South West Yorkshire Partnership Teaching
NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 29 September 2026 at 09:15
Upstairs Meeting Room
Cheswold Park Hospital
AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	**9.15**	**Welcome, introductions and apologies**	Chair	**Verbal item**	1	To receive
2.	**9.16**	**Declarations of interest**	Chair	**Paper**	2	To receive
3.	**9.18**	**Questions from the public**				
		(received in advance in writing by e:mail to membership@swyt.nhs.uk)	Chair	**Verbal item**	5	To receive
4.	**9.23**	**Minutes from previous Trust Board meeting held 28 July 2026**	Chair	**Paper**	2	To approve
5.	**9.25**	**Matters arising from previous Trust Board meeting held 28 July 2026 and board action log**	Chair	**Paper**	5	To approve
6.	**9.30**	**Service User / Staff Member / Carer Story**	Chief Operating Officer	**Verbal item**	10	To receive
7.	**9.40**	**Resident doctors ten-point plan**	Chief Medical Officer	**Paper**	10	To receive
8.	**9.50**	**Chair's remarks**	Chair	**Verbal item**	3	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
9.	**9.53**	**Chief Executive's report**	Chief Executive	**Paper**	7	To receive
10.	**10.00**	**Assurance from Trust Board Committees and Members Council** - Joint Partnership Board 20 July 2026 - Members Council 12 August 2026 - Commissioning Committee 14 August 2026 - Mental Health Act Committee 26 August 2026 - Quality and Safety Committee 8 September 2026 - People and Remuneration Committee 15 September 2026 - Finance, Investment & Performance Committee 23 September 2026	Chairs of committees/Members' Council	**Paper**	25	To receive
11.	**10.25**	**Performance**				
	10.25	11.1 Integrated performance report Month 5 2026/27	Executive Directors	**Paper**	25	To receive
	10.50	11.2 Care group performance report	Chief Operating Officer	**Paper**	10	To receive
	11.00	*Break*			*10*	
12.	**11.10**	**Risk and Assurance**				
	11.10	12.1 Patient Safety Oversight report	Chief Nurse & Director of Quality and Professions	**Paper**	5	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.15	12.2 Fuller inquiry board assurance framework	Chief Nurse & Director of Quality and Professions	**Paper**	5	To approve
	11.20	12.3 Medical appraisal / revalidation annual report	Chief Medical Officer	**Paper**	5	To approve
	11.25	12.4 Sustainability Annual report	Director of Strategy, Inclusion and Change/Deputy Chief Executive	**Paper**	5	To receive
	11.30	12.5 Winter Planning	Chief Operating Officer	**Paper**	5	To receive
	11.35	12.6 Out of area placements	Chief Operating Officer	**Paper**	5	To receive
	11.40	12.7 NHS Oversight Framework	Director of Finance, Estates and Resources	**Paper**	5	To receive
13.	**11.45**	**Integrated Care Systems and Partnerships**				
	11.45	13.1 South Yorkshire update including South Yorkshire Integrated Care System (SYICS)	Chief Executive/ Director of Strategy and Change	**Paper**	10	To receive
	11.55	13.2 West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update	Chief Executive	**Paper**	10	To receive
	12.05	13.3 Specialised Provider Collaboratives and Alliances	Director of Finance, Estates and Resources	**Paper**	5	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
14.	**12.10**	**Governance matters**				
	12.10	14.1 Trust Seal	Company Secretary	**Paper**	5	To receive
15.	**12.15**	**Strategies and Policies**				
	12.15	15.1 Estates Strategy update	Director of Finance, Estates and Resources	**Paper**	8	To receive
	12.23	15.2 Research and Development Strategy	Chief Medical Officer	**Paper**	7	To approve
	12.30	15.3 Customer Services Policy	Chief Nurse & Director of Quality and Professions	**Paper**	5	To approve
16.	**12.35**	**Trust Board work programme for 2026/27**	Chair	**Paper**	2	To receive
17.	**12.37**	**Date of next meeting** The next Trust Board meeting held in public will be held on Tuesday 27 October 2026 at Kendray Hospital	Chair	**Verbal item**	1	To note
18.	**12.38**	**Any other business**	Chair	**Verbal item**	2	To note
	12.40	*Close*				

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29 September 2026
Agenda item 2

Private/Public paper:	**Public**		
Title:	**Trust Board declaration of interests**		
Lead Director:	**Jayne Brown – Chair**		
Mission/values:	We are respectful, honest, open and transparent		
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the UK Corporate Governance Code, NHS England's Code of Governance for NHS Provider Trusts, the Trust's own Constitution and Fit and Proper Persons Test (FPPT) framework standards.		
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):	N/A		
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 compliance with Fit and Proper Persons Test (FPPT) framework, standards, including declarations of interest, provides assurance to commissioners and partners that the Trust is well led.		
Any background papers / previously considered by:	Previous annual declaration of interest papers to the Trust Board.		
Executive summary:	**Declaration of interests** The Trust's Constitution, the UK Corporate Governance Code and NHS England's Code of Governance for NHS Provider Trusts, require Trust Board		

	members to receive and consider details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a register of interests. During the year, if any declarations should change, the Chair and Directors are required to notify the Head of Corporate Governance (Company Secretary) so that the Register can be amended and reported to Trust Board. Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise and the requirement for the Chair and Directors to consider and declare any interests at each meeting. In the attached paper are declarations of interest for Celia Weldon – Non-Executive Director.
Recommendation:	**Trust Board members are asked to:** • **CONSIDER** the attached summary, particularly in terms of any risk presented to the Trust as a result of a director's declaration, and, subject to any comment, amendment or other action, formally record the details in the minutes of this meeting.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board 30 June 2026
Register of interests of the directors (Trust Board)
From 1 April 2026 to 31 March 2027

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

The following declarations of interest have been made by members of the Trust Board since the annual declarations report on 31 March 2026:

Non-Executive Directors	
Name	**Interests**
WELDON, Celia	• Occasional consultancy work on a self-employed basis with non-NHS clients • Non-Executive Director, University Hospitals Tees

South West Yorkshire Partnership Teaching NHS Foundation Trust

Minutes of the public Trust Board meeting held on 28 July 2026
Small Conference Room, Wellbeing and Development Centre, Fieldhead Hospital Wakefield

Present:	Jayne Brown (JB)	Trust Chair (Chair)
	Natalie McMillan (NMc)	Deputy Chair, Senior Independent Director
	Mike Ford (MF)	Non-Executive Director
	Gary Ellis (GE)	Non-Executive Director
	Margaret Kitching (MK) (MS Teams)	Non-Executive Director
	Martin Neeson (MN)	Non-Executive Director
	Mitch Waterman (MW)	Appointed University of Leeds Associate Non-Executive Director
	Mark Brooks (MBr)	Chief Executive
	Dawn Lawson (DL)	Deputy Chief Executive and Director of Strategy, Inclusion and Change
	Adrian Snarr (AS)	Director of Finance, Estates and Resources
	Prof. Subha Thiyagesh (ST)	Chief Medical Officer
	Caroline Johnson (CJ)	Chief Nurse and Director of Quality and Professions
Apologies:	Andy Lister (AL)	Company Secretary
	Rokaiya Khan (RK)	Non-Executive Director
In attendance:	Izzy Worswick (IW)	Deputy Director of Partnerships, Planning and Governance
	Christine Brereton (CB)	Chief People Officer
	Adele Fox (AF)	Chief Operating Officer
	Fareena Rasaq (FR)	Learning Disability Services Manager (item 6 only)
	Gemma Lockwood (GL)	Corporate Governance Manager
	Debbie Beynon-Fisher (DBF)	Corporate Governance Officer (author)
Observers	Mike Gill	NHS Alliance
	Christopher Denton (MS Teams)	Public Governor – Barnsley

TB/26/66 Welcome, introductions and apologies (agenda item 1)

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

JB introduced Mike Gill from NHS Alliance who was in attendance to observe the Board meeting.

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.

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

JB reminded members of the public that there would be an opportunity at item three to respond to questions and comments received in writing.

TB/26/67 Declarations of interest (agenda item 2)
No declarations of interest were noted.

It was RESOLVED to NOTE the declarations of interest.

TB/26/68 Questions from the public (agenda item 3)
No questions were received from members of the public.

TB/26/69 Minutes from previous Trust Board meeting held 30 June 2026 (agenda item 4)
The minutes of the meeting held on 30 June 2026 were accepted as an accurate record.

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 30 June 2026 as a true and accurate record.

TB/26/70 Matters arising from previous Trust Board meeting held 30 June 2026 and Board action log (agenda item 5)

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

TB/26/71 Service User/Staff Member/Carer story (agenda item 6)
JB introduced Fareena Rasaq (FR), Learning Disability Services Manager, to present an update on progress in embedding the Trust's Green Light Principles and improving support for people with learning disabilities and autism within mainstream mental health services.

FR explained that the Green Light Principles are designed to ensure people with learning disabilities receive the right care, in the right place, and that specialist learning disability services are accessed only when required. Following a review of arrangements, the Trust adopted a more integrated approach between learning disability and mental health services, recognising the complementary expertise within each service and the benefits of collaborative working.

A Trust-wide engagement and awareness programme had been undertaken, including presentations to extended EMT, engagement with mental health trio's, creation of a Green Light Champions Network and learning disability specialist links for clinical teams. Training covered reasonable adjustments, autism awareness, communication, sensory needs, the Mental Capacity Act, STOMP (stopping over medication of people with a learning disability), dynamic support registers, care and treatment reviews, and an easy-read library.

The Champions Network had initially attracted fifty-five champions. The service is now reviewing how the network could be refreshed and strengthened. Links between learning disability specialists and mental health teams have significantly improved, resulting in increased requests for specialist advice and earlier support to clinical teams caring for patients with learning disabilities and autism.

FR presented a case study showing the impact of the Green Light approach, where a service user with a learning disability in mental health crisis was supported in a mainstream inpatient setting through a Green Light Champion, with specialist learning disability input and reasonable adjustments, enabling their planned discharge home.

FR outlined proposals to establish locality-based forums bringing together learning disability and mental health services, social care and other partners to identify barriers, coordinate support and

improve pathways for individuals whose needs sit across multiple services. The intention is to retain and strengthen the Champions Network whilst improving its effectiveness and sustainability.

Adele Fox (AF) requested clarification regarding the current number of champions and what support was required to improve engagement.

FR advised that approximately forty champions remained active but attendance at network meetings has reduced significantly, with a disproportionate representation of corporate colleagues compared with clinical staff.

Nat McMillan (NMc) suggested that learning from the successful relaunch of staff networks elsewhere in the Trust could be used to inform the refresh of the Green Light Champions Network.

Caroline Johnson (CJ) agreed to meet FR to explore how the Executive Trio could support engagement with staff not currently involved in the network. CJ also noted that the Clinical Governance Group could help provide oversight and support more consistent embedding of learning within clinical practice.

Action – Caroline Johnson

Mark Brooks (MBr) acknowledged the importance of the Green Light programme in addressing health inequalities experienced by people with learning disabilities and autism, recognising ongoing challenges relating to poorer health outcomes, lower life expectancy and preventable deaths. He noted that the programme forms part of a broader Trust commitment to improving outcomes through partnership working, physical health initiatives, screening programmes and system leadership.

JB noted the significant value of the Champions Network and the need to consider how learning could become embedded within everyday practice rather than relying solely on champions. The importance of multidisciplinary working and shared ownership of care was also acknowledged.

It was RESOLVED to NOTE the Service User Story and the comments made.

TB/26/72 Chair's remarks (agenda item 7)

JB expressed appreciation for the ongoing support received since taking up the role as Chair and advised that the private Board meeting would include:

- Private Organisational Risk Register
- Complex clinical matters report
- West and South Yorkshire System updates
- Specialised Provider Collaboratives and partnership updates
- Well led update
- Financial forecast for 26/27

It was RESOLVED to NOTE the Chair's remarks.

TB/26/73 Chief Executive's report (agenda item 8)

Chief Executive's report

MB requested the report be taken as read and highlighted the following updates:

- The significant impact of the prolonged period of hot weather experienced across the region was acknowledged which created additional pressures across Trust services, particularly within inpatient environments. MBr confirmed that the Trust is actively exploring practical measures to mitigate the impact of periods of extreme heat.
- The Nottingham Maternity and Neonatal Review (Ockenden Report) is being considered albeit the services concerned are not directly provided by the Trust. Relevant learning will be reviewed through the Quality and Safety Committee and incorporated into existing governance arrangements where applicable.

- The latest LeDeR report (Learning from Lives and Deaths – People with a Learning Disability and Autistic People) has been published which has identified encouraging improvements, including increased life expectancy and a reduction in preventable deaths amongst people with learning disabilities. However, significant inequalities remain and there remains a need to ensure sustained focus on improving health outcomes of people with a learning disability.
- The National Quality Board has published a Quality Strategy for NHS-funded care in England, with oversight to be provided by the Quality and Safety Committee.
- National guidance concerning unauthorised access to patient records has been received and is being reviewed against existing Trust information governance arrangements.
- The NHS financial environment is increasingly challenging and sector-wide risks were acknowledged.
- The reorganisation of Integrated Care Boards (ICBs) continues and new structures and appointments are being established. System partner engagement remains positive.
- Demand across mental health inpatient services remains exceptionally high, creating sustained pressure on inpatient capacity and service delivery. There have been significant efforts by clinical and operational teams to manage demand.
- MBr reiterated the importance of improving the Trust's financial run rate in order to achieve future financial sustainability and maintain delivery of the planned financial position.
- MBr thanked Nick Phillips, Deputy Director of Facilities, who had recently left the organisation following many years of service. MBr noted his significant contribution to improving Trust facilities, estates and therapeutic environments for patients and staff.
- MBr also formally thanked Mike Ford (MF) ahead of his departure from the role of Non-Executive Director and Audit Committee Chair, recognising the expertise, constructive challenge and support he had provided throughout his tenure.

Margaret Kitching (MK) welcomed the renewed focus on personalised care approaches and stated that implementation of the Mental Health Personalised Care Framework will be monitored, reviewed and evaluated through the Quality and Safety Committee.

MK also sought assurance regarding future commissioning arrangements for Talking Therapies services, noting national expectations alongside reported challenges in funding growth in line with population demand.

MBr advised that South Yorkshire ICB had recently been subject to scrutiny by NHS England (NHSE) in relation to Talking Therapies performance and investment. Whilst Trust performance against recovery standards remained strong, delivery of national access targets continued to be affected by resource and investment limitations. The importance of ongoing dialogue with commissioners regarding future service provision was acknowledged.

NMc noted the national media coverage concerning inappropriate access to patient records and the need to maintain public confidence in the confidentiality and security of health records whilst ensuring staff understood their responsibilities and asked what actions the Trust had taken in relation to this.

MBr confirmed that targeted communications and reminders are being shared with staff, and additional controls are being reviewed to reduce the risk of inappropriate access to sensitive records.

Adrian Snarr (AS) added that work was underway to strengthen arrangements for managing access to high-profile patient records and to provide assurance through future Audit Committee reporting.

JB noted recent correspondence from NHS England regarding system financial performance and emphasised the importance of maintaining focused Board oversight of the Trust's financial trajectory highlighting, the increasing significance of the Trust's financial sustainability.

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

TB/26/74 Assurance and receipt of minutes from Trust Board Committees and Members' Council (agenda item 9)

Quality and Safety Committee 7 July 2026

Margaret Kitching (MK) provided an update following the Quality and Safety Committee on 7 July 2026:

- Assurance was received regarding business continuity arrangements at The Poplars. The Committee had noted the isolated nature of the service and the associated operational risks that would be present during the transition to future operational arrangements.
- Pressures within mental health inpatient services remain high with recent periods at OPEL 4 (Operational Pressure Escalation Levels). The Committee reviewed the mitigations in place, including the use of contingency arrangements including the occasional use of non-designated beds, and had been assured that robust actions were being taken to manage demand. Given the sustained operational pressures being experienced across services, the Committee agreed this remained an area requiring close oversight.
- An external review of community apparent suicides has been commissioned and was expected to conclude shortly. The findings, outcomes and any resulting actions will be reported through the Trust's governance framework.
- Progress on the development of the Equality, Diversity and Inclusion (EDI) dashboard was noted and the Committee requested further analytical information to support more meaningful scrutiny and strengthened assurance regarding performance trends and outcomes.
- There is continued focus on pressure ulcer prevention and management with extensive work being undertaken both locally and regionally to support improvement.
- The Committee received a presentation from the Health Inclusion and Tuberculosis (TB) Services team regarding work to reduce DNA (Did Not Attend) rates within migrant immunisation services. Early evidence suggested improvements in patient experience and engagement however longer-term outcomes will need to be monitored.

NMc sought clarification on the Trust's reported position as having the second highest level of seclusion nationally and expressed concern given the long-standing work to reduce prone restraint and restrictive practice.

MK advised that the Committee had discussed the issue in detail and is considering whether the data provided like-for-like comparisons, looking at underlying contributory factors and any cultural, environmental or practice issues. The Committee has supported an external review to provide independent scrutiny.

CJ confirmed that the review was due to conclude imminently and would inform a comprehensive improvement programme. Work was already underway to develop a more proactive restrictive practice function to support clinical teams, promote best practice, strengthen de-escalation and influence culture.

NMc sought assurance that action would not be delayed pending the external review.

CJ confirmed actions had been prioritised since her appointment, with work already underway to strengthen oversight and practice.

ST advised that regional and national peer discussions had informed understanding of comparative performance and best practice, with early analysis indicating multiple contributory factors requiring a structured response.

The minutes of the previous Quality and Safety Committee meeting of 9 June 2026 were noted.

