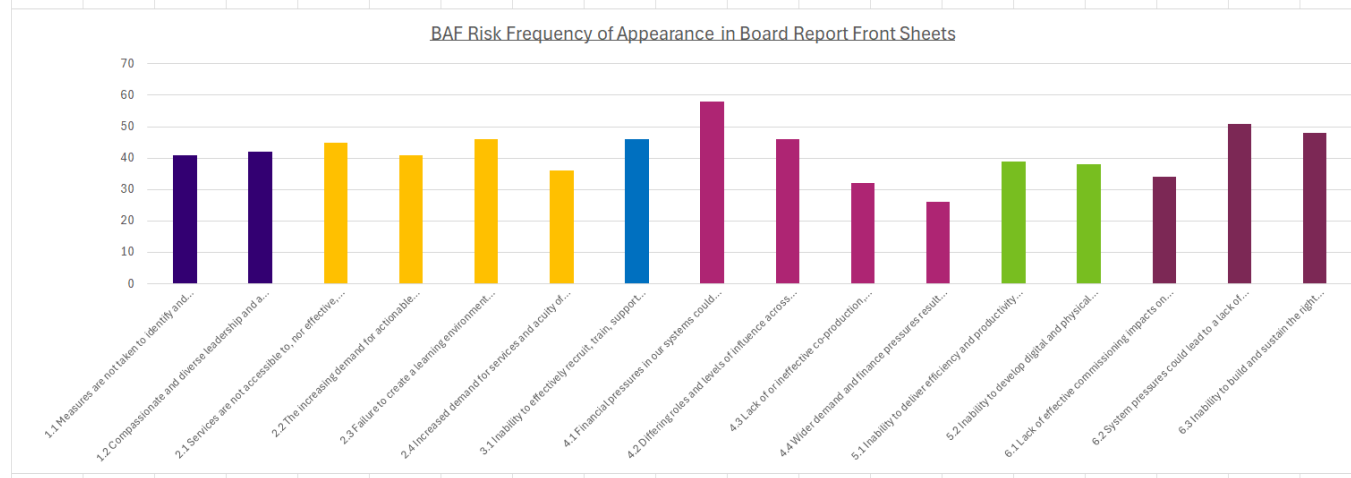
1. We will live our values	1.1 Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience. (DSC)	41
	1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience (CPO)	42
	2.1 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.	45
	2.2 The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.	41
	2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents.	46
	2.4 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.	36
	2.5 Inability to effectively recruit, train, support the wellbeing of and retain a skilled and engaged workforce leads to poor service user and staff experience.	46
	2.6 Best Place to work and learn	58
	4.1 Financial pressures in our systems could result in less focus on mental health, learning, disability and autism, community services and/or Place.	58
	4.2 Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.	46
2. Be the best we can be: Best Quality	4.3 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	32
	4.4 Wider demand and finance pressures result in an insufficient focus on environmental sustainability meaning the Trust does not achieve its national net zero targets.	26
	5.1 Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.	39
	5.2 Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision.	38
	6.1 Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care	34
	6.2 System pressures could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience.	51
	6.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.	48
	3. We will be ambitious	
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	Best Quality	168
	Best Place to Work and Learn	46
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	Best Value	77
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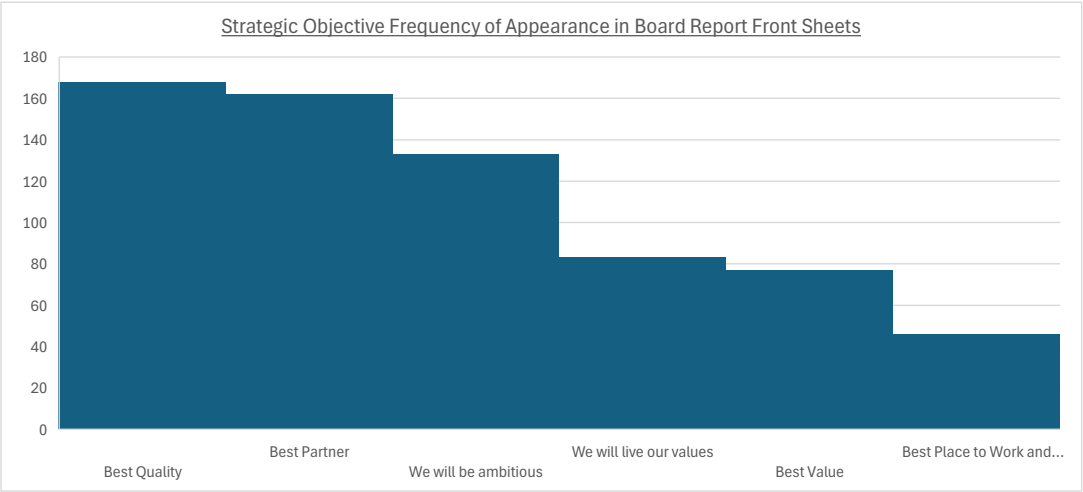
Option 1 - plain bar / frequency chart ordered by most frequent