Audit Committee 14 July 2026

MF provided an update following the Audit Committee on 14 July 2026:

- The Audit Committee requested a substantive report on executive and wider organisational management capacity. Although updates had been received through routine reporting, the Committee recognised this as a significant strategic risk and agreed that a detailed paper was required to provide assurance on leadership resilience, capacity and succession arrangements.
- An Internal Audit has been completed to review the Trust's risk management arrangements, which has received a "moderate assurance opinion". The findings are predominantly related to the consistent embedding of risk management processes at care group level. A revised Risk Management Procedure has been developed in response to the audit findings and addressed the recommendations raised through the review.
- The Committee considered a proposal to amend the Internal Audit Plan in response to recent national concerns relating to inappropriate access to patient records. The Committee expressed reservations, questioning the removal of an agreed audit for an issue not identified locally as high risk, and supported maintaining a risk-based approach to internal audit. AS confirmed that no changes to the Internal Audit Plan had been agreed.
- The Committee reviewed progress against the Trust's Systems Development Programme and agreed that future oversight of this work would be more appropriately aligned with the proposed Transformation Innovation and Sustainability Committee (TISC) rather than continuing solely through the Audit Committee.
- MBr noted that the Trust received positive assurance regarding medical devices servicing and maintenance arrangements and a measure would be added to the Integrated Performance Report.

The minutes of the Audit Committee meeting held on 12 June 2026 were noted.

<u>People and Remuneration Committee 14 July 2026</u>
NMc provided a verbal update on key points from the last People and Remuneration meeting held on 14 July 2026:

- The Committee received assurance that concerns raised previously regarding completion of the Collective Workforce Agreement has been resolved following work undertaken by the relevant teams.
- The Committee discussed bank staff expenditure, workforce efficiency and performance against planned trajectories, agreeing to continue monitoring. If the Trust remains off trajectory by September, a detailed review will be undertaken to identify causes and consider further actions or contingency measures to support workforce and financial objective. A positive presentation from the relaunched staff networks was received, and the Committee welcomed the progress, enthusiasm and engagement of network chairs, and noted the additional support available and the networks' contribution to equality, diversity, inclusion and staff voice.

MBr stated that bank expenditure should not be viewed in isolation and emphasised the importance of considering overall workforce expenditure and staffing. The reduction of bank usage was not solely a financial objective, but should be considered alongside quality, continuity of care and patient safety.

MK supported this position, noting the importance of balancing financial considerations with quality and operational pressures.

JB requested assurance that equality, diversity and inclusion considerations were becoming embedded within Committee discussions and work programmes and work plans had been reviewed to ensure ongoing oversight of relevant issues.

MBr suggested that a formal review should be undertaken after six months to assess how equality, diversity and inclusion considerations had been integrated across the Board committee structure.

Action: Izzy Worswick

Audit planning, estates reporting, accessibility and risk management processes would also provide opportunities for equality and inclusion considerations to be incorporated across other committee portfolios.

The minutes of the People and Remuneration Committee meeting held on 5 May 2026 were noted.

Finance, Investment and Performance Committee 20 July 2026

Gary Ellis (GE) provided an update following the Finance, Investment and Performance Committee meeting held on 20 July 2026.

- NHSE has advised that systems nationally are forecasting a significant overspend position and that considerable emphasis is being placed on recovery planning and financial discipline across organisations and systems. Discussions at national and regional level continue to focus on strengthening organisational accountability and financial autonomy.
- The Committee reviewed the Trust's current financial position and noted that, at the end of Quarter 1, the Trust remained broadly on plan. However, the current financial trajectory remains fragile and maintaining financial balance will become increasingly challenging.
- Workforce expenditure and pay-related pressures continue to represent the most significant area of financial volatility. The Committee reviewed the impact of staffing costs, including bank staffing expenditure, and considered the wider implications for delivery of the Trust's financial plan.
- Financial pressures arising from Provider Collaborative arrangements and the continued delivery of the Trust's Value for Money (VFM) programme were noted. Progress against the programme remains on track and the Committee recognised that a significant level of delivery risk remains attached to the achievement of planned savings and efficiency targets.
- Whilst the Trust remains close to plan at this early stage of the financial year, immediate and sustained action is required to reduce the Trust's financial run rate and secure delivery of a balanced financial position.
- The Trust's capital programmes were reviewed, including Older People's Service transformation with progress noted on contractual arrangements, affordability and establishing a guaranteed maximum price. Revised costs are expected to exceed the approved regional business case, requiring formal Board approval before contracts are finalised.

MBr highlighted the continuing challenge associated with NHS pay awards and the impact of national funding arrangements for mental health and community providers. The Trust was required to absorb significant additional pay costs that were not fully funded through national allocations, creating a substantial recurring financial pressure. These unfunded cost increases represented a significant proportion of the Trust's current deficit challenge and further reinforced the need for continued focus on financial sustainability and productivity improvements.

MBr confirmed that correspondence had been received from NHSE and NHS regional leadership regarding organisational financial performance and accountability. MBr stated that the Trust continued to be regarded as a relatively lower-risk organisation and proposed that a revised financial delivery plan be developed with a revised trajectory aimed at returning the Trust to a break-even position. Maintaining proactive oversight of financial performance would be essential given the increasing challenges facing the wider NHS sector. The Board supported the proposal.

Action – Adrian Snarr

The minutes of the Finance, Investment and Performance Committee meeting held on 22 June 2026 were noted.

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

TB/26/75 Risk and Assurance (agenda item 10)

TB/26/75a Board Assurance Framework (agenda item 10.1)

Dawn Lawson (DL) advised that the Board Assurance Framework (BAF) had been reviewed as part of the Trust's planning process to ensure alignment with the Trust's strategic objectives, values and organisational priorities, whilst incorporating feedback and stakeholder perspectives.

IW summarised the key areas of focus:

- The BAF has been updated to incorporate the Trust's risk appetite statement, approved by the Board in March 2026 and provided a clearer assessment of whether individual strategic risks were operating within, or outside, the Board's agreed appetite for risk.
- The BAF has undergone a comprehensive quarterly review and individual discussions took place with Executive Directors to ensure all information remained current and accurately reflected the Trust's operating environment.
- The BAF was reviewed and discussed in detail at the Executive Management Team meeting on 9 July 2026.
- Consideration has been given to the reorganisation of ICBs, the development of Place Provider Partnerships, sustained operational pressures across services, increasing financial constraints and the implications of the updated NHS Oversight Framework for 2026/27.

MF welcomed the continued development of the framework and the inclusion of risk appetite information. He suggested future reports provide a clearer visual indication of how each strategic risk aligned with the Board's agreed risk appetite, to help identify areas outside tolerance. IW noted that further detail had been included in the appendices and agreed to explore further presentation refinements in future BAF reports.

Action – Izzy Worswick

JB acknowledged the considerable detail contained within the report and commended the comprehensive nature of the work undertaken.

It was RESOLVED to APPROVE the proposed updates to the Board Assurance Framework.

TB/26/75b Corporate / Organisational Risk Register (agenda item 10.2)

IW presented the Organisational Risk Register (ORR) and advised that following the last presentation of the risk register at Trust Board in April 2026, a full review of risks, controls and actions had taken place with Executive Directors in May and June 2026. A detailed review of the ORR took place at the Executive Management Team (EMT) meeting on 9 July 2026. IW provided a summary of the review:

- EMT identified several emerging risks requiring further consideration, including the implementation of revised national nursing job profiles and the potential impact of future consultant industrial action, and agreed that emerging risks would be developed and brought through the Trust's risk management process once further detail and assessment had been completed.
- EMT also considered the Freedom to Speak Up risk and whether the likelihood score could be reduced in light of current mitigations and progress. EMT had recommended that the existing risk rating should remain unchanged at this stage.
- A number of technical changes had been made to the risk register following implementation of the Trust's revised risk appetite statement. Several risks had been realigned to new risk categories, resulting in consequential changes to risk appetite scores. These reflected changes in categorisation rather than changes in the underlying risks themselves.
- The Organisational Risk Register contained thirty two organisational risks, consistent with the previous quarter. The highest concentration of risks remained within the quality domain, reflecting the Trust's continuing focus on patient safety, quality of care and service delivery.

Risk 1839 – Lack of provision across the system prevents transferring people that are clinically ready for discharge.

GE questioned whether the likelihood rating for delays in transferring patients clinically ready for discharge reflected persistent Trust and system pressures and whether the risk likelihood should be 'almost certain' rather than 'likely'. AF noted that, while delayed discharges represented a small proportion overall, some areas, particularly learning disability inpatient services, experienced delays as highly likely due to limited community placements and wider system constraints. MBr added that, although statistical likelihood remains quite low across all services, the impact on affected individuals could be significant, particularly for vulnerable patients. It was agreed that EMT would review whether the risk description, measurement and likelihood assessment for risk 1839 adequately reflected system pressures and patient impact in the next review of the ORR.

Action: Adele Fox

Risk 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.

NMc referred to recent discussions within both EMT and the Audit Committee regarding the Freedom to Speak Up risk and welcomed the recommendation not to reduce the risk score at the current time. The Board agreed that consideration should be given to incorporating learning from the culture review commissioned by the People and Remuneration Committee within the controls and assurance arrangements for this risk.

Action: Izzy Worswick

Risk 1888 - Risk that individuals do not feel safe from sexual harm whilst being cared for, working for, or visiting the Trust.

GE stated that the current risk combined two distinct issues—patient safety and staff safety—and questioned whether it required separate consideration and management arrangements. The Board agreed that whilst there were common themes across the risk, the controls, mitigations and risk profiles for staff and patients could differ significantly. Following discussion, it was agreed that Executive leads consider whether splitting the risk into separate components would provide better oversight and assurance and bring any recommendations back to Trust Board.

Action: Caroline Johnson/Christine Brereton

Following review, Trust Board approved the proposed changes to the Organisational Risk Register.

It was RESOLVED to CONFIRM that Trust Board are ASSURED that current risk levels are appropriate, considering the Trust risk appetite, and given the current operating environment.

In addition, Trust Board RESOLVED to 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.

TB/26/75c Equality, Diversity and Inclusion Annual Report (agenda item 10.3)

Dawn Lawson (DL) presented the Equality, Diversity and Inclusion (EDI) Annual Report for 2025/26 and the Integrated EDI Single Operational Plan.

- The report represented the first annual report following approval of the Trust's new EDI Strategy and provided an overview of progress against the strategy's six objectives, together with plans for 2026/27 and compliance with the Public Sector Equality Duty.
- Further work is required, with delivery to be maintained through a single integrated EDI operational plan for the coming year.

NMc reflected on the progress made over the previous year and suggested developing a more visual and accessible summary of EDI achievements, drawing on examples from other organisations where annual reports had successfully combined key metrics. This could support wider communication and engagement across the organisation and demonstrate how EDI activity was making a tangible difference to staff and service users.

MK also noted the importance of ensuring that equality and health inequality considerations remained embedded within the Trust's governance framework and suggested consideration be given to developing a more integrated method of monitoring outcomes and demonstrating progress.

DL welcomed these suggestions and agreed that further consideration would be given to how equality and health inequality measures could be incorporated into the developing suite of organisational metrics.

Action: Dawn Lawson

AF noted the considerable amount of EDI activity taking place across the Trust. She highlighted examples of work undertaken with deaf communities, minority communities and other protected groups where interventions often had a significant positive impact on patient and staff experience.

MF sought clarification regarding the relationship between the strategic objectives set out within the report and the supporting delivery plans.

DL explained that the six objectives represented the key areas of delivery arising from the wider EDI strategy which had been developed to provide greater clarity and accountability for implementation.

MBr acknowledged the significant progress that had been made over recent years however, staff survey findings continued to demonstrate inequalities in experience for some groups, particularly colleagues from ethnic minority backgrounds, disabled staff and LGBT+ staff. Whilst progress should be recognised and celebrated, the Trust must maintain a sustained focus on addressing these ongoing disparities.

Christine Brereton (CB) added that the annual report was supported by a detailed EDI action plan, overseen through the People and Remuneration Committee, which provided a more detailed level of scrutiny regarding workforce experience and performance data.

JB welcomed the report's balance between celebrating achievements and identifying further improvement. She suggested future reporting include qualitative evidence and personal experiences, alongside performance data, to better demonstrate the impact of EDI initiatives on staff and service users.

Action: Dawn Lawson

It was RESOLVED to APPROVE the Equality, Diversity and Inclusion Annual Report.

TB/26/75d Infection Prevention and Control BAF (agenda item 10.4)

CJ presented the six-monthly Infection Prevention and Control Board Assurance Framework (IPC BAF) report and confirmed that the Trust remained compliant with nine of the ten national infection prevention and control assurance criteria.

- The only area of partial compliance related to FFP3 fit testing. CJ explained that full compliance was challenging for mental health and community providers, as many community staff do not routinely undertake aerosol-generating procedures or require FFP3 masks. The Trust has therefore taken a proportionate, risk-based approach, prioritising fit testing for inpatient and clinical areas where aerosol-generating procedures, resuscitation or other higher-risk interventions may occur.
- CJ confirmed that robust business continuity and preparedness arrangements were in place for future infectious disease outbreaks or pandemic situations, with assurance previously

reviewed through the Quality and Safety Committee. Staff groups routinely undertake aerosol-generating procedures, including specialist clinical services, and are fully compliant. The non-compliance rating therefore related only to staff groups for whom universal fit testing would have limited practical benefit.

It was RESOLVED to RECEIVE the Infection Prevention and Control BAF.

TB/26/75e Safer Staffing report (agenda item 10.5)

CJ presented the Safer Staffing Report and advised that the report provided assurance regarding staffing levels across Trust services as well as an update on the ongoing establishment review programme.

- The report represented an interim position and a further, more detailed report would be brought to the Board following completion of additional work arising from the recent Mental Health Optimal Staffing Tool (MHOST) reviews and wider workforce transformation activity.
- CJ confirmed that the Trust had completed the first full cycle of MHOST reviews across mental health inpatient services. The reviews identified no immediate patient safety concerns, with clinical fill rates consistently above 90%, providing assurance that current staffing models supported safe care. However, while establishments were assessed as safe, some did not fully reflect increasing patient acuity and complexity, resulting in continued use of temporary staffing to support enhanced observations and complex clinical presentations.
- The greatest staffing pressures continued to be experienced within forensic services, working age adult wards, Psychiatric Intensive Care Units (PICUs) and older people services. Investment has previously been made to strengthen substantive staffing establishment within working age adult and PICU services and further work is underway to understand future workforce requirements within forensic services.
- CJ added that a wider review was considering how multidisciplinary care models, including Allied Health Professional input, peripatetic staffing, enhanced ward-based therapeutic support and New Models of Care, could better support service delivery.
- Findings from the MHOST reviews and wider workforce and service redesign work will inform a comprehensive analysis and recommendations will be reported through the appropriate governance process later in the year.

It was RESOLVED to RECEIVE the Safer Staffing report.

TB/26/75f National Staff Standards (agenda item 10.6)

CB presented the new NHS Staff Standards, launched by NHSE on 6 July 2026, and advised that they had been introduced to establish a consistent national framework for measuring and improving staff experience across NHS organisations.

- The framework comprises six core standards, each supported by a series of assessment criteria against which organisations will be expected to evaluate their performance.
- CB reported that the Trust is well placed to respond, with staff experience already reflected in the People Strategy and annual priorities on safe, healthy workplaces and compassionate, inclusive leadership. Much of the required work is already underway, with the new framework providing a structured way to assess and evidence delivery.
- A key first-year requirement will be a self-assessment against the six standards, using evidence such as Staff Survey results, People Promise measures, workforce metrics and wider staff experience data.
- It was proposed that detailed oversight of the implementation programme should be undertaken through the People and Remuneration Committee (PRC), with regular reports provided to the Trust Board. A further update would be brought to the Board in December 2026 outlining progress against the self-assessment framework and implementation plan.

Action: Christine Brereton

- CB advised that a communications and engagement plan was currently being developed in partnership with Staff Side colleagues. Initial engagement would commence through the

extended Executive Management Team before being cascaded more widely across the organisation.

MF sought clarification regarding the relationship between the new Staff Standards and existing frameworks, including the NHS People Promise.

CB explained that the Staff Standards were not intended to replace existing workforce frameworks but instead acted as an overarching assurance framework that brought together evidence from a range of existing programmes and metrics. The standards would therefore provide a mechanism for assessing organisational performance rather than creating a separate set of requirements.

MF noted that there appeared to be no explicit reference to Freedom to Speak Up within the published framework and queried how this important aspect of workforce culture would be reflected.

CB advised that the ability of staff to speak up, raise concerns and feel psychologically safe was intrinsically linked to several of the six standards and would therefore form an important part of the supporting evidence used during the self-assessment process.

It was RESOLVED to RECEIVE the National Staff Standards and APPROVE the proposal for assurance and oversight through the People and Remuneration Committee.

TB/26/75g NHS Leadership and Management Framework (agenda item 10.7)

CB presented the NHS Leadership and Management Framework, launched by NHSE on 6 July 2026 alongside the NHS College of Leadership and Management.

- The framework sets national leadership and management standards to support consistent behaviours, accountability, development and self-assessment across NHS organisations.
- CB reported that initial implementation had begun, with information published on the Trust intranet and incorporated into leadership and management development programmes.
- The Trust is considering how to embed the framework within existing people management, appraisal and self-assessment processes, including potential alignment with the People Management Essentials programme.
- It is proposed that oversight of implementation should sit with the People and Remuneration Committee, with future reports being brought to the Board to demonstrate progress and assurance regarding adoption of the framework across the organization.
- CB confirmed that the framework is principally concerned with leadership and management behaviours, accountability and the effective management of people, rather than solely functional or technical expertise.
- The self-assessment process is designed to support leaders in reflecting on how they lead teams, create positive workplace cultures and deliver organisational values through their leadership practice.

It was RESOLVED to RECEIVE the NHS Leadership and Management Framework

TB/26/75i Premises Assurance Model annual report (agenda item 10.9)

AS presented the Premises Assurance Model (PAM) Annual Report and advised that the PAM submission is a mandatory annual exercise for NHS providers and provides a comprehensive assessment of estate performance, statutory compliance, safety and infrastructure management. AS provided a summary of the key points to note:

- The Trust achieved a strong overall position, with all principal domains assessed as either “Good” or “Outstanding”. The assessment comprised a large number of detailed criteria across multiple estate and facilities management domains and the Trust had performed consistently well across the vast majority of these measures.

- Almost all sub-domains within the assessment have achieved ratings of “Good” or “Outstanding”, demonstrating strong levels of compliance and assurance across estate management functions.
- A small number of domains achieved lower scores where further improvement work is required, although these remained close to the threshold for higher ratings.
- One of the principal areas affecting performance related to medical devices servicing and maintenance compliance. At the point where the PAM submission was completed, compliance levels had not yet reached the Trust’s desired standard, resulting in a reduction in scores.
- A limited number of reductions in compliance scores related to statutory inspections and authorised engineering arrangements and actions had already been implemented to address these issues and performance is continuing to improve.
- The report provided strong assurance regarding the safety, compliance and management of the Trust’s estate and that the submission reflected a positive position across the organisation.

MBr requested clarification regarding the external peer review process associated with the PAM submission.

AS advised that peer reviews are undertaken as part of the national assurance process and involve comparison against other NHS organisations, including mental health providers. Previous peer reviews had not identified any significant concerns regarding the Trust’s self-assessment or performance ratings and that external feedback had been consistently positive.

JB sought clarification regarding the significance of "yes/no" responses within the PAM process and how these contributed to overall scoring.

AS explained that some questions within the PAM framework are binary in nature and can result in a "fail" response even where the overall level of assurance remains high. These responses are subsequently incorporated into the wider assessment methodology to provide a balanced overall picture of performance.

It was RESOLVED to APPROVE submission of the Premises Assurance Model annual report to NHS England.

TB/26/75j Patient led assessments of the care environments (PLACE) scores (agenda item 10.10)

AS presented the 2025 Patient-Led Assessments of the Care Environment (PLACE) results and advised that PLACE assessments are a nationally mandated benchmarking tool used by NHS organisations to assess and compare patient environments across a range of domains.

- AS advised the Trust has historically achieved strong PLACE scores, including some of the highest national rankings.
- The 2025 results showed a slight overall deterioration, largely due to the inclusion of Cheswold Park Hospital. Therefore, the report separated Cheswold Park results from wider Trust scores in order to clarify performance and identify site-specific issues.
- A £6m Estates Safety Fund programme will support refurbishment of parts of the site and make a significant contribution to improving the environment for patients and staff.
- AS added that the Dales Unit scored slightly below the Trust average, reflecting its leased building and comprehensive facilities management arrangements, which limited direct Trust control over some environmental factors. Discussions are underway with partners to identify improvement opportunities.
- Food quality and catering continued to be key factors influencing patient feedback and work is ongoing to respond to comments regarding menu choice, portion sizes and nutritional support, including strengthening dietetic input where appropriate.

MBr stated that PLACE results were an important source of intelligence but should be considered alongside patient feedback, complaints, quality metrics and other service user experience data to provide a fuller understanding of patient needs and priorities.

DL noted that similar themes regarding food quality, catering and the role of food in supporting recovery had also emerged through wider equality and patient experience reporting. The consistency of this feedback reinforced the need for ongoing focus and improvement in this area.

It was RESOLVED to RECEIVE the Patient led assessments of the care environments (PLACE) scores.

TB/26/76 Performance (agenda item 11)

TB/26/76a Integrated Performance Report (IPR) month 3 2026/27 (agenda item 11.1)

AS provided a summarised review of the Integrated Performance Report and noted the following highlights:

- There has been continued progress in relation to reducing prone restraint.
- The number of Information Governance breaches reported during the month has reduced to six, representing the lowest monthly figure for a significant period. This reflects the impact of ongoing quality improvement work however it was too early to determine whether this represented a sustained trend.
- The report included the newly developed health inequalities reporting section which contained a prototype dashboard rather than live performance data.
- Sickness absence has increased marginally to 5.3% in month, taking performance outside the Trust's target range. Further analysis is underway to understand the contributing factors, including the balance between short-term and long-term sickness absence.
- Staff appraisal compliance is 93.5%, though performance may fluctuate as the new appraisal system and transitional arrangements take place.
- Paediatric audiology waiting times were reported at 96.9%, significantly above national requirements and showing sustained improvement
- The Trust is delivering its planned financial position, however the underlying position remains pressured.
- Workforce expenditure remains the most significant area of financial volatility with approximately £5 million of the Value for Money Programme classified as high risk.
- There are continued financial and operational pressures within the Specialist Provider Collaboratives. Referral rates across both West Yorkshire and South Yorkshire continued to place pressure on commissioned specialist placements and service capacity. Opportunities are being explored to support improved utilisation of available capacity whilst maintaining safe care standards and responding effectively to commissioning pressures.

AF reported continued positive progress in the CAMHS (Children and Adolescent Mental Health Services) service, with sustained improvement in access following targeted quality improvement work. However, significant pressures remained across mental health inpatient services demonstrating sustained pressure across acute mental health pathways.

AF added that despite increasing demand and capacity challenges, staff remained committed to maintaining care standards and performance.

CJ reported positive movement in risk assessment and care plan performance, noting that improvement pilots are in place and are showing results in the areas where they have been implemented.

MBr raised the following points following the review of the IPR:

- There were three deaths in the community reported, emphasising the need to understand and learn from these events to improve safety for the future.

- Supervision rates have been impacted due to a recent change in approach, which has affected completion levels.
- Out-of-area bed usage averaged around four per day, which is among the lowest nationally.. There was slight increase in out of area placements last month, attributed to high demand.
- The percentage of clinically ready for discharge patients is 4.3% and requires continuous focused attention due to its operational impact.

MK raised a question about whether occupancy is routinely calculated excluding patients on leave, and whether this is a local or national practice.

MK highlighted concerns about quality and safety impacts when patients on Section 17 leave return and no beds are available, leading to placement elsewhere.

MBr advised that both occupancy metrics (excluding and including leave) are measured locally and suggested that both should be included in dashboard reporting for clarity and assurance.

Action – Adele Fox

NMc asked about the recent admission of an under 18-year-old to an adult ward, referencing the governance and safeguarding processes in place and requested clarification on why this occurred, whether it is likely to become more common, and how the Trust ensures the young person's experience and outcomes are safeguarded beyond basic safety measures.

AF confirmed that such admissions are a last resort, only occurring when no suitable alternatives are available. The specific case involved a one-day admission to manage the young person safely until a transition could be arranged. The situation has improved compared to previous years, with fewer such admissions, largely due to improvements at Red Kite View in Leeds.

Subha Thiyagesh (ST) noted previous Board requests to strengthen how feedback from young people admitted to adult wards was captured and reviewed, recognising the challenges of obtaining meaningful feedback in such circumstances.

CJ advised that work had updated its reporting of supervision requirements across the Trust. Engagement with operational leaders was supporting a consistent approach to recording, and recent variation in reported compliance reflected improved recording practice rather than reduced supervision activity.

Martin Neeson (MN) raised a question regarding the capital investment planning for Poplars and whether the issues regarding design status and requirements alignment have been resolved.

AS confirmed that the contractor is now determining final pricing and it is expected that costs will be higher than the original business case, and that the final value will come back to the Board for approval. Construction activities are planned to start in November 2026, and the financial plan will align with the updated start date.

Following recent discussions in the Commissioning Committee, MN asked whether estate capacity at Cheswold Park Hospital could be adjusted in response to demand. MN emphasised the need for the Cheswold work to progress at a faster pace and questioned how the optimum staffing model and environmental restrictions would be integrated to maximise bed usage and address regional pressures.

AS stated that there are two strands of work underway: one on long-term medical staffing requirements to support current and expanded capacity at Cheswold Park, and another on determining the optimal bed base across the secure estate (including Cheswold, Newton Lodge and the Bretton Centre). The current focus is on aligning the use of learning disability (LD) secure beds with demand, potentially freeing capacity for other pathways, particularly given under-occupancy in LD wards and pressures elsewhere.

AS advised that he was working with AF to ensure provider and commissioner perspectives are integrated, with plans to share outcomes with regional partners.

AS agreed that while internal mobilisation is progressing, it needs to accelerate, and that as the largest provider, the Trust should drive pace while respecting commissioning boundaries.

It was RESOLVED to NOTE the Integrated Performance Report and the associated comments.

TB/26/77b Care Group Performance Report (agenda item 11.2)

AF provided a summary of the Care Group Performance Report for the Barnsley Physical Health and Wellbeing Care Group:

- There has been a consistently strong level of performance across the Care Group despite increasing demand and ongoing operational pressures.
- There has been continued increase in demand across a number of community-based services, including Urgent Community Response (UCR) and Musculoskeletal (MSK) services. However, the Care Group continue to achieve its key performance targets and maintain timely access to services.
- Sickness absence levels increased slightly within the Care Group due to a combination of short-term absences and a number of longer-term absences relating to serious health conditions.
- Workforce turnover has reduced compared with previous periods. Recruitment and retention arrangements remain effective, enabling services to maintain staffing levels and service delivery.
- Supervision performance has been affected by the Trust-wide changes to recording and reporting arrangements. There are no concerns regarding the level of supervision being provided.
- There has been continued strong performance within Paediatric Audiology services and plans are in place to manage anticipated seasonal fluctuations and maintain performance during periods of increased leave and reduced attendance.
- Safer staffing arrangements remain robust, with no concerns regarding patient safety identified.
- There is continued focus on pressure ulcer reduction and prevention with close monitoring and transparent reporting arrangements in place to ensure clear oversight of pressure ulcers that developed whilst patients were receiving Trust care.

NMc highlighted Barnsley Care Group's consistently strong performance, noting its ability to manage challenges effectively, including rising demand and sickness rates and asked what could be learned from Barnsley's approach and whether its success could be replicated across other care groups. DL explained that Barnsley's success was partly due to having a single contract and Commissioner, with clear outcomes and annual performance conversations. It was also noted that Barnsley has a different service user group and benefits from constant director-level learning and sharing of best practices across care groups.

AS added that Barnsley was the first locality to complete a loss-making service review, demonstrating clear decision-making and action planning, which has been used as a model for other care groups.

Following a recent visit to services in Barnsley, JB noted that Barnsley's leadership quality, integrated working across organisations and clear vision were evident and suggested raising the profile of Barnsley's work as an example for the wider organisation. Teams are able to articulate clearly their service journey, improvement work and achievements, suggesting a strong culture of ownership, innovation and continuous improvement.

It was RESOLVED to RECEIVE and NOTE the care group report for the Barnsley care group.

TB/26/78 Integrated Care Systems and Partnerships (agenda item 12)

TB/26/78a South Yorkshire update including South Yorkshire Integrated Care System (SYICS) (agenda item 12.1)

MBr provided an update on South Yorkshire and advised:

- South Yorkshire ICB is progressing through a significant organisational restructuring programme in response to national requirements to reduce operating costs.
- The ICB has undertaken two voluntary redundancy processes. A number of senior and experienced personnel have already left the organisation, and recruitment to the new reduced organisational structure is continuing.
- The newly constituted ICB Board has now commenced operation and is noted to be significantly smaller than the previous Board structure. A number of key leadership positions remain subject to ongoing recruitment processes and are expected to be finalised over the coming months.
- The South Yorkshire ICB is broadly on track financially.
- The Trust continues to be involved in the development of Place Provider Partnerships and wider sector partnership working across South Yorkshire. Work is underway to establish revised governance arrangements and strengthen provider collaboration.

In relation to Barnsley, DL provided an update and advised:

- The Barnsley Provider Collaborative has been formally established and is operating under interim governance arrangements. DL advised MBr will assume the role of Chair for a 12-month period, supporting the partnership as it moves from establishment into delivery.
- Three initial priority workstreams have been agreed:
  - Hospital at Home
  - Neighbourhood Development
  - Discharge Improvement
- DL is leading the Neighbourhood Development workstream and is actively contributing to delivery across all three programme areas.
- Partnership development will initially focus on developing the work programmes, building relationships and delivering practical improvements before finalising more formal governance arrangements and partnership documentation.
- Leadership changes are also taking place within partner organisations and are expected to support continuity and maintain strong partnership relationships across the Barnsley system.
- Workstreams are now operational and progressing positively with a focus on delivering tangible improvements through collaborative working and strengthening integration across health and care services within Barnsley.

It was RESOLVED to NOTE the South Yorkshire Integrated Care System and Barnsley Place updates.

TB/26/78b 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 (WYHCP), associated place-based partnerships and the Mental Health, Learning Disability and Autism Collaborative:

- Recruitment to the revised West Yorkshire ICB leadership structure is progressing. The outcome of the recruitment process for the Chief Executive role has not yet been announced.
- Broader organisational restructuring is continuing and will result in changes to place leadership arrangements in Calderdale, Kirklees and Wakefield

- West Yorkshire recently hosted a visit from Professor Claire Fuller, National Lead for Primary Care and Neighbourhood Health Services, to review developments relating to neighbourhood working and integrated care.
- A number of priorities are currently being addressed through the West Yorkshire Mental Health, Learning Disability and Autism Collaborative, including the delivery of the Mental Health Investment Standard as well as work on eating disorder services.
- Place Provider Partnerships across Calderdale, Kirklees and Wakefield are currently operating in shadow form. Meetings have commenced and partnership arrangements are developing positively. Formal governance arrangements and committee structures are expected to become more established over the coming months as the revised ICB structures and place-based partnerships become fully operational.

It was RESOLVED to NOTE the update on the development of Integrated Care Systems and Collaborations and NOTE the minutes of relevant partnership boards/committees.

TB/26/78c Specialised Provider Collaboratives and Alliances (agenda item 12.3)

AS provided an update on the West Yorkshire and South Yorkshire and Bassetlaw Provider Collaboratives and Alliances:

- NHS England requested assurance that all patients placed within St Andrew's Healthcare, Northampton, be reviewed with a view to identifying opportunities for repatriation closer to home. Four patients across the West Yorkshire and specialised commissioning footprint have been subject to this review process. One patient has already been successfully discharged into an appropriate community placement and a further discharge is planned for September 2026. Subject to the planned discharge proceeding as expected, it is anticipated that there will be no patients remaining within St Andrew's Healthcare by the end of September 2026.
- In relation to the South Yorkshire Provider Collaborative annual quality review programme, routine quality visits to providers have commenced and, to date, no significant concerns have been identified across the provider network. This included Cheswold Park Hospital and represented a significant improvement compared to the early stages following acquisition of the service.
- Regarding the future of specialised commissioning arrangements, AS advised that, whilst NHSE have not yet published formal proposals relating to the next phase of specialised commissioning, early indications suggested that providers will be expected to demonstrate collaboration at a Yorkshire and Humber footprint level. In anticipation of these developments, the Trust has already commenced preparatory work with partners across the region. Four key priority areas have been identified to strengthen collaboration and support future specialised commissioning arrangements. These include:
  - Development of a more aligned single point of access approach across the Yorkshire and Humber footprint.
  - Further collaboration across learning disability pathways, including consideration of opportunities where the Trust's role as a major regional provider could support improved pathway design and service integration.
  - Improved alignment and sharing of specialist service data across organisations.
  - Exploration of opportunities to reduce out-of-area placements, whilst recognising the additional complexity associated with specialised and secure services, including Ministry of Justice restrictions and individual patient requirements.
  - Initial analytical work has already been undertaken to understand patterns of out-of-area placements. However, further clinical engagement and analysis will be required before any significant changes can be implemented.

JB sought clarification regarding the extent of provider engagement across the proposed Yorkshire and Humber collaboration arrangements.

AS confirmed that all relevant NHS mental health providers across the region have participated in initial collaborative discussions, including a regional workshop held earlier in the year, and collectively agreed a series of actions designed to improve collaborative working and prepare for anticipated future commissioning requirements. Whilst enhanced collaboration presents significant opportunities to improve service pathways, patient flow and commissioning arrangements, any future redesign will need to be undertaken carefully and collaboratively. Ongoing engagement with providers remains a key aspect of the work programme and any future proposals will be developed in partnership across the provider network.

It was RESOLVED to NOTE the update on the Specialised Provider Collaboratives and Alliances.

TB/26/79 Governance (agenda item 13)

TB/26/79a Assessment against NHS Constitution (agenda item 13.1)

Izzy Worswick (IW) advised that the annual self-assessment against the NHS Constitution has been completed and reviewed in detail by the Executive Management Team. The assessment considered how the Trust demonstrates compliance with the principles and commitments of the NHS Constitution and how these are reflected in the planning, delivery and development of services.

A number of updates have been made since the previous submission:

- Strengthening the narrative relating to the increasing use of data and intelligence to understand inequity and inform service improvement activity.
- The Trust's Equality, Diversity and Inclusion governance arrangements and the implementation of the Trust's People Strategy, including developments relating to workforce experience and inclusion.
- Significant work undertaken to improve paediatric audiology waiting times, ensuring compliance with national standards.
- Overall, the assessment provided assurance that the Trust remained compliant with the key requirements of the NHS Constitution and continued to embed its principles across both patient care and workforce practices.

MF queried whether the areas recorded as "not applicable" within the assessment reflected the Trust's own interpretation and whether any external assurance mechanisms existed to test the robustness of the assessment.

IW explained that the assessment was currently an internal self-assessment undertaken by the Trust to demonstrate compliance with the Constitution. It was not routinely subject to external audit or formal validation by NHSE. However, many of the areas covered within the assessment were subject to assurance through other governance and regulatory mechanisms across the organisation.

It was RESOLVED to RECEIVE and APPROVE the Assessment against NHS Constitution.

TB/26/79b Transformation, Innovation and Sustainability Committee Terms of Reference and Workplan (agenda item 13.2)

DL presented the Terms of Reference and initial work programme for the proposed Transformation, Innovation and Sustainability Committee (TISC), which would provide dedicated Board oversight of strategic transformation, innovation, sustainability, digital developments, emerging technologies and system-related opportunities not fully covered by existing committees.