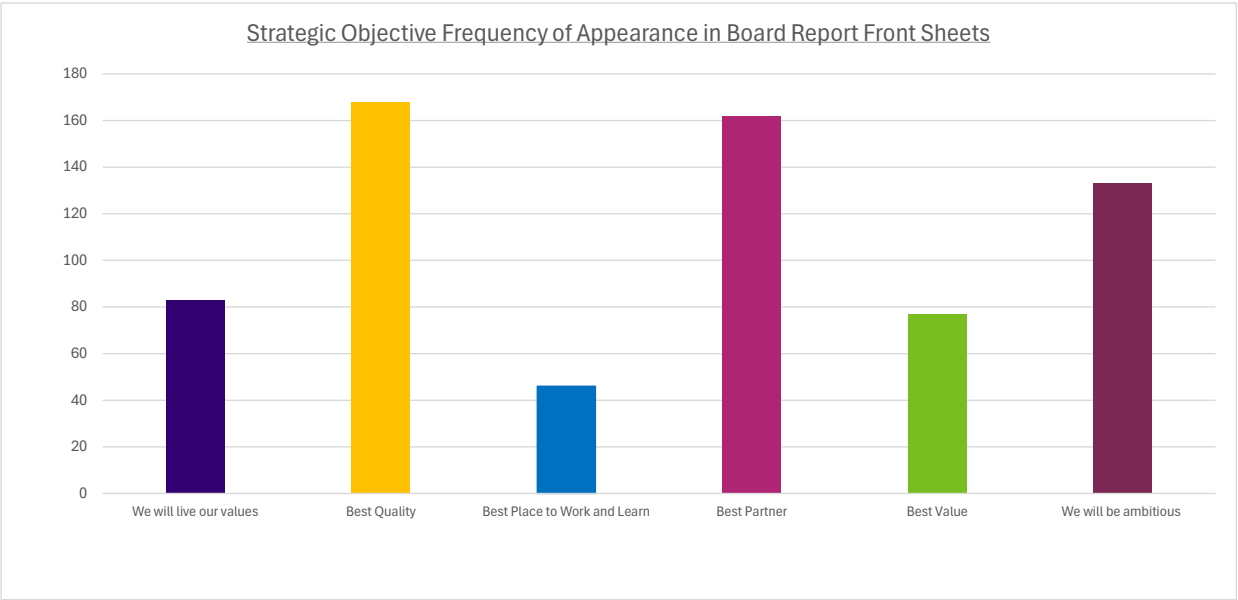
Option 2 - bar chart ordered by BAF risk



Option 1 - plain bar / frequency chart ordered by highest frequency



Option 2 - plain bar / frequency chart ordered by Strategic Objective

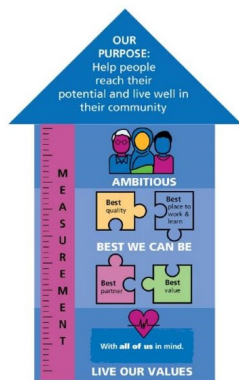


Strategic aim three in 2025/2026

Annual review final version May 2026

1.0 Background and introduction

On 1st October 2024, the Trust Board formally agreed the new strategy to take the Trust up to 2030. The strategy has three strategic aims which are summarised below.