The Committee will support consideration of the Trust's medium and longer-term strategic direction and strengthen alignment between organisational strategy, partnership developments and innovation activity. The proposed Terms of Reference and accompanying work programme have been developed to address identified governance gaps whilst avoiding duplication with the responsibilities of existing Board Committees.

MF welcomed the proposal and suggested that Tony Wright, Sustainability Change Manager, be formally identified within the Committee arrangements as an attendee or advisor when relevant agenda items were being considered. DL agreed that the documentation should be amended to reflect appropriate specialist input to the Committee.

Action – Dawn Lawson

MF also suggested that oversight of the Systems Development Programme, currently reported through the Audit Committee, would be more appropriately aligned with the remit of the new TISC Committee. DL agreed and confirmed that future reporting arrangements would be reviewed as part of implementation of the Committee structure.

Action: Dawn Lawson

MK questioned whether annual reporting on the Older People's Transformation Programme would provide sufficient oversight, given its links to organisational risks, or whether more frequent reviews were needed. DL noted the need to avoid duplication with other Committees where operational and performance matters are already scrutinised and agreed that reporting frequency will be reviewed as the Committee and work programme developed.

MF highlighted the importance of ensuring that annual reviews of Committee effectiveness were scheduled appropriately within the work programme to allow sufficient time for reporting through the Trust Board and Audit Committee governance cycle.

DL advised that digital transformation activity was anticipated to be reported twice yearly through the Committee and agreed that this should be clearly reflected within the proposed work programme.

Mitch Waterman (MW) noted that there appeared to be some overlap between elements of the proposed Committee remit and the work undertaken through the Trust's partnership arrangements with academic organisations and universities.

DL agreed that effective communication and coordination between the various governance forums would be required to ensure alignment and avoid duplication of effort.

JB noted that the proposed membership was relatively small and highlighted the importance of maintaining attendance levels to ensure the Committee could operate effectively and consistently meet quorum requirements.

It was RESOLVED to RECEIVE the Transformation, Innovation and Sustainability Committee Terms of Reference and Workplan.

TB/26/80 Strategies and Policies (agenda item 14)

TB/26/80a Trust Strategy Measurement (agenda item 14.1)

DL presented the first annual update on the Trust Strategy Measurement Framework, which assessed progress against the Trust Strategy and provided assurance on Board leadership of strategic objectives.

- This is the first full year of applying the framework, it has been developed collaboratively to support ongoing review of strategic delivery, achievements and areas for further development.
- The framework shows strong progress against the Trust's first two strategic objectives and alignment between organisational activity and strategic priorities. It highlights opportunities to define future ambitions, strengthen delivery plans and support ongoing learning, development and continuous improvement.
- The framework will continue to evolve and inform Board discussions throughout the year, rather than operate solely as an annual report.

DL added the review incorporated feedback from external system partners, providing an additional perspective on the Trust's performance and contribution within the wider health and care system.

It was RESOLVED to RECEIVE the Trust Strategy Measurement.

TB/26/81 Trust Board work programme for 2026/27 (agenda item 15)
The Trust Board work programme for 2026/27 was noted.

It was RESOLVED to RECEIVE the work programme.

TB/26/82 Any other business (agenda item 16)
No further business.

TB/26/83 Date of next meeting (agenda item 17)
The next Trust Board meeting in public will be held on Tuesday 29 September 2026 at Cheswold Park Hospital, Doncaster.

Signature:

Date:

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29 September 2026
Agenda item 9

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.	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:	Positively the Trust has retained its segment 1 rating in the Quarter 1 NHS Oversight Framework (NOF) ratings. This is strong recognition of our performance across a notable range of measures and is a real credit to colleagues across all services. It is recognised, particularly given the financial pressures we face, that it will be challenging to maintain this rating. Nevertheless, we remain committed to continuing our focus on improvement to support our NOF rating on a sustainable basis. The Trust has received notification from NHS England (NHSE) that having reviewed operational plans and the current plan delivery position, our Trust has been identified as lower risk and therefore we will not require a face-to-face mid-year review with the NHSE regional leadership team. Following on from its introduction last year all Trust Boards are required to complete a provider capability assessment. This has been developed building		

	on what we learnt from last year's submission and has received helpful input from both executive and non-executive directors. It is presented to the Trust Board for approval today. Our preparations for Winter are progressing. This includes our annual flu vaccination campaign, which is being led by our Chief Nurse, Caroline Johnson. We have engaged with a range of Trust leaders and colleagues to understand what worked well last year and where we could improve. This feedback has been considered to inform this year's vaccination programme. Trust Board papers also include our Winter Planning Board Assurance submission. The 2026 NHS staff survey has now opened. The Trust has a good record of engagement and has achieved some positive results in recent years. We very much value the feedback provided from the staff which enables both Trust and team led improvement initiatives to take place. Board members will be kept appraised of the progress being made. The Trust's financial position remains challenging with a deficit of £2.2m recorded at the end of month 5. The main contributory factors to the deficit are the unfunded pay increase, workforce pressures in operational services and the adult secure provider collaborative. Further grip and oversight are taking place to drive a reduction in our run rate without adversely impacting on service quality. The process relating to the previously reported Mutually Agreed Resignation Scheme (MARS) has moved to the next stage. Following agreement at the People & Remuneration Committee, formal approval is now being sought from NHS England. Baroness Casey of Blackstock who is leading a review on social care has launched 'The Big Conversation on Care'. Between now and April 2027, The Big Conversation will give people across England the opportunity to say what they want and expect from a future National Care Service, including who it should support, what families should reasonably be expected to do, and how the country should pay for care in a fair and sustainable way. A link is provided for Board members to access. The Big Conversation on Care | The Casey Commission Lady Justice Thirlwall has recently published the final conclusions of her investigation into events at the Countess of Chester Hospital. Our thoughts are first and foremost with the babies and families affected by these terrible events. As with all such reports we will review in detail and identify any learning opportunities and recommendations for our Trust. Key themes include the requirement for well-functioning clinical governance, formal regulation of NHS managers, duty of candour and openness, focus on reputation, and approach to whistleblowing. Both South and West Yorkshire integrated care boards (ICB) are continuing to progress their move to new operating models following the implementation of their 50% cost reduction requirements. Many staff have now left the ICBs and the process to populate the new structures has been taking place during the summer months. This has understandably been a very challenging process and concerning time for many colleagues. At the time of writing this report a good proportion of roles specific to Calderdale, Kirklees and Wakefield have been

	filled, but the leadership roles for Calderdale and Kirklees remain outstanding. In West Yorkshire 615 colleagues are confirmed in post with a further 92 in a redeployment process considering suitable opportunities that remain within the ICB. At a senior level Jonathan Webb has been confirmed as the substantive chief executive for the West Yorkshire ICB and Julie Clennell has been appointed as chief nurse. Mel Brown who was previously the accountable officer for Wakefield has been appointed to the role of director of integration across Calderdale, Kirklees, and Wakefield. We look forward to continuing to work with each of them. The establishment of place provider partnerships continues to develop in each of our four places, and we are fully engaged in each of these. The period of operating in shadow in West Yorkshire has been extended to April 2028 which will provide more time to fully define the scope of services, contractual, finance and risk arrangements, and to ensure the implications of moving to new and very different ways of working are understood and effectively planned for. Our operational performance typically remains good with the Trust continuing to meet many national, local and internal targets. Despite significant demand pressures and challenges with specialist onward placements, out of area bed usage remains in low single figures and it is encouraging to note sustained improvements in access to CAMHS and paediatric audiology. Training compliance also remains consistently strong and the year of transition to the updated annual appraisal timescales has encouragingly seen 70% of colleagues complete their appraisal at the time of writing this report. Mention is also given to our customer services team who ensured 100% of complaints were completed within the national 6-month target in August. During September we held our annual members' meeting. The event was attended by over 50 people in-person and was also streamed on-line. I would particularly like to thank all of those involved in the organisation of what was a successful event, the market stall holders, and everyone who took the time to attend. The government has announced a major expansion of community mental health centres and dedicated mental health emergency departments (MHEDs) across England. 159 new centres will open across England starting from this autumn. This includes the creation of another 59 dedicated MHEDs and 100 centres based in communities. The aim of these being to catch problems early, so fewer people reach crisis point. Capital funding for a MHED has been approved for Barnsley and working groups have been established to consider the model for Wakefield and Calderdale. The Trust has recently commissioned a review into its female pathway. A draft report has been received and is initially being reviewed by the executive trio, and headlines will be shared with the Quality & Safety Committee at its October meeting. The final report will be shared with the Trust Board. The Medicines and Healthcare products Regulatory Agency (MHRA) has recently published guidance on the regulatory status of ambient voice technology (AVT) products. This guidance has been developed with input from NHS clinicians and patient safety advocates and provides greater clarity on how

	AVT products are regulated. This guidance will be incorporated into the Trust's processes for the use of AVT products. Every year the General Medical Council (GMC) conducts an annual training survey (ATS). Encouragingly the Trust has ranked 7th among all UK trusts which is testament to the dedication and hard work of all who contribute to and work in the postgraduate medical education team. This is excellent news for our reputation as a Teaching Trust. I would like to welcome Celia Weldon to her first Trust Board meeting as our new non-executive director. I am sure I speak on behalf of the rest of the Trust Board in looking forward to working with Celia and continuing the strong work of our Audit Committee. 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. • We were successfully awarded Triangle of Care Star 2 accreditation by Carers Trust. This accreditation reflects our continued commitment to listening to carers, involving them in decision-making, and ensuring their voices help shape services across the Trust. • Following on from my July report our catering managers Daniel French and Jake Fawcett secured their place in the finals of the NHS Chef of the Year 2026 competition by winning the Yorkshire/North East regional heat and will now participate in the national final at Edgbaston, Birmingham in October. • The Art Recovery and Creativity group at Newton Lodge recently received a commended award from judges at the Koestler Awards 2026. The group submitted a piece of art inspired by this year's themed category - 'Roots'. • Patients and staff at Cheswold Park Hospital came together on 10 September for a successful Physical Health Fair, promoting healthy lifestyles and increasing awareness of important physical health topics.
Recommendation:	**Trust Board members are asked to:** • **NOTE** the Chief Executive's report.

The Brief

27 August 2026

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

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

With **all of us** in mind.

Our purpose and values

NHS
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

Trust Porter Phil Bates shared a lovely poem inspired whilst carrying out his daily duties and connecting with various colleagues from the sites he visits. Read Phil's poem on our website.

Our priorities for 2026-2027

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

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

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.

#allofusimprove
and be outstanding

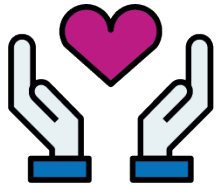
With **all of us** in mind.

JOB NO 5581 MAR26

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 focus– transforming clinical pathways

Personalised care framework implementation planning
Following publication of national guidance, the personalised care framework is being reviewed across adults, older adults, forensics and CAMHS. Work is moving towards a gap analysis and implementation plan, covering reviews, outcomes, named worker arrangements and workforce implications.

Reducing clinical admin burden
Work is commencing to explore redesign of risk assessment and care planning so people can tell their story once, with clearer standards, reduced duplication and a more joined-up approach across teams.

SPA referral improvements
A revised mental health SPA referral form has been tested and is due to go live in Calderdale and Kirklees. Feedback will help inform any wider roll-out across other areas.

Forensic programme
A new forensic strategic programme board is being developed to oversee bed modelling, lead provider arrangements and wider regional pathway work across West Yorkshire, South Yorkshire and The Humber.

Children and young people access and waits improvement
Children and young people's services remain in a positive position on 18-week waits, with fortnightly review helping teams maintain focus, understand local pressures and take action early.

Children and young people neurodevelopmental pathway improvement
Work is underway to better understand demand, capacity and pathway pressures across CYP ADHD and ASD services, including transition into adult services, post-diagnostic support and opportunities to use digital tools to reduce reporting burden.

Leading Well

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

Our leading well conversations and preparation for a future well led inspection continue. Please continue to share your thinking and conversations via leadingwell@swyt.nhs.uk . A summary of the evidence gathered to date is available on the intranet as are resources to support your conversations. We will continue to monitor feedback as it comes in from teams and the engagement sessions, incorporating any learning from the NHS Alliance work.

#allofusimprove
and be outstanding

We will shortly be launching our new **Quality Improvement Hub** on the intranet. The allofusimprove Improvement hub is a new space designed to help colleagues share ideas, learn from one another, celebrate success and improve services together.

Our first challenge on the new hub will ask colleagues to share ideas and learning as a part of our ongoing leading well conversations.

It will be an opportunity to share what is working well, what our strengths are, and where we can improve. This will help us to demonstrate how we lead well. further understanding our key strengths, and where we can find opportunities improve. Keep an eye on our communication channels for more information.

A range of information and resources to support your leading well conversations are available on the intranet. Please take a look and see how they can help you and your teams to prepare. This includes a helpful infographic on what type of CQC inspection we can expect, along with multiple presentations to aid discussion and learning.

We have updated our ‘all of us getting to know the Trust’ booklet, which has info on our governance, priorities and key themes and activity.

Best partner

NHS
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.

The Trust is looking for people with experience of **stammering** to help produce a series of training videos. We are working with charity STAMMA to achieve better interactions with people who stammer. People who stammer or have stammered in the past, family members, friends, or colleagues of people who stammer are invited to attend events to help co-produce the videos.

People across Barnsley are invited to take part in the '**Shaping the future: Barnsley 2040**' survey. The views will help shape a shared vision for Barnsley's future and influence the priorities that matter most to local communities. The survey is open until 20 December, with more opportunities to get involved planned throughout the year.

Local people are invited to get tips and advice from organisations and teams at our **Falls Awareness Day** event in Barnsley Market Hall on Friday 25 September, 9am - 3pm.

All staff are invited to attend our **annual members' meeting** on Wednesday 16 September, 10am to 2pm, at the Learning and Wellbeing Centre, Fieldhead Hospital. The event is an opportunity to explore the impact of our work/partnerships at our marketplace, hear about key Trust updates, reflect on achievements from the past year, and learn about our priorities for the year ahead. Attendance is free, book your place via our eventbrite booking page.

A new **workplace mental health toolkit** is now available for health and care colleagues across West Yorkshire. Colleagues can request access to the toolkit by completing the Workplace Mental Health Toolkit registration form.

We have been invited to run two workshops at This May Contain Strong Language festival, which is a collaboration between the BBC and National Poetry Centre. The first event on 25 September will explore the Hope Collective poetry project and how it came about, as well as what it meant to poets who submitted to the second anthology. On 26 September, alongside researchers from University of Southampton, we will co-facilitate a workshop exploring the power of poetry in supporting communication and connection.

Managing risk

South West Yorkshire Partnership Teaching NHS Foundation Trust

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

Key areas of risk identified in the risk register are:

- Increased demand, acuity and complexity
- Staffing, recruitment, and access to temporary staffing where it is needed
- Staff wellbeing
- Patient safety
- Out of area bed placements
- Young people waiting for treatment and access to inpatient beds
- Confidence in our services resulting from waiting times
- IT infrastructure and cyber crime
- Health inequalities
- 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

The Trust has been formally notified of its duty to support the Independent Inquiry into Grooming Gangs. As part of this, we are legally required to identify, retain, and preserve all potentially relevant information. This applies to all staff, regardless of role, and includes information held in both official systems and local or personal storage. If we don't do this, it could undermine the Inquiry, place the Trust at risk of non-compliance, and result in serious legal and professional consequences. Read what you must do on the intranet.

Date change to annual service of portable firefighting equipment. Due to the logistics and circumstances beyond control of the Trust the annual service of all portable firefighting equipment for Kendray Hospital and the Barnsley satellite locations (owned by the Trust) will take place week commencing Monday 21 September to Friday 25 September 2026. More information is 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. This includes physical health monitoring and emergency equipment such as Automatic External Defibrillators (AED), ECG Machines, blood pressure monitors and other diagnostic equipment

Please ensure you familiarise yourself with the **risk management governance framework**.

Best quality

Our performance in July

South West Yorkshire Partnership Teaching NHS Foundation Trust

- **55.2%** of people completing Talking Therapies treatment and moving into recovery
- **100%** of Talking Therapies referrals beginning treatment within 18 weeks. **99%** within 6 weeks.
- **90%** of MH service users followed up within 72 hours of discharge from inpatient care
- **70.3%** assessed within 14 days
- **91.7%** inpatient risk assessment completed within 24 hours before or after admission
- **93.5%** on community active caseload at month end with a risk assessment which has been reviewed within the last year
- **90%** of people died in a place of their choosing
- **87%** in CAMHS services waiting less than 18 weeks for treatment

There is a new intranet site for the **community palliative care and end of life care services in Barnsley**. A new suite of pages has been created to provide teams with helpful guidance and information on the various aspects of palliative and end of life care.

Friends and Family: 88% of people in our mental health services rated us good or very good. 95% in our physical health community services.

Our **customer services** team dealt with 39 new formal complaints in July, a 3% increase from last month. 9 complaints were closed and 100% were closed within the six-month statutory timeframe.

The **Equality Act 2010 Code of Practice** has been updated with new guidance coming into force this month. The new Code provides greater clarity about how existing duties should be understood and applied to make reasonable adjustments. Read the dedicated intranet page explaining how staff must identify, record and meet the communication and information needs of individuals under the Accessible Information Standard (AIS).

There is an **Equality Delivery System** stakeholder panel to feedback on the action plans from this year's process, due to take place on Monday 2 November from 10am-12noon at Fieldhead hospital. The services that are updating are Inpatient learning disability, Calderdale early intervention in psychosis, and Barnsley epilepsy services. The Eventbrite link to book your place is here. We will also be hosting the stakeholder panel on Monday 25 January 2027 from 10.30am-1.30pm on Microsoft Teams and out in the community at Brian Jackson Centre, Huddersfield and Barnsley CVS. The Eventbrite link to book your place is here.

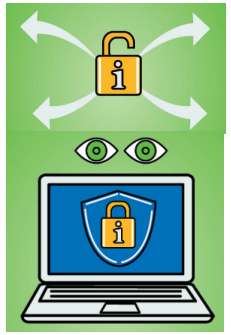
Best quality

Our performance in July

South West Yorkshire Partnership Teaching NHS Foundation Trust

- **116** inappropriate out of area bed days
- **1** child / young person under 18 in an adult inpatient ward
- **3.8%** of service users clinically ready to discharge. There were 24 people still delayed at the end of the month.
- **97.6%** with care plan that includes service user input/views
- **95.3%** of our service users have their ethnicity equality data recorded, **57.0%** their disability status, **58.3%** their sexual orientation, and **99.6%** deprivation (postcode)
- We had **16** information governance breaches

We have seen an increase in **information governance** (IG) breaches this month. It is very important that we do all we can to protect people's personal information and data. Please also make sure you are up to date with your IG mandatory training. The most common reasons for incidents reported are wrong house number written on envelope, unauthorised person copied on an email in error, another patient's details included in documents sent out, and letters and emails sent to the wrong addresses.



We have now gone live with our **electronic prescription service (EPS)** across adult ADHD, CAMHS, Barnsley community mental health teams, and Calderdale community teams. The EPS system allows prescribers to send prescriptions electronically to a community pharmacy of the service user's choice, helping to make the prescribing and dispensing process more efficient and convenient for service users and staff.

Sexual safety relaunch: Improving sexual safety across our Trust. Creating a safe and respectful environment for patients, staff, and visitors is a key Trust priority. Sexual safety means ensuring people are protected from unwanted or inappropriate sexual behaviour, and that any concerns are recognised, reported, and addressed promptly. As part of our commitment to strengthening sexual safety, we are increasing awareness and supporting staff through a range of resources, including a Sexual Safety Standards poster and the *Safe to Talk* leaflet for service users, an SBAR tool to support responses to service user-related sexual safety incidents, and guidance on reporting sexual safety incidents. Further information is available on the intranet.

Effective safeguarding means looking beyond the individual in front of us. Through **Think Family**, a strengths-based intervention model, our services can consider each family's needs as a whole and provide tailored targeted support that empowers families in our care to sustain change.

Intelligence change

Understanding the story behind our July data

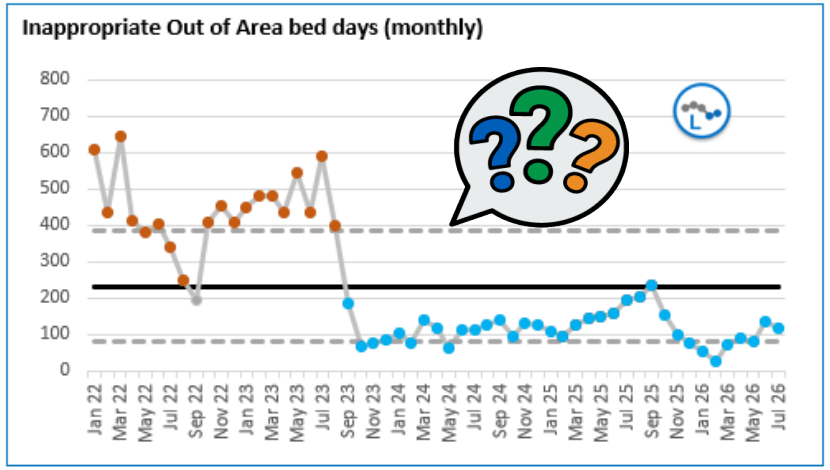
South West Yorkshire Partnership Teaching NHS Foundation Trust

- **116** inappropriate out of area bed days

This is important data, but on its own it may not tell the full story.

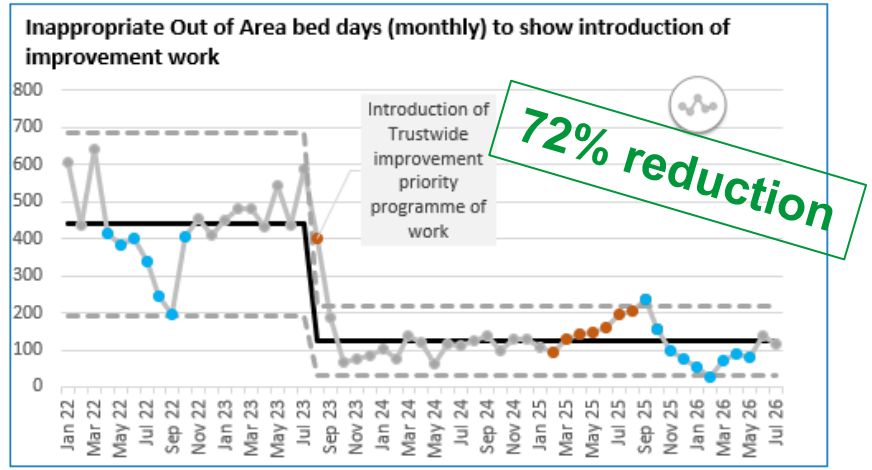
MEASUREMENT

Looking at our data over time allows us to see where we were, compared with where we are now.



Significant and sustained change in our data over time.

This work continues and in quality improvement, **understanding** the story behind the data is just as important as the data itself.



By looking at our data (numbers and voice) in context, it helps us **recognise progress, understand variation, and identify the right next steps** for improvement. Reflecting on progress over time, alongside the learning gained throughout the journey, enables us to make informed decisions and continue improving outcomes.

Data shows us what is happening; understanding helps us know why.

Check out our SharePoint page for more information about data visualisation and using Data for improvement

Best quality
Triangle of Care

South West Yorkshire Partnership Teaching NHS Foundation Trust

In August 2026, we were successfully awarded Triangle of Care (ToC) Star 2 Accreditation by the Carers Trust.

The Triangle of Care membership scheme is a three-stage recognition process for services who commit to self-assessing their existing services and action planning to ensure the Triangle of Care standards are achieved.

Following a comprehensive submission process and successful peer review panel assessment, the review panel recognised the Trust's substantial progress in embedding the Triangle of Care across inpatient, crisis, community, forensic, CAMHS, specialist and Recovery College services.

Highlights included our strong governance arrangements, partnership working with local carers' organisations, young carer co-production, and alignment with the Patient and Carer Race Equality Framework (PCREF).

The panel also praised the Trust's accessible resources for carers, and the growing influence of lived experience in training, recruitment and service improvement.

What we've done

- Early identification of carers and the use of carers passports
- Over 700 staff trained through face to face and e-learning, improving confidence in carer engagement and support.
- Strengthened policies and co-produced resources
- Expanded the Carer Champion network
- Improved carer packs and pathway information


CARERS TRUST

TRIANGLE OF CARE

This is to certify that

South West Yorkshire Partnership Teaching NHS Foundation Trust

has achieved Stage 2 of the Triangle of Care

K E McHugh

Kirsty McHugh
Chief Executive, Carers Trust

Date: 20th August 2026

The panel concluded that the Trust is well positioned to continue building on its achievements, with a strong organisational commitment to recognising carers, families and friends as valued partners in care.

Best place to work and learn

Our performance in July

South West Yorkshire Partnership Teaching NHS Foundation Trust

- **5.54%** sickness rate for the month.
- The rolling 12 months sickness rate is **5.1%**

We have moved from a rolling 12-month **appraisal** cycle to a fixed annual appraisal window, running from April to September. Therefore, overall compliance is less than 50% as we transition. All staff need a completed appraisal by the end of September. Don't leave it until the last minute.

Have you embedded a **trauma-informed approach** in your service or team? Share your learning and good practice at our learning and celebration event on 11 November. If you are interested in presenting or hosting a discussion table complete this short form.

If you're interested in becoming a **carers champion**, visit the intranet to review the descriptor and complete the agreement form. Please discuss the role with your line manager to agree appropriate support and protected time where possible.

Following recent appointments to key positions in our **staff networks** we are encouraging colleagues to take a look and join. The staff networks help connect people and can enhance your sense of belonging at work.

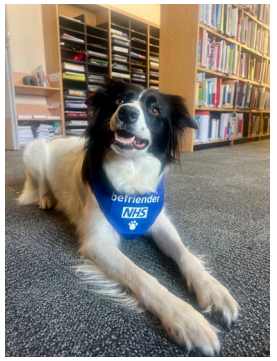
To mark **South Asian Heritage Month**, our Diversity Inclusion and Belonging Lead Iffath Hussain shared her "Where are you from?" blog about her culture, values and heritage.

Share your **flu** feedback – whether you had your flu vaccination last year or not, we'd like to better understand your choice. Please complete our short, anonymous survey.

Our **Freedom to Speak Up** Guardian Estelle Myers will be visiting our Forensics services across Trust sites. Come along and meet Estelle, find out more about FTSU, discuss any concerns or issues, and get advice and support. Details are on the intranet.

Read the August edition of the **volunteer** newsletter as they celebrate 10 years of the service.

As part of the Library's ongoing commitment to supporting the wellbeing of colleagues, the team are proud to add their much-loved library visitor Cami as their official **Canine Befriender**. Cami's visits will provide colleagues with a welcome opportunity to take a short break from busy working days, helping to create moments of connection, relaxation and wellbeing. Read more.



Share your views on our Trust behaviours. Your input will help us understand whether our behaviours are still the right fit and inform our next steps. Find out more and have your say by completing the survey.

Best place to work and learn

NHS Staff Survey: listening, learning and working together to be the best we can be

South West Yorkshire Partnership Teaching NHS Foundation Trust

We're evolving how we use the staff survey to make sure every voice counts. Our next annual staff survey launches on 21 September - everything you need to know, including accessing our resources, insights and feedback can be found on our dedicated intranet hub.

We are compassionate and inclusive

What teams are doing:

- Providing valuable feedback on Our Behaviours to help ensure they are refreshed in a way that is meaningful and helpful to all colleagues
- Increasing opportunities to share learning from avoidable harm and improvement work
- Helping to shape and test the People Management Essentials programme through participation and feedback.

We are safe and healthy

What teams are doing:

- Continuing to review Freedom to Speak Up themes and trends to identify and respond to emerging concerns
- Strengthening awareness and conversations around sexual safety
- Ensuring colleagues have supportive conversations about wellbeing, development and attendance.

We each have a voice that counts

What teams are doing:

- Creating regular opportunities for feedback through management meetings, governance forums and team discussions
- Embedding National Staff Survey discussions into existing governance and operational meetings
- Building confidence in using survey dashboards and local data to support improvement conversations.

We are a team

What teams are doing:

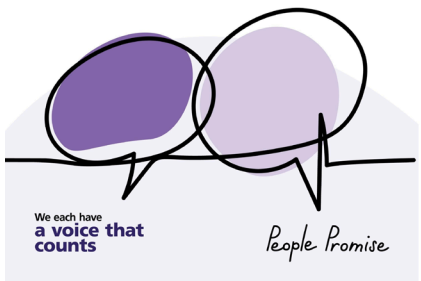
- Integrating staff survey findings into wider culture reviews and improvement work
- Strengthening appraisal, development and attendance support processes with a focus on growth, wellbeing and inclusion
- Promoting leadership and management development to support positive team experiences.

We are always learning

What teams are doing:

- Refreshing and implementing the new appraisal process
- Supporting the rollout of the People Management Essentials programme
- Providing development opportunities for managers and aspiring leaders.

The 2026 survey starts soon, get ready to share your views.



Best value

Our finances in July

South West Yorkshire Partnership Teaching NHS Foundation Trust

Performance Indicator		Year to Date	2026/27 Forecast
	NHS Oversight Framework	1	1
1	Surplus / (Deficit)	(£2.0m)	£0m
2	Agency Spend	£0.6m	£1.9m
3	Bank Spend	£7.6m	£19.6m
4	Financial sustainability and efficiencies	£4.6m	£17.7m
5	Cash	£58m	£60.1m
6	Capital Spend	£3m	£14.9m
7	Better Payment Practice Code	98%	

The year-to-date financial position at July 2026 is a deficit of £2m which is in line with plan. We need to make significant savings during the remainder of the year to enable us to achieve our break-even target

Agency spend, which continues to be limited to a small number of medical posts, has increased from £138k to £162k in month.

Bank spend reduced by £72k in July. Year to date expenditure is £7.6m, representing 7.3% of the Trust pay bill, with most spend relating to nursing cover in inpatient areas. The forecast is under review and has been updated to amber, at £0.6m above target.

The current cash position continues to be positive at £58m

The Trust continues to progress its capital programme, with pricing and profiles for the main schemes expected to be agreed shortly.

98% of all valid invoices have been paid within 30 days of receipt.

Best value

Our value for money and efficiency 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. Below are some updates and examples of things you can do to help…

To help manage our **temporary staffing** costs we are looking to recruit more substantive health care assistants to work in our clinical areas. A new targeted recruitment campaign will be starting in the Autumn.

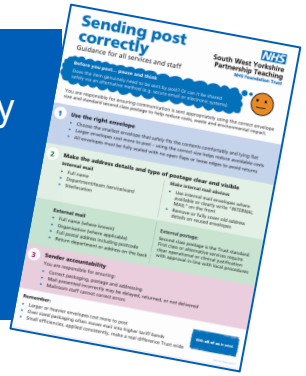
Stationery spend is reducing, following previous Trustwide action. Our colleagues in procurement are looking to host new stationary amnesties in the Autumn. More information will be coming out soon!

We are continuing to reduce our spend on **patient travel**, including the use of taxis. This is supported by the introduction of the "Safe transportation of patients procedure" and with new provider contracts which became operational in March.

Mike Steel, our driver from the Stores and Distribution team shares his feedback on the benefits of using an e-Bike. The bikes help with our drive to be more efficient and sustainable. Mike said: "It has had a huge positive impact on my life. I've lost weight, feel fitter, and enjoy being more active. It's one of the best things I've done for my health." Register your interest in loaning a free Trust e-Bike. **Find out more on the intranet** and email **e.bike@swyt.nhs.uk** to book.

Reducing postage costs

Read our guidance for sending post correctly and efficiently. A new poster provides useful steps to use and consider when you are posting, to help reduce costs, waste and environmental impact.



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. Please continue to send through your suggestions and ideas. You can send your ideas through the value for money section on the intranet.

Take home messages

NHS
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.

Continue to share your thoughts and views as a part of our ‘leading well’ conversations.

If you, or someone you know, stammers then get involved in our upcoming series of films.

If you live in Barnsley have your say by taking part in the ‘shaping the future’ survey.

Learn more about the Trust and recent developments at our Annual Members’ Meeting.

Make sure you look after other people’s information and data, and complete your IG training if you need to.

Prepare for the upcoming NHS Staff Survey by discussing last year’s results in your teams.

Make sure you have your appraisal before the end of September. Don’t leave it until the last minute!

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.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29 September 2026
Agenda item 12.1

Private/Public paper:	**Public**		
Title:	**Patient Safety Oversight Report Quarter 1 2026/27**		
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 quarterly report is to provide the Trust Board with oversight and assurance on the Trust's management of patient safety in line with the Patient Safety Incident Response Framework (PSIRF). It presents incident trends, harm and emerging risks; summarises learning responses and improvement activity; and reports on progress in translating learning into measurable and sustained improvement. The report also provides assurance on the Trust's arrangements for learning from healthcare deaths and identifies areas requiring continued focus or further development.		
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):	2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Delivering safe and effective services is a priority of all health and social care providers. This is a shared priority across the Integrated Care System, Integrated Care Board, Place based partnerships and is a regular feature of our shared objectives and actions. Ensuring there is understanding of the incidents which take place within our services, the impact of these and the learning to ensure future risk or harm can be avoided or reduced is essential. Sharing learning and best practice, themes, trends and analysis can help to identify opportunities to work together to address concerns or celebrate good practice. Learning from incidents is vital to improve patient safety, staff and service user/carer experience and to provide assurance of good governance and risk management processes.		
Any background papers / previously considered by:	The Trust Board and Quality and Safety Committee receive the Patient Safety Oversight Report on a quarterly basis. The Trust Board last received the Q4 2025/26 report in June 2026. The Quality and Safety Committee considered this Q1 2026/27 report on 8 September 2026.		

	This report has been reviewed by the Executive Management Team. Reporting is one month retrospective to allow sufficient time for the report preparation.
Executive summary:	This report provides quarterly oversight and assurance on patient safety activity in Q1 2026/27. The Trust has established systems to identify, review and learn from patient safety events, providing reasonable assurance that patient safety is actively managed. No Never Events or significant emerging concerns requiring escalation beyond established governance arrangements were reported. Self-harm incidents have reduced since November 2025, while falls, medication errors, violence and aggression, and pressure ulcers remained within expected statistical variation. Most incidents resulted in no or low harm. Continued focus is required on repeat falls, missed medication doses, consistent use of EPMA, and violence and aggression incidents resulting in moderate harm. Learning responses identified recurring themes relating to deteriorating physical health, care planning and risk formulation, therapeutic engagement and observations, communication and documentation, and reliable use of clinical systems. Targeted improvement activity is underway, with early evidence of progress in several areas. The refreshed PSIRF Plan and strengthened oversight arrangements are intended to improve triangulation and evidence of measurable and sustained impact. Revised mortality leadership and review processes are also in place. Q2 priorities include care planning and risk formulation, enhanced therapeutic observations, electronic NEWS2, reducing clinical administrative burden, and more reliable use of EPMA and SystmOne documentation.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** the report and take assurance that arrangements are in place to oversee patient safety, identify and respond to emerging risks, and support learning and improvement in line with the Patient Safety Incident Response Framework.