Our strategic aims:

1. We will live our values
2. We will be the best we can be
3. We will be ambitious

Alignment between annual planning and the trust strategy in 2025 was strong. The operational plan for 2025/26 therefore set out how we would deliver the first year requirements of strategic aims one and two from the strategy. We established a separate plan for strategic aim three which set out the areas of focus for 2025/26, in line with our strategic aim to be ambitious.

This report provides an update on progress against this milestone plan up to March 2026, at the end of the first year of the deployment of the new strategy. The report includes information provided in previous updates (September 2025 and December 2025) and therefore provides an annual review. A draft version was considered by EMT in April, this report is updated following feedback. The content of this report will form part of the annual review of the first year of the deployment of the Trust strategy.

Work has commenced on the Trust Strategic Overview: PESTLE & SWOT. Once this has been finalised, we will develop our plans for 2026/7 against strategic aim three.

2.0 Strategic aim three: We will be ambitious

We are ambitious for our service users, patients, carers and colleagues. We have lots of positive areas across our organisation, but there are key areas of unique strength, that with focussed development will support our journey to being outstanding.

We identified four strategic ambitions where we want to be outstanding and receive national recognition. These ambitions build on the areas identified in strategic aim two – to be the best we can – and provide areas of focus on where we want to excel.

These are:

- Living our values and demonstrating inclusive, compassionate leadership and care where our colleagues are proud to work and want to stay.
- Providing high quality neighbourhood and community-based services and support which help people live well in their community with strong features of prevention and earlier intervention.
- Our leadership in reducing health inequalities through inclusive community connections and co-creation including in creativity and health.
- Providing high quality, inclusive and responsive specialist forensic mental health care with excellent outcomes and experience for all our service users and their carers.

This is set out below - We will be ambitious for our service users, patients, carers and colleagues through our strategic ambitions:

Figure one



We have previously identified what we will do to achieve these strategic ambitions and what we will see when we reach our ambition. This is set out below:

Figure two

Ambitious for living our values



Ambitious for our neighbourhoods and community services



Ambitious for innovatively reducing health inequalities

Our leadership in reducing health inequalities through inclusive community connections and co-creation including in creativity and health

To reach our ambition we will:

Actively work with our partners to understand the health inequalities of each place
Identify the areas we will collectively work on year on year

Maximise and measure the impact we are having on health inequalities, including a focus on the impact that our work on creativity and recovery has

Take a strategic approach to leverage the impact of our Recovery Colleges, charities and linked charities, to support the development of our narrative

When we reach our ambition, we will:

Have inclusive leadership that addresses health inequalities as business as usual

Be well known for our approach to inclusive leadership and regularly present at national and international conferences

Have a strong portfolio of investment that has built creativity and health into business as usual.

Ambitious for our input into high quality specialist forensic mental health care

Providing high quality, inclusive and responsive specialist forensic mental health care with excellent outcomes and experience for all our service users and their carers

To reach our ambition we will:

Seize opportunities to lead specialist forensic mental health care and services in the health and justice environment

Fully understand the impact of our services on all the people we serve through consideration of comprehensive outcome and experience data, analysing by protected characteristics and responding to what we find

Proactively seek opportunities to learn about good practice in specialist forensic mental health care and to share our experience
Build a bolder narrative about the excellence of the care that we provide

Take a clear and proactive approach to applying for awards, recognition and service accreditation.

When we reach our ambition, we will:

Be a nationally recognised provider of specialist forensic mental health care

Have created a culture shift regarding inclusive and responsive forensic mental health services that is recognised nationally

3.0 Progress against our milestone plan for 2025/26

3.1 Background and introduction

To be successful on delivering these ambitions over the lifetime of the strategy requires us to be intentional in our actions whilst recognising that this work is strategic and emergent and needs to respond to changes in the environment. We therefore developed a milestone plan for strategic aim three which was approved in June 2025. This identified that we needed a coherent communications strategy and focussed use of our improvement expertise and research and development resources with proactive senior leadership. We set out a path to develop our confidence to be bold about our impact and to develop and sustain our narrative and share this widely. We explored how we would prioritise some external engagement, including national meeting attendance, conference attendance and presentations in line with our ambitions. We identified generic actions across all four ambitions, and some which were specific to one area.