South West Yorkshire Partnership NHS Foundation Trust

Patient Safety Oversight Report

Quarter 1 2026/27
(1 April 2026 to 30 June 2026)

Prepared by Patient Safety Support Team

Trust Board – 29 September 2026

With **all of us** in mind.

Contents

1. Purpose and Executive Summary

This report provides the Trust Board with oversight and assurance on patient safety activity during Quarter 1 (Q1) 2026/27, focusing on material trends, learning, improvement, health inequalities and mortality.

Overall assurance: The Trust has established systems to identify, review and learn from patient safety events. These provide reasonable assurance that patient safety is actively managed. No Never Events or significant emerging concerns requiring escalation beyond established governance arrangements were reported in Q1. Further work is required to demonstrate consistently that learning responses result in measurable and sustained improvement across care groups.

Key findings: Self-harm incidents have shown a sustained decrease since November 2025. Falls, medication errors, violence and aggression, and pressure ulcers remained within expected statistical variation. Most incidents resulted in no or low harm; however, 27 patients accounted for 59% of inpatient falls, missed medication doses and inconsistent use of the electronic prescribing and medicines administration system remain concerns, and 9% of violence and aggression incidents resulted in moderate harm.

Learning and improvement: During Q1, 304 service-learning reviews, 67 debriefs, two SWARMs, three After Action Reviews and one thematic Patient Safety Incident Investigation were recorded. SWARM and After-Action Review approaches are at an early stage of implementation. Recurring organisational themes relate to deteriorating physical health, care planning and risk formulation, therapeutic engagement and observation, clinical communication and documentation, and the reliability and consistent use of clinical information systems.

PSIRF and governance: The refreshed PSIRF Plan has been finalised and is scheduled for publication by the end of August 2026. Governance and learning response methodologies have been strengthened. The Learning and Improvement Oversight Group will provide clearer oversight of actions, reduce duplication and support evidence of measurable and sustained improvement.

Mortality assurance: Dedicated mortality leadership, revised review processes and strengthened governance arrangements are in place. Further thematic analysis is planned to improve the timeliness of review and ensure that learning is translated into improvement.

Assurance limitations: Equality-data completeness and triangulation across incidents, complaints, mortality and patient experience require further development. The inpatient and community setting percentages for violence and aggression remain incomplete in the underlying data. Evidence that improvement actions are producing sustained and quantifiable impact is also variable.

Priority response: The principal Q2 responses are delivery of the care planning and risk formulation quality improvement programme led by the Deputy Director of Nursing; implementation of the Enhanced Therapeutic Observations of Care policy; extension of electronic NEWS2 and strengthened escalation of physical deterioration; progression of the Reducing Clinical Administrative Burden work; and improved reliability and consistent use of EPMA, SystmOne care plans and risk documentation.

2. PSIRF Implementation and Review

PSIRF implementation continues to mature. During Q1, the Trust progressed from establishing core processes to strengthening the quality, consistency and impact of learning responses. Governance arrangements and learning methodologies have been improved, alongside oversight of related improvement activity. The priority for 2026/27 is to evidence measurable and sustained change and to target resources towards areas with the greatest potential patient safety benefit.

2.1 Framework principles and revised priorities

Implementation is guided by four core PSIRF principles: compassionate engagement with those affected; system-based learning; considered and proportionate responses; and supportive oversight

focused on strengthening systems and improvement.

The 2025/26 PSIRF Plan identified nine priorities: self-harm, inpatient falls, medication errors, violence and aggression against patients, pressure ulcers, apparent suicides, risk assessment, the interface between physical and mental health, and patients absent without leave. Review of incident data, learning responses and wider safety intelligence informed a more focused, system-based set of priorities for 2026/27.

- **Recognition and response to deterioration.**
  System factors affecting the assessment, recognition, escalation or response to deterioration or changes in clinical presentation, including delayed recognition, ineffective transitions of care, inadequate monitoring, incomplete assessment and inconsistent escalation across inpatient and community settings.
- **Safety of the physical environment.**
  Risks associated with ward design and layout, ligature points, observation limitations, access and egress, environmental hazards, equipment and device safety, and security arrangements.
- **Clinical communication and decision-making.**
  Incomplete, delayed, ineffective or inaccurate communication within and between teams, or with patients and carers, which may affect assessment, treatment, risk formulation and care planning.
- **Emerging system-based themes**.
  New or escalating risks identified through specialist review or structured analysis of patient safety data that require focused exploration and response.

The focus for 2026/27 is to strengthen oversight, operational ownership and triangulation, ensuring that learning across these priorities is translated into measurable and sustained organisational improvement.

PSIRF implementation requires organisations to establish, embed and evaluate an integrated set of systems and processes. During 2026/27, the Trust will review its PSIRF Plan against updated NHS England guidance and progress the following workstreams:

Table 1 PSIRF Review Workstreams

PSIRF review workstream	Key actions for 2026/27
Incident reporting and management	• Improve Datix functionality, data completeness and care group sign-off. • Provide targeted drop-in support and incident-reporting input within preceptorship.
PSIRF Plan and policy	• Align learning responses and resources with the refreshed priorities, increasing thematic review where appropriate. • Re-establish the Learning and Improvement Oversight Group and strengthen mortality review and thematic learning.
Compassionate engagement	• Review Being Open guidance using feedback from staff and care groups. • Develop clear information for families and improve staff information and signposting.
PSIRF training	• Deliver further accredited AAR and SWARM training. • Develop a sustainable internal training offer and targeted care group support.

3. Overview of Learning Responses

Table 2 summarises Q1 PSIRF responses. Activity was weighted towards proportionate assessment and rapid team learning, with 304 service-learning reviews and 67 debriefs. More resource-intensive responses were used selectively: one thematic Patient Safety Incident Investigation, one external investigation, one case-note review and five Structured Judgement Reviews were recorded.

Assurance: The response profile is consistent with PSIRF's expectation that learning activity should be proportionate to the opportunity for system learning and improvement, rather than determined solely by incident severity.

Development area: Use of SWARM and After-Action Review remains limited, with two SWARMs and three reviews recorded in Q1. These approaches are expected to increase as care group capability develops.

Table 2. Total PSIRF Responses in Q1

PSIRF response type	Response	Number
Assessment responses	Service-Learning Review (replaced the manager's 48-hour rapid review in February 2026)	304
Learning responses	Debrief	67
	SWARM (team-led)	2
	After Action Review	3
	Specialist Learning Review	0
	Patient Safety Incident Investigation (individual case)	0
	Patient Safety Incident Investigation (thematic project)	1
	Involvement in an external Patient Safety Incident Investigation	1
	Case-note review (Infection Prevention and Control)	0
	Case-note review	1
	Structured Judgement Review	5

Accredited AAR and SWARM training was delivered to Quality and Governance Leads and Matrons in March 2026. From September 2026, the Patient Safety Support Team will provide targeted care group support to improve the quality and timeliness of learning responses and accelerate the sharing of learning.

4. Learning themes and actions

This section brings together the key learning identified during Q1 from incident reviews, learning responses, mortality reviews, specialist oversight, complaints and wider patient safety intelligence. It summarises the recurring organisational themes, the position across the patient safety priorities, the improvement actions under way and the areas where further assurance is required. Detailed supporting analysis is provided in Appendix 1.

Governance and dissemination: From August 2026, the newly implemented Learning and Improvement Oversight Group will commission and oversee improvement activity, assess impact and support the consistent embedding of learning across the Trust. Immediate learning will continue to be shared through safety alerts, Blue Lights and the Learning Network.

Strengthening rapid learning: SWARM debriefs and Patient Safety Huddles, commencing in September 2026, will bring together care group and specialist leads to support timely review, shared understanding and action following incidents.

Q1 thematic review: One thematic Patient Safety Incident Investigation examined recurrent head-banging incidents involving a small cohort of inpatients at Cheswold park Hospital (CPH). The review identified the need for more individualised care and risk-management plans, improved staff understanding of the function and triggers of head-banging, consistent post-incident debriefs, stronger multidisciplinary oversight and appropriate environmental safety measures.

Wider Q1 learning themes: Triangulation of learning responses, incident and mortality reviews, and specialist oversight identified five recurring organisational themes:

- Recognition and escalation of deteriorating physical health.
- Quality and consistency of care planning and risk formulation.
- Therapeutic engagement and observation practice.
- Clinical communication and documentation.
- Reliability and consistent use of clinical information systems.

Table 3 below sets out why each theme matters, the Trust response and the evidence required to demonstrate improvement during Q2.

Theme	Why it matters	Action	Q2 assurance sought
Deteriorating physical health	Delayed recognition or escalation may result in avoidable harm and poorer outcomes.	Extend electronic NEWS2, strengthen observations and escalation, and improve long-term-condition management.	Improved completion of observations and health checks, timely escalation and

Theme	Why it matters	Action	Q2 assurance sought
			evidence of improved outcomes.
Care planning and risk formulation	Inconsistent plans may weaken personalised care, risk management and continuity.	Deliver the Trust-wide quality improvement programme, led by the Deputy Director of Nursing, to improve the quality and consistency of care planning, risk assessment, risk formulation and associated clinical documentation.	Programme delivery against agreed milestones, supported by audit evidence of improved quality, patient involvement and consistent use in practice.
Therapeutic engagement and observation	Variation may reduce prevention, early intervention and meaningful patient engagement.	Implement the Enhanced Therapeutic Observations of Care policy and strengthen staff capability.	Implementation data, practice-audit findings and evidence of improved patient experience and safety.
Clinical communication and documentation	Gaps may affect continuity, clinical decisions, escalation and shared understanding.	Use the Reducing Clinical Administrative Burden work to simplify and strengthen clinical documentation and information flow, alongside improved multidisciplinary communication, supervision and shared learning.	Evidence of reduced avoidable administrative burden, fewer documentation gaps, more timely recording and improved audit or review findings on communication and escalation.
Clinical information systems	Inconsistent use or system reliability may delay documentation, meaning current risk information is not shared promptly between clinicians and may not inform safe clinical decisions.	Improve system reliability and consistent use of EPMA, SystmOne care plans and risk documentation.	Evidence of reliable system use, timely recording and fewer documentation or workflow gaps.

4.1 Summary of patient safety priorities

The table below summarises the Q1 position and key residual risks across the patient safety priorities. Further analysis of trends, harm, equality, learning, actions and impact is provided in Appendix 1.

Area	Q1 position	Key residual risk / focus	Improvement and assurance position
Self-harm	Sustained improvement since November 2025; most incidents resulted in no or low harm.	Complex presentations and incidents causing moderate or severe harm.	**Evidence of improvement:** care and risk-management plans, staff education and debriefing have strengthened at CPH. Continued oversight is required to confirm sustained impact across services.
Inpatient falls	Within expected variation; 95% resulted in no or low harm.	Repeat falls concentrated among a small cohort with complex needs.	**Evidence of impact:** more than 98% had a multifactorial risk assessment and 97% a mobility plan; frequent-faller reviews are associated with fewer falls per patient.
Medication safety	Within expected variation; more than 99% resulted in no or low harm.	Missed doses, medicines administration and consistent use of EPMA.	**Partial evidence of impact:** medication errors reduced at CPH. The Trust-wide administration plan starts in September 2026 and its impact requires monitoring.
Violence and aggression	Within expected variation, with established specialist oversight.	Moderate-harm incidents, incomplete setting data and evidence of impact.	**Implementation underway:** monthly thematic review, preventive interventions and targeted ward support are in place; measurable impact is not yet established.
Pressure ulcers	Within expected variation; no severe-harm ulcers reported.	Documentation, risk assessment and timely scheduling of care.	**Early evidence of improvement:** Purpose T has improved identification and screening, and audits indicate greater consistency; sustained impact remains under review.
Apparent suicides	Specialist review and monthly oversight are in place; data remains provisional.	Risk formulation, family involvement, dual-diagnosis expertise and staff support.	**Implementation underway:** Trust-wide and local improvement activity is progressing, but further assurance is required that actions are delivering sustained improvement.
Physical health	Key risks are understood and improvement work is under way.	Reliable monitoring, escalation, health checks and evidence of improved outcomes.	**Early implementation:** electronic NEWS2 has been piloted successfully and wider actions are planned; quantified evidence of consistent practice and improved outcomes is still required.

Priority actions arising from Q1 learning and triangulation: The table above identifies where improvement is evident and where further assurance is required. The following cross-cutting and highest-priority actions address the principal residual risks and will strengthen evidence of

measurable and sustained improvement. Detailed actions for each patient safety priority, including falls, medication safety and pressure ulcers, are set out in Appendix 1.

- **Violence and aggression:** review section 136 pathways and the impact on staff.
- **Physical health:** strengthen monitoring of long-term conditions and escalation of deterioration.
- **Care planning and risk formulation:** deliver the Trust-wide quality improvement programme led by the Deputy Director of Nursing to improve the quality and consistency of care planning, risk assessment, risk formulation and associated clinical documentation.
- **Suicide prevention:** progress Trust-wide actions, including analysis of deaths following recent discharge.
- **Therapeutic observations:** implement the Enhanced Therapeutic Observations of Care policy.
- **Clinical communication and documentation:** progress the Reducing Clinical Administrative Burden work to simplify documentation, improve information flow and support timely, high-quality clinical recording.
- **Clinical systems:** improve the reliability and consistent use of EPMA, SystmOne care plans and risk documentation so records are complete and updated promptly.

The following section explains how learning from these priorities is triangulated, governed and translated into Trust-wide improvement.

5. Trust-wide Learning, Triangulation and Improvement Oversight

This section brings together learning from the patient safety priorities and outlines how intelligence is triangulated to identify risks, coordinate improvement and monitor impact across the Trust.

Current approach: Patient safety intelligence is triangulated across incidents, complaints, learning responses, mortality reviews, coronial outcomes and wider safety data to identify emerging risks and recurring themes. Findings are tested with specialist advisors and frontline teams to ensure that organisational learning reflects clinical practice.

Governance: The Learning and Improvement Oversight Group implemented in June 2026 will provide a single mechanism to commission and oversee improvement activity, reduce duplication and track whether learning is translated into measurable and sustained change across care groups.

Developing insight: The Trust's "learning journey" currently brings together themes from learning responses. During 2026/27, this will be expanded to include a broader range of patient safety intelligence, enabling clearer identification of system risks, cross-cutting themes and opportunities for improvement.

Health inequalities: Ethnicity data is reported within each patient safety priority to improve visibility of potential differences in risk and experience. No significant disproportionality has been identified in Q1; however, improved data completeness and triangulation with complaints, mortality, patient experience, local population and service-use data are required before firm conclusions can be drawn.

Digital oversight: A central SharePoint platform, planned for launch by the end of September 2026, will provide live oversight of improvement activity, strengthen action tracking and improve alignment across programmes.

Engagement: Feedback from stakeholders during the PSIRF review has informed this approach and will continue to support collaborative, organisation-wide learning and improvement.

Assurance: The Trust has established arrangements to bring together patient safety intelligence and convert learning into coordinated improvement. The Learning and Improvement Oversight Group and central tracking platform will strengthen accountability and oversight. Further work is required to demonstrate measurable and sustained impact and to improve the completeness and triangulation of equality data.

6. Learning from deaths

The Q1 Learning from Deaths report is presented separately alongside this paper.

All reported deaths are reviewed by patient safety specialists, irrespective of cause or initially assessed severity. Cases primarily relate to people who died while receiving community care or within six months of contact with Trust services. Each case is screened against the criteria for formal mortality review. Governance has been strengthened through dedicated mortality leadership, revised review processes and enhanced thematic analysis. These changes are intended to improve timeliness, organisational learning and assurance regarding avoidable harm.

7. Next Steps and Delivery Actions

Key delivery actions for Q2 and the remainder of 2026/27 are:

- **PSIRF and capability:** embed the refreshed plan, expand AAR and SWARM capability and provide targeted care group support.
- **Learning and improvement oversight:** embed the Learning and Improvement Oversight group and reporting to demonstrate delivery and sustained impact.
- **Data and insight:** improve DatixWeb and equality-data completeness, triangulation and wider patient safety insight.
- **Digital oversight:** launch the central SharePoint platform by the end of September 2026 to track improvement actions and alignment.
- **Compassionate engagement:** review Being Open guidance and improve information and signposting for patients, families and staff.

Delivery accountability: Progress, exceptions and evidence of impact will be reported through the Learning and Improvement Oversight Group.

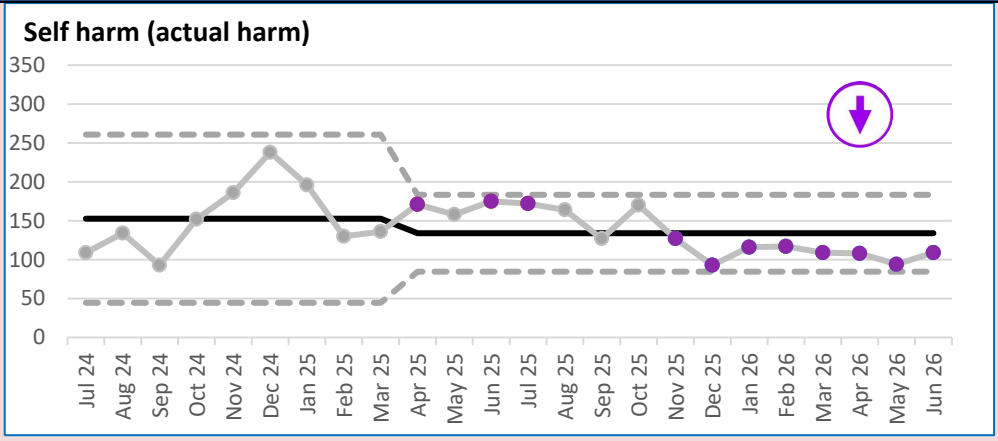
8. Recommendations

The Trust Board is asked to receive the report and take assurance that arrangements are in place to oversee patient safety, identify and respond to emerging risks, and support learning and improvement in line with the Patient Safety Incident Response Framework.

Appendix 1 PSIRF Priorities Review

This appendix provides detailed analysis of the patient safety priorities summarised in Section 4, including incident trends, harm and equality data, learning, improvement actions, impact and the resulting assurance position.

Appendix 1.1 Self-harm

Patient safety priority	Statistical Process Control chart (where available)
Self-harm **PSIRF plan focus:** • Inpatient – self harm associated with ligatures or swallowing objects Community – overdose of prescribed medication	

Data analysis

Trend: Self-harm incidents have shown sustained special-cause improvement since November 2025.

Harm profile: In Q1, 92% of incidents resulted in no or low harm, or were unrelated to Trust care; 7% resulted in moderate harm and fewer than 1% in severe harm.

Mental Health inpatient – Q1 26/27

Inpatient settings: 83% of incidents occurred in mental health inpatient services. Of these, 94% resulted in no or low harm, or were unrelated to Trust care; 6% resulted in moderate harm requiring acute hospital treatment.

Ethnicity data MH inpatient:

White - English/Welsh/Scottish/Northern Irish/British	96%
Asian/Asian British - Pakistani	1%
Asian/Asian British – Indian	<1%
Black/African/Caribbean/Black British – African	<1%
White – any other white background	<1%
Unknown/not stated	1%

Mental Health community – Q1 2026/27

Community settings: 17% of incidents were reported by mental health community teams. Of these, 80% resulted in no or low harm, or were unrelated to Trust care; 18% resulted in moderate harm and 2% in severe harm.

Ethnicity data MH community:

White – English/Welsh/Scottish/Northern Irish/British	84%
Asian/Asian British – Pakistani	5%
Mixed/multiple ethnic groups – white and Asian	2%
Mixed/multiple ethnic groups – other mixed or multiple ethnic groups	2%
Asian/Asian British - Any other Asian background	2%
Unknown/not stated	5%

Learning identified

- Co-produced safety plans should be reviewed regularly with patients and include positive therapeutic risk-taking and clear escalation where risk increases.
- **CPH thematic review:** A local review of recurrent head-banging incidents involving a small inpatient cohort identified the need for individualised care and risk-management plans, better understanding of triggers and function, consistent post-incident debriefs, stronger

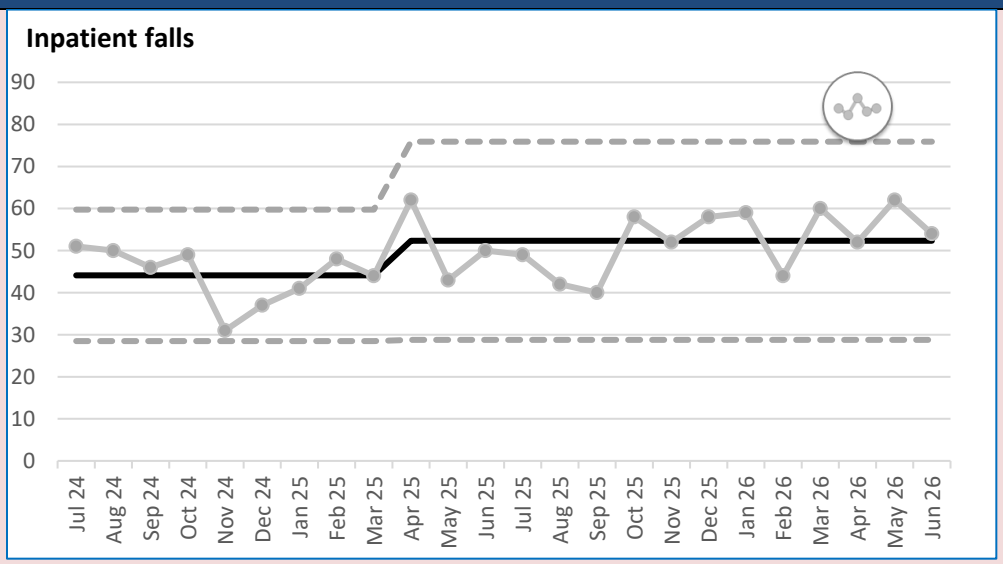
multidisciplinary oversight and appropriate environmental safety measures.
- Safeguarding advice should be sought where collective self-harm behaviours create a risk of contagion.

Improvement work underway and planned for Q2
- Deliver trauma-informed training to strengthen staff responses to risk and distress.
- Develop Multi-Service Support Plans to improve coordinated multi-agency management of complex risk.
- Progress the Therapeutic Inpatient Environments programme and Women's Pathway, informed by external peer review.
- Complete external wound-management and self-harm pathways.
- Embed the patient safety escalation process and review delivery against NICE guideline NG225.

Impact
- Co-produced safety planning is associated with fewer repeat incidents and positive feedback about involvement in care.
- In response to the CPH review, professional meetings and staff debriefs have increased; care and risk-management plans have been strengthened; staff education has been provided; and a safety wedge has been introduced on Skipton Ward.

Assurance: Self-harm risks are being actively managed, supported by sustained improvement since November 2025, a predominantly no- or low-harm profile and targeted improvement activity. Residual risk remains in cases resulting in moderate or severe harm and in complex inpatient presentations; continued oversight is required to evidence sustained impact across services.

Appendix 1.2 Inpatient falls

Patient safety priority	Statistical Process Control chart (where available)
Inpatient falls PSIRF Plan: • Learning from well managed incidents and/or near misses • Priority area covered by Improvement plan • Learning response by exception only	

Data analysis

Trend: Inpatient falls remain within expected statistical variation.
Reporting: Active promotion of reporting, including no-harm events, has increased visibility of low-harm falls and the opportunity for learning.

Ethnicity data Q1 2026/27:

White - English/Welsh/Scottish/Northern Irish/British	83%
Black/African/Caribbean/Black British - Caribbean	3%
Asian/Asian British - Indian	2%
Asian/Asian British - Pakistani	2%
Black/African/Caribbean/Black British - African	2%
Black/African/Caribbean/Black British - Any other Black background	1%
White - any other white background	<1%

In Q1 2026/27:

- 95% of falls occurred on mental health inpatient wards; 53% of these were within older people's services.
- 5% occurred on general community inpatient wards.
- Risk was concentrated: 27 patients experienced 102 falls, representing 59% of inpatient falls.
- Younger patients accounted for 47% of inpatient falls, associated with neurological conditions, agitation, activity, overreaching and rolling from bed.
- 43 falls, representing 29% of inpatient falls, were preceded by agitation, aggression or pacing.

Mixed/multiple ethnic groups - white and black Caribbean	<1%
Unknown/not stated	5%

Harm profile: 56% of reported falls resulted in no harm, 39% in low harm and 5% in moderate harm requiring acute hospital treatment, typically for fractures.

Learning identified

- Frequent falls are multifactorial and affect both older and younger patients.
- Reviews identified links with trauma, fear, agitation, pacing, fatigue, physical deterioration, post-ECT care and medication side effects.
- An After-Action Review following a fall with injury identified improvement actions with defined timescales.

Patient complexity: Across older adult and stroke/neurorehabilitation units, approximately 63% of patients were at significant risk of falls, more than 70% required support with daily living and more than 85% had a long-term physical health condition.

Improvement work underway and planned for Q2

- Continued implementation of NICE Quality Standard QS86 for patients at high risk of falls.
- Update falls e-learning and develop holistic training aligned with the 2025 NICE guidance, including deterioration, trauma and long-term conditions.
- Trial a combined falls-environment and ligature checklist.
- Complete the review of younger adult falls and share learning from frequent-faller reviews and the After-Action Review.
- Use Falls Awareness Week to strengthen staff and patient education.

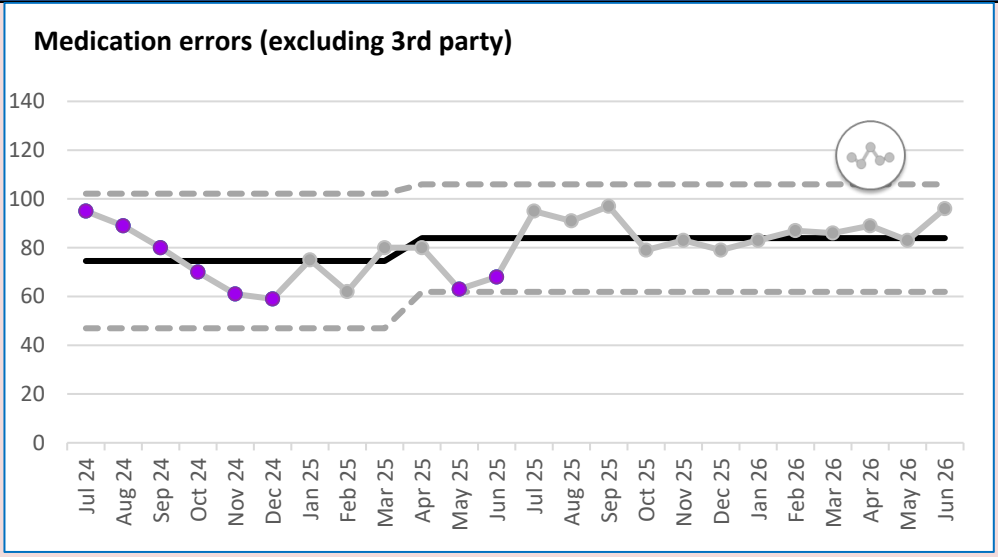
Impact

- More than 98% of patients had a good-quality multifactorial falls risk assessment documented.
- 97% had a good-quality multifactorial mobility plan, including therapy input and education.
- Frequent-faller reviews have prompted ward and multidisciplinary review, supported discharge planning and are associated with fewer falls per patient.
- 95% of reported falls resulted in no or low harm.
- One severe-harm event involved an older adult with deteriorating physical health who died following acute hospital admission. Trust review identified no significant learning; further information has been requested from the acute provider and the case has been referred to the coroner.

Assurance: Inpatient falls risks are being identified and managed, supported by stable statistical variation, high completion of multifactorial assessments and mobility plans, and 95% of reported falls

resulting in no or low harm. Residual risk remains concentrated among a small cohort of patients with complex needs and requires continued oversight of repeat falls and associated harm.

Appendix 1.3 Medication errors

Patient safety priority	Statistical Process Control chart (where available)
Medication errors **PSIRF plan:** • Administration of insulin • Medication storage (fridges/clinic rooms)	

Data analysis

Trend: Medication errors remain within expected statistical variation.

Q1 distribution:

- 54% occurred on mental health inpatient wards.
- 24% occurred in mental health community settings.
- 17% occurred in general community services.
- 3% occurred on general community inpatient wards.
- 2% were reported by Trust-wide pharmacy services.

Harm profile: 93% of incidents resulted in no harm, 7% in low harm and fewer than 1% in moderate harm.

Oversight: Detailed analysis and assurance are provided through the Safe Medicines Practice Group.

Ethnicity data (inpatient settings) Q1 2026/27:

White – English/Welsh/Scottish/Northern Irish/British	63%
Asian/Asian British - Pakistani	9%
Black/African/Caribbean/Black British - African	6%
Mixed/multiple ethnic groups – white and black Caribbean	4%
White – any other white background	3%
Mixed/multiple ethnic groups - other mixed or multiple ethnic groups	1.5%
Mixed/multiple ethnic group - white and black African	<1%
Asian/Asian British – Indian	<1%
Asian/Asian British - Chinese	<1%
Unknown/not stated	12%

Ethnicity data (community settings) Q1 2026/27:

White – English/Welsh/Scottish/Northern Irish/British	64%
Asian/Asian British – Pakistani	9%
Asian/Asian British – Indian	2%
Any other ethnic group	2%
White – any other white background	1%
Black/African/Caribbean/Black British - Caribbean	1%
Mixed/multiple ethnic groups – white and black Caribbean	1%
Mixed/multiple ethnic groups – other mixed or multiple ethnic groups	1%
Asian/Asian British – Any other Asian background	1%
Black/African/Caribbean/Black British – African	1%
Other ethnic group – Arab	1%
Unknown/not stated	14%

Learning identified

- Missed doses have not shown significant improvement.
- Issues continue with transdermal patches and medicines administration.
- Use of the electronic prescribing and medicines administration system remains inconsistent.

Improvement work underway and planned for Q2

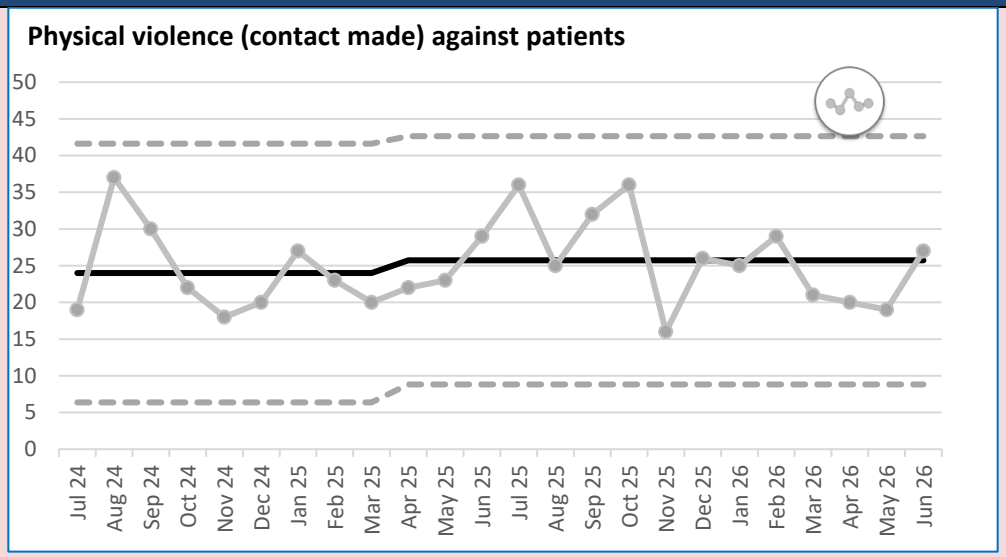
- Continue implementation and consistent use of the electronic prescribing and medicines administration system.
- Commence the medicines administration improvement plan in September 2026, linking revised training, Medicines with Respect and related quality-improvement work.

Impact

- Medication errors at CPH have reduced significantly; sustained impact across Trust services will require further evaluation.

Assurance: Medication safety is subject to established specialist oversight. Incidents remain within expected variation, with more than 99% resulting in no or low harm. Residual risk remains in missed doses, medicines administration and inconsistent use of EPMA; the impact of the improvement plan commencing in September 2026 will require close monitoring.

Appendix 1.4 Violence and aggression against patients

Patient safety priority	Statistical Process Control chart (where available)
Violence and aggression against patients • Violence resulting in moderate harm or above • Incidents involving use of force resulting in moderate harm or above • Incidents where system issue identified	

Data analysis

The Trust continues to observe 'normal' variation in the number of violence and aggression incidents against patients.

In Q1 2026/27:

- The percentage of incidents occurring in mental health inpatient settings was unavailable at the time of reporting.
- The percentage occurring in mental health community settings was unavailable at the time of reporting.

Of these incidents, 42.5% resulted in no harm, 48.5% in low harm, and 9% in moderate harm. This profile reflects the higher acuity and concentration of risk within inpatient settings.

Detailed oversight and analysis are provided through the **Reducing Restrictive Physical Intervention Group**.

Ethnicity data Q1 26/27:

White – English/Welsh/Scottish/Northern Irish/British	60%
Asian/Asian British – Pakistani	15%
White – any other white background	6%
Black/African/Caribbean/Black British – African	3%
Asian/Asian British – Indian	1%
Asian/Asian British – Any other Asian background	1%
Mixed/multiple ethnic groups – other mixed or multiple ethnic groups	1%
Black/African/Caribbean/Black British – Any other Black background	1%
Unknown/not stated	11%

Most incidents involved patients from a White British background (60%), broadly reflecting the Trust's inpatient population. A higher proportion were recorded for patients from Asian (particularly Pakistani, 15%) and Black ethnic groups (including African, 3%), highlighting the need for continued monitoring to understand any potential variation in risk or experience.

A proportion of incidents (11%) were recorded as unknown or not stated, indicating an opportunity to improve data completeness. Further work is required to triangulate ethnicity data across multiple sources to inform targeted improvement.

Learning:

- Incident review identified an opportunity to strengthen preventive and environmental strategies to reduce the likelihood or severity of patient-on-patient assaults.

- To further support the reduction of restrictive practices, the RRP Team is developing a template aligned with the eight NHS England domains for reducing restrictive practice. The intention is for ward areas to complete the template and return it for discussion at TAG meetings, enabling services to identify strengths, share learning, and develop focused improvement plans

Improvement work underway and planned for Q2

- Continue thematic review of patient-on-patient assaults and embed preventive interventions, positive behavioural support and de-escalation strategies.
- Establish regular ward community meetings to support Safewards, respectful behaviour and early resolution of conflict.
- Review access to therapeutic activity and meaningful occupation across inpatient services.
- Continue targeted team attendance at professional and multidisciplinary meetings.
- Strengthen post-incident debriefing, dissemination of learning and governance oversight of actions.