3.2 Context

Since the agreement of the plan in June 2025 there have been significant changes in the context that we are operating. Some elements of the plan have been affected more than others by these changes and therefore some elements have moved faster than expected and in slightly different directions. This is reflected in the update below

3.3 Update

An update is provided in the table below. The items identified in green are complete.

Table one – Update against milestone plan April 2026

Action	Executive Owner	Timescale	Update	
1. Develop and deliver an external communication plan to proactively promote the good practice examples that we have under each of our strategic ambitions	Dawn Lawson	July 2025	As a part of our approach to marketing and communications we weave into key messages our values and objectives, and link to our strategic ambitions wherever possible. This is a part of our behavioural science approach which ‘drip feeds’ information and ensures that our values and ambitions become a part of usual messaging and thinking. Complete	
2. Identify and target opportunities to attend national and regional events	All of EMT	Ongoing	Ongoing action Significant review of learning and development offer undertaken. We continue to attend national events in line with strategic ambitions and maximise opportunities to showcase our work.	

which are in line with our strategic ambitions			Examples include • Presentation to the NHS Confed on the development of the strategy • Health Innovation presentations
3. Use excellence award nominations to identify areas to apply for awards, recognition and accreditation	Dawn Lawson	July 2025	Our Marketing and Communications team routinely explore opportunities to promote good practice into external award schemes. This includes using the submissions for the Excellence awards. For example, 5 Excellence award nominations in 2025 were submitted to the HSJ Awards this year. We will continue to promote excellence award nominees, and other good practice examples, into external awards. Complete
4. Build on our success in the Wakefield Alliance and actively play a leadership role in the developments of integrated neighbourhood working	Mark Brooks supported by Dawn Lawson and Adele Fox	Ongoing	We recognise that integrated neighbourhood working covers two distinct areas: • How our Trust services (both physical and mental health) integrate into neighbourhood models of delivery • How we participate and lead the development of neighbourhood partnership structures in each place These areas have both been identified as priority areas for 2026/7. A key vehicle for the development of neighbourhood partnership structures is the development of Place Provider Partnerships (PPP) in each of our places. Our CEO is Chair of the Calderdale, Kirklees, Wakefield (CKW) sponsors' group which consists of the chief executives from Mid Yorkshire Teaching NHS Trust (MYTT), Calderdale & Huddersfield NHS Foundation Trust (CHFT), and our own Trust along with the chief officers from Calderdale, Kirklees, and Wakefield places, who are ICB employees. This group oversees development of PPPs in each of our places. The Trust is taking a lead role in the implementation of the Kirklees PPP. We have representation at key implementation groups including: • CKW implementation group • CKW governance group • Due diligence group
5. Consider the changes set out in the ICB blueprint and how we can best support our places going forward	Mark Brooks and Dawn Lawson	Ongoing	We continue to support our ICB colleagues. Detailed work is being undertaken with partners on the development of neighbourhoods Ongoing action with updates provided to private Board. The below is an excerpt from the CEO update to Board in January To facilitate the required 50% cost reduction the West Yorkshire Integrated Care Board (ICB) went live with its voluntary redundancy programme late in 2025. Over 370 applications were received and 246 have been recommended for approval with circa 120 not agreed. There will be a second round of applications for voluntary redundancy shortly, as circa 70 more staff exits are required to reach the required savings. It is

			important to note that the ICB's responsibilities cover a wide range of different functions so there needs to be a balance between staffing in those functions for redundancies to be approved. In addition, it is worth noting some roles are required for a transition period, but voluntary redundancy could be approved in the future. Consultation on the new structures has commenced and will conclude on 26th February. Once feedback has been received and deliberated, staff will begin to leave the organisation by the end of March. Recruitment into the new roles in what is effectively a new organisation and structure is expected to be completed by the end of June, with all staff due to exit coming to the end of their employment by the end of September 2026. We have had access to high level structures that are being consulted on without necessarily knowing the detail and remit of the individual roles. Within Calderdale, Kirklees, and Wakefield (CKW) there will be a much-reduced number of roles, some of which will perform a function across CKW with a smaller number dedicated specifically to place. There is clearly a risk given there will be much experience, expertise and organisational memory leaving the ICB shortly and at once. At this stage, the exact details of what functions will continue to be provided by the ICB and similarly whilst high level organisation charts are available the exact detail of what each role will be performed by those roles has not yet been finalised. Across all places there is an action to review the current functions provided by the ICB, the likely provision in the future and therefore what the gaps are. From this work further assessment can take place of what work will in future be conducted by the NHS England region, what provider partnerships will be expected to pick up, and what may no longer be provided
6. Ensure our work on integrated neighbourhood working is recognised and shared	Dawn Lawson supported by Adele Fox	Ongoing	This work is ongoing Work is being undertaken, as part of our response to the 10 year plan, to develop a shared narrative which celebrates our integrated neighbourhood working
7. Actively work with our partners to understand the health inequalities of each place and our role in helping to address these	Dawn Lawson	Ongoing	Health inequalities work is taking place across the trust with connections into each of our places. A summary of this work has been presented into EMT Toolkit in place and work undertaken by each care group as part of annual planning Complete
8. Produce, and share widely, information on our learning and improvements at Cheswold Park	Adele Fox	October 2025	We are working with NHSE to undertake a review of learning from acquisition of learning from Cheswold Park. This review is now in progress and a draft report prepared Complete

9. Develop agreed model of care and pathways with partners across South Yorkshire	Mark Brooks and Dawn Lawson	Ongoing	This work is included in the neighbourhood development work taking place in South Yorkshire. The Trust is helping to lead this work Updates are provided in the West Yorkshire and South Yorkshire reports to Board and updates from the coordination group to EMT. Complete
10. Set specific objectives for research and development (R & D) activity, including publications in the trust in line with our strategic ambitions	Subha Thiyagesh	July 2025	A piece of work has been completed to align the work of R & D to the strategic ambitions of the trust. This will form a separate report to be presented into EMT in the near future Complete Work presented into EMT

4.0 Conclusions and next steps

This annual review of strategic aim three “We will be ambitious for our service users, patients, carers and colleagues” provides evidence of our progress against this milestone plan

The content will form part of the annual review of the deployment of the Trust strategy.

Once the Trust SWOT/PESTLE has been agreed we will develop a 2026-2027 plan to deliver our strategic ambitions. It will be based on:

- Information submitted as part of the annual planning process
- A review of the content and structure of this plan for 25/26
- Our strategic analysis (SWOT/PESTLE)

5.0 Conclusion and recommendations

Our Trust strategy sets clear areas where we want to be ambitious for our service users, patients, carers and colleagues.

Our strategic aim three plan identified actions to enable focussed development on our key areas of unique strength to support our journey to being outstanding. This review sets out our progress against this plan.

Trust Board annual work programme 2026-27

	Business and risk
	Performance and monitoring
	Strategic Board Meeting
✗	Item deferred

Note that some items may be verbal

Agenda item / issue	28 Apr	26 May	30 June	28 July	25 Aug	29 Sep	27 Oct	1 Dec (Nov)	15 Dec	26 Jan	23 Feb	30 Mar
<u>Standing Items</u>												
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	✗		✗	✗		✗	✗	✗		✗		✗
Chief Executive's Report	✗		✗	✗		✗	✗	✗		✗		✗
Questions from the public (item 3)	✗		✗	✗		✗	✗	✗		✗		✗

Agenda item / issue	28 Apr	26 May	30 June	28 July	25 Aug	29 Sep	27 Oct	1 Dec (Nov)	15 Dec	26 Jan	23 Feb	30 Mar
Any other business (public and private)	x		x	x		x	x	x		x		x
Assurance from Trust Board committees and Members' Council and Joint Partnership Board (Teaching Trust)	x		x	x		x	x	x		x		x
<u>Risk and Assurance</u>												
Board Assurance Framework	x			x			x			x		
Corporate / organisational risk register	x			x			x			x		
Strategic overview of business and associated risk											x	x
Review of Risk Appetite statement												x
Complex Clinical Matters update (private session)	x		x	x		x	x	x		x		x
Patient Safety Oversight Report (formerly Incident management quarterly report (public))			x (annual)			x		x				x
Guardian of safe working hours annual report							x					
Workforce Equality Standards						x						
Medical appraisal / revalidation annual report						x						
Ligature Annual Report								x				
Freedom to Speak Up Annual report (October Annual report and April 6 monthly update)	x						x					
Medical Education Annual Board report								x				
Data Security and Protection toolkit (delegated authority required for submission for 30 June)		x	x									
Cyber Board training (TBC)												
Annual report and accounts (private)		x	x									
Quality Account			x									

Agenda item / issue	28 Apr	26 May	30 June	28 July	25 Aug	29 Sep	27 Oct	1 Dec (Nov)	15 Dec	26 Jan	23 Feb	30 Mar
Annual Governance Statement	x											
Equality and diversity annual report				x								
Incident management annual report			x									
Health and safety annual report				x								
Patient Experience annual report			x									
Sustainability annual report						x						
Premises Assurance Model annual report				x								
PLACE assessment annual report				x								
EPRR Compliance report							x					
IPC BAF				x								x
NHS Staff Survey												x
Resident Doctors 10 point plan						x						
Staff standards				x					x			
Leadership and Management Framework				x						x		
Safer Staffing report			x	x						x		
Integrated Care Systems and Partnerships												
South Yorkshire update including the South Yorkshire Integrated Care System (SY ICS)	x		x	x		x	x	x		x		x
West Yorkshire update including the West Yorkshire & Health & Care Partnership (WYHCP)	x		x	x		x	x	x		x		x
Provider Collaboratives and Alliances	x		x	x		x	x	x		x		x

Agenda item / issue	28 Apr	26 May	30 June	28 July	25 Aug	29 Sep	27 Oct	1 Dec (Nov)	15 Dec	26 Jan	23 Feb	30 Mar
<u>Performance reports</u>												
Integrated Performance Report (IPR)	x		x	x		x	x	x		x		x
Care Group Performance report	x		x	x		x	x	x		x		x
CQC action plan updates			x			x		x				x
<u>Strategic Direction</u>												
Board Development		x			x				x		x	
Investment Appraisal Framework (private)	x							x				
Strategic Objectives/Priority Programmes												x
Trust Board Annual Work Programme												x
Trust Plan (private)						x (draft / private)	x (draft / private)	x (1 st draft)		x (final draft)		
Finance and value for money updates (private)	x		x	x		x	x	x		x		x
<u>Governance</u>												
Constitution (including Standing Orders) and Scheme of Delegation (every 2 years – next Jan 2027)										x		
Compliance with NHS provider licence conditions and code of governance			x									
Going Concern Statement	x											
Assessment against NHS Constitution				x								
Audit Committee annual report including committee annual reports and terms of reference	x											
Use of Trust Seal			x			x		x				x
Internal governance structure review												x
<u>Strategies and Policies</u>												

Agenda item / issue	28 Apr	26 May	30 June	28 July	25 Aug	29 Sep	27 Oct	1 Dec (Nov)	15 Dec	26 Jan	23 Feb	30 Mar
Digital strategy (including IMT) update			x							x		
Estates strategy update				x		x				x		
Customer Services Policy						x						
Trust Board declaration and register of fit and proper persons, interests and independence policy						x						
Quality Strategy (date to be TBC after March 2026)												
Research and Development Strategy (TBC)												
People Strategy update												x
Trust Strategy Measurement				x								

Policy / strategy review dates:

- Trust Strategy (*July 2030*)
- 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 (Jan 2027) (or as required)
- Equality, Diversity and Inclusion Strategy (*March 2028*)
- Emergency Preparedness Resilience and Response Policy (*October 2027*)
- Customer Services Policy (*September 2026*)
- Digital Strategy (*January 2030*)
- Clinical Strategy (*March 2030*)
- Estates Strategy (*July 2033*)
- Learning from Healthcare Deaths Policy (*June 2027*)
- Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) (*April 2027*)
- Quality Strategy (*TBC- subject to review by QSC*)
- Risk management governance framework (*next due for review in April 2028*)
- Standards of Conduct in Public Service Policy (conflicts of interest) (*next due for review in April 2029*)
- 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*)
- People Strategy (*December 2028*)
- Research and Development Strategy (*TBC*)