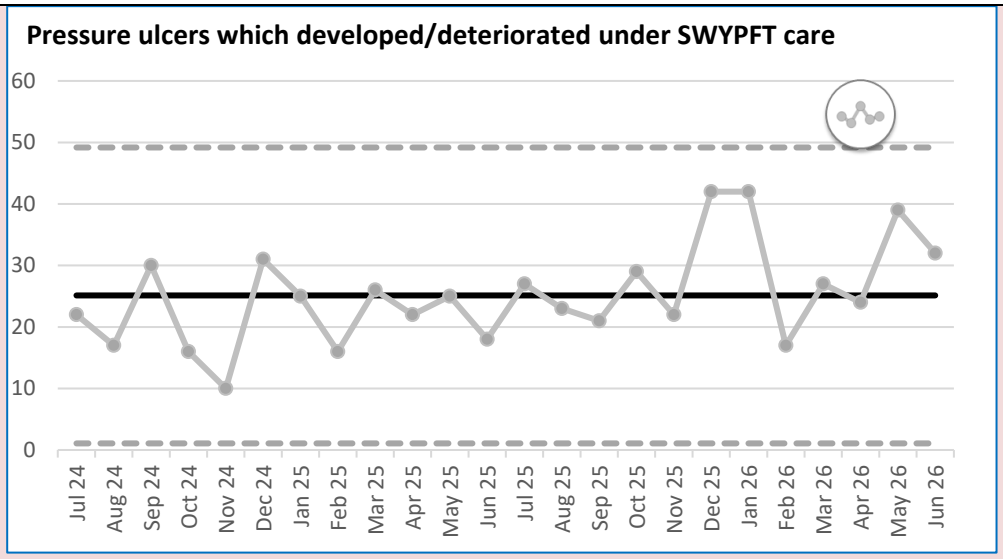
Impact

- All incidents are reviewed through the monthly TAG process to identify themes, share learning and support service improvement.
- The Reducing Restrictive Practice Team reviews Datix reports, provides advice and offers targeted ward support where required; measurable impact will continue to be evaluated.

Assurance: Violence and aggression risks are being monitored through the Reducing Restrictive Physical Intervention Group, monthly thematic reviews and targeted support to wards. We will continue to address the areas requiring improvement, including incidents resulting in moderate harm,

incomplete setting data and the need to demonstrate measurable impact from the actions being taken.

Appendix 1.5 Pressure ulcers

Pressure ulcers • Category 2 resulting in learning not covered in existing improvement work. • Category 2 or 3 deteriorating to category 3 or 4 (unrelated to end of life) Clinical documentation including Waterlow risk assessment	
Data analysis **Trend:** Pressure ulcers at Categories 2–4 that developed or worsened while patients were under Trust care remained within expected statistical variation. **Service distribution:** Incidents were concentrated in Barnsley community physical health services, which accounted for 98% of reports. One incident was reported in mental health inpatient services and one on a general community inpatient ward.	**Ethnicity data Q1 2026/27:** **Equality data:** 96% of incidents involved patients recorded as White British, while ethnicity was unknown or not stated in 4%. Comparison with local population and service-use data is needed before any conclusions can be drawn about differences between ethnic groups. **Harm profile:** 89% of pressure ulcers were assessed as low harm, usually Category 2, and 11% as moderate harm, usually Category 3. No Category 4 or other severe-harm pressure ulcers were reported in Q1. The harm rating describes the severity of the wound and does not, on its own, indicate shortcomings in care.

Learning identified

- Variation in documentation, Waterlow risk assessment and scheduling of care was identified as the principal contributory factor.

Improvement work underway and planned for Q2

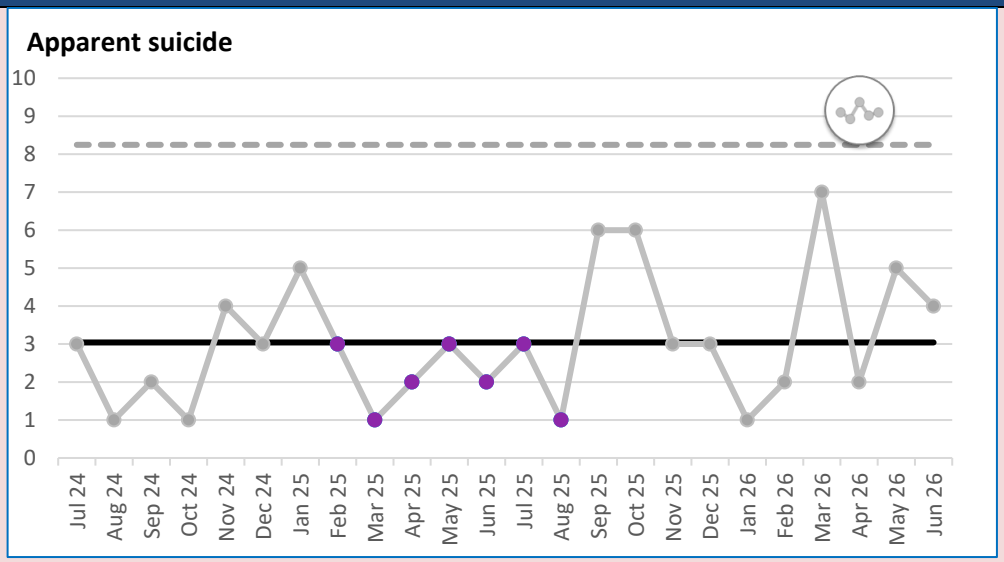
- Embed Purpose T across neighbourhood teams, informed by completed audit activity.
- Develop a standardised wound-care template to improve documentation.
- Review care plans and implement the SystmOne Auto Planner to support timely interventions.
- Implement a combined safeguarding and pressure-ulcer tool to strengthen oversight and risk management.

Impact

- Purpose T has improved the identification and screening of patients at risk across neighbourhood teams.
- Audit activity indicates greater consistency in documentation and risk-assessment processes; sustained impact will continue to be monitored.

Assurance: Pressure-ulcer risks are being actively managed. Incidents remained within expected variation, no severe-harm ulcers were reported in Q1, and Purpose T is supporting improved identification of patients at risk. We will continue to address variations in documentation, risk assessment and timely scheduling of care, and monitor whether planned system improvements deliver sustained change.

Appendix 1.6 Apparent suicides

Patient safety priority	Statistical Process Control chart (where available)
Apparent suicides PSIRF plan: Focus on suicide prevention at team level	

Data analysis

Scope: The SPC includes all deaths recorded on Datix as apparent suicides under the Trust's Learning from Deaths policy. These are deaths of people who were receiving, or had recently received, Trust care and where suicide is considered the likely cause.

Data caveat: "Apparent suicide" is a provisional classification and does not represent a confirmed coroner's conclusion. Records are updated when further information becomes available, including where a death is subsequently determined to have resulted from natural causes. Data may therefore change over time and is reported by incident date.

Oversight: Statistical Process Control data is reviewed monthly through the Operational Management Group.

Service setting: In Q1 2026/27, 82% of apparent suicides were recorded in community mental health services. The remaining 18% (n=2) were linked to inpatient mental health services; both deaths occurred in the community or another non-mental-health inpatient setting following contact with inpatient mental health care.

Equality data: 89% of people were recorded as White British and 11% as Asian or Asian British – Pakistani. Given the small number of deaths, these figures should be interpreted with caution and monitored alongside wider population and service-use data.

Learning identified

- Risk formulation and recording are not yet consistently completed in the correct sections of the clinical record.
- Families and trusted others should be involved more consistently in decisions about care and treatment, where appropriate.
- Access to dual-diagnosis expertise requires further development where substance use is identified as a risk factor.

Improvement work underway and planned for Q2

- Local Quality Improvement Plans to continue alongside the Trust-wide quality improvement programme led by the Deputy Director of Nursing to improve the quality and consistency of risk assessment, care planning, clinical record-keeping and risk documentation.
- Continue suicide-prevention drop-in sessions, including adaptable safety planning for autistic people, gambling-related harm and the impact of poverty.
- Strengthen links between Trust and wider-system suicide-prevention programmes.
- Complete the review of staff experience following traumatic incidents and improve postvention support for staff and teams.
- Progress inpatient improvement work at Elmdale and Nostell to reduce self-harm incidents, improve experience and reduce risk.
- Complete the external wound pathway in Q2 for self-harm and embed the escalation process for people presenting with high or complex risk.

Impact and wider learning

- Learning from ligature incidents is informing policy and procedure review.
- Improved reporting of drug- and alcohol-related deaths is strengthening mortality review and Trust-wide insight.
- Learning from structured reviews, staff engagement and patient experience is informing the review of female inpatient services.
- Post-incident support is being communicated more clearly and is informing the People Directorate's staff-support offer.
- Family information booklets are being used where suicide risk is identified; wider use is planned to improve visibility and family involvement.

Staff and teams are actively engaged in improvement work and are increasingly applying systems-based approaches to learning and action.

Assurance: All reported apparent suicides are subject to specialist review and monthly statistical oversight, with improvement work in place. The data remains provisional pending coronial outcomes. We will continue to strengthen risk formulation and recording, family involvement, access to dual-diagnosis expertise and support for staff following traumatic incidents and monitor whether these actions deliver sustained improvement.

Appendix 1.7 Physical health and mental health

People with severe mental illness experience significant physical health inequalities, including a higher prevalence of long-term conditions and premature mortality. Review of Q1 incidents, mortality reviews, audits, complaints, patient feedback and ward quality inspections identified recurring opportunities to strengthen physical health monitoring, recognition and escalation of deterioration, management of long-term conditions, and communication across services. This section summarises the principal themes and the improvement work under way.

Themes and trends

The themes below were identified through triangulation of Datix incidents and reviews, physical health audits, complaints and patient feedback, mortality reviews and ward quality inspections. The available evidence is primarily thematic; work is continuing to develop quantified measures of prevalence, compliance and impact.

- **Recognition and escalation of deterioration:** incidents and reviews identified delayed recognition of acute illness, inconsistent escalation of concerns and physical observations that were not always completed to the expected standard.
- **Physical health monitoring:** audits and quality inspections identified missed annual health checks and incomplete physical assessments, limiting opportunities for early intervention.
- **Long-term conditions:** recurring issues included the management of diabetes and the need for closer coordination between mental health, primary care and acute services.

- **Medication-related physical health:** weight gain and obesity remain important risks for people receiving psychotropic medication and require proactive monitoring and support.
- **Nutrition, hydration and lifestyle:** poor dietary intake, physical inactivity and poor sleep were recurring factors affecting physical health and recovery.
- **Communication and care coordination:** learning identified opportunities to improve communication across teams and organisations, adherence to agreed care plans and timely access to medical review when symptoms worsen.

Learning identified: Triangulation of incidents, mortality reviews, audits, complaints and quality inspections identified inconsistent completion and recording of physical observations, variation in recognising and escalating deterioration, and gaps in coordination between mental health, primary care and acute services. Care plans and risk assessments did not always set out clear actions for managing physical health needs or long-term conditions. The learning reinforces the need for reliable monitoring, clear escalation routes, timely medical review and staff capability to manage physical and mental health needs together.

Improvement work underway and planned for Q2

The improvement programme is focused on strengthening the full pathway from routine physical health monitoring to timely recognition, escalation and coordinated treatment. Work during Q2 will build on the successful pilot of electronic NEWS2 observations and address the recurring themes identified through incidents, audits and reviews. Delivery will be coordinated across clinical services, digital, workforce and governance teams, with progress monitored through relevant oversight arrangements.

- **Monitoring and deterioration:** extend electronic NEWS2 observations following the successful inpatient pilot, strengthen completion of vital signs and physical observations, and clarify escalation pathways, clinical oversight and multidisciplinary response.
- **Preventive care and long-term conditions:** improve completion of annual physical health checks and strengthen the management of conditions such as diabetes, including closer working with primary and acute care.
- **Medical review and coordination:** improve communication between mental health and acute hospital teams and ensure timely medical review when physical symptoms worsen.
- **Healthy lifestyles:** increase access to smoking cessation, nutrition, physical activity and other lifestyle support.
- **Documentation and care planning:** improve the quality of physical health care plans, risk assessments and SystmOne intervention plans.
- **Workforce capability:** align physical health and risk-assessment training with the Trust training review and strengthen clinical supervision and reflective practice so staff are confident in managing complex physical and mental health needs.

Impact
By strengthening physical health management, risk assessment, communication and escalation processes, services can support earlier identification and intervention, reduce avoidable harm and improve health outcomes. This is particularly important given the well-established health inequalities experienced by people with severe mental illness, who are at greater risk of developing long-term physical health conditions and dying prematurely compared with the general population.

Assurance: The key physical-health risks are understood and improvement work is under way, including electronic NEWS2 observations and strengthened escalation arrangements. Further evidence is required to demonstrate consistent completion of physical observations and health checks, reliable escalation of deterioration, effective long-term-condition management and measurable improvement in outcomes.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29 September 2026
Agenda item 12.2

Private/Public paper:	**Public**		
Title:	**Fuller Inquiry Board Assurance Framework**		
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:	To present an appraisal of the 29 recommendations arising from the Fuller Inquiry, established to examine how David Fuller was able to commit prolonged abuse of deceased people in NHS mortuaries without detection and to identify the governance, security and safeguarding improvements required to protect the dignity and safety of the deceased. The report assesses the recommendations identified by NHS England as immediately relevant to NHS providers, their applicability to the Trust and the adequacy of current governance, safeguarding and care-after-death controls. It also presents the Board assurance statement submitted to NHS England for Board approval and noting.		
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	The Trust works collaboratively with Integrated Care System partners, the Integrated Care Board, place-based partnerships, NHS England and other relevant organisations to strengthen safeguarding, governance and care after death. This report supports shared assurance that learning from the Nottingham maternity review and the Fuller Inquiry is being considered and translated into proportionate local action. Learning and good practice will continue to be shared across local, regional and national networks to promote consistent standards, protect the dignity and safety of deceased people and reduce the risk of recurrence.		
Any background papers / previously considered by:	This report was reviewed by Executive Management Team on 3 September 2026 and Quality and Safety Committee on 8 September 2026 prior to submission to Trust Board. This report has been reviewed by the Executive		

	Management Team. Reporting is one month retrospective to allow sufficient time for the report preparation.
Executive summary:	The Fuller Inquiry examined whether NHS organisations have adequate arrangements in place to safeguard the security, dignity and respectful care of deceased people. Following publication of Phase 2 of the Inquiry, NHS England identified 29 recommendations requiring immediate consideration by NHS providers. This report assesses the applicability of those recommendations to South West Yorkshire Partnership Teaching NHS Foundation Trust (SWYPFT) and the level of assurance that can be provided to the Board. SWYPFT does not operate a mortuary, body store, pathology service, post-mortem facility or ambulance service. Consequently, a significant proportion of the recommendations are not directly applicable to the Trust. However, the principles underpinning the Inquiry, namely dignity, security, safeguarding, governance, oversight and the management of concerns, remain relevant and have been considered within the context of the Trust's responsibilities following the death of an inpatient. The review confirms that the Trust has strengthened its arrangements through the refreshed Procedure Following the Death of an Inpatient, which sets out the requirements for verification of death, communication with families, liaison with coroners and Medical Examiners, secure and authorised transfer of the deceased, preservation of records and evidence, incident reporting, learning and governance oversight. These arrangements are further supported by established safeguarding, patient safety, Learning from Deaths, Freedom to Speak Up and legal governance processes. The assessment also recognises that the Chief Nurse and Director of Quality and Professions is both the Executive Lead for Safeguarding and Executive Lead for the inpatient death procedure, providing clear executive accountability and alignment with the expectations of the NHS Safeguarding Accountability and Assurance Framework. Overall, the review concludes that the Trust can take assurance that proportionate arrangements are in place to protect the dignity, security and respectful care of deceased people. Further assurance will be strengthened through formal approval and implementation of the refreshed procedure, audit and exception reporting. The report includes the Board assurance statement submitted to NHS England for Board approval and noting.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** the report as assurance, **APPROVE** the proposed assurance statement, and **NOTE** its submission to NHS England.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Fuller Inquiry – Board Assurance Report

Executive Summary

This paper assesses the 29 recommendations from Phase 2 of the David Fuller Inquiry identified by NHS England as immediately relevant to NHS providers. It considers their applicability to SWYPFT and the assurance available to the Board regarding the dignity, security and respectful care of deceased people.

SWYPFT does not operate a mortuary, body store, pathology or post-mortem facility, or ambulance service; recommendations specific to these functions are therefore not applicable. The Trust nevertheless remains accountable for safe, lawful, compassionate and culturally sensitive care following an inpatient death, including secure and authorised transfer, support for families, preservation of evidence, statutory notification, incident reporting, learning and oversight.

The principal source of assurance is the Procedure Following the Death of an Inpatient. This establishes controls for expected and unexpected deaths, verification and certification, Medical Examiner and coroner referral, direct transfer in the absence of a Trust mortuary, authorised release, recording of destination, family communication, faith and cultural needs, preservation of records and evidence, Datix reporting and annual audit. These arrangements are supported by established incident management, significant incident response, Learning from Healthcare Deaths, safeguarding, legal and Freedom to Speak Up processes.

Executive accountability is clearly aligned. The Chief Nurse and Director of Quality and Professions is both Executive Lead for Safeguarding and Executive Lead for the inpatient death procedure, supporting oversight of deceased-person safeguarding in line with the 2026 NHS Safeguarding Accountability and Assurance Framework and the expectations arising from the Fuller Inquiry.

Overall, the Trust Board can take assurance that proportionate governance and operational arrangements are in place. The Board assurance statement submission to NHS England is included at Appendix 1. This assurance remains conditional on formal approval and implementation of the inpatient death procedure, confirmation of local and out-of-hours transfer arrangements, staff awareness testing, completion of the planned audit and exception-based reporting through established governance routes.

Key assurance points

- The absence of a Trust mortuary materially limits exposure to the mortuary-specific risks considered by the Inquiry.
- The inpatient death procedure explicitly addresses the Trust-specific risk created by direct transfer from wards to a coroner-directed facility or funeral director.
- Established Datix, PSIRF, Learning from Healthcare Deaths, Medical Examiner, legal, safeguarding and Freedom to Speak Up arrangements support governance and learning.

- Annual audit and exception reporting are needed to demonstrate that the procedure is embedded in practice, rather than relying on documentary compliance alone.

1. Purpose

This paper appraises the 29 recommendations from Phase 2 of the David Fuller Inquiry identified by NHS England as immediately relevant to NHS providers. It assesses their applicability to SWYPFT, the controls currently in place and the further action required to support the Board's assurance and submission to NHS England.

2. Background and Trust Context

The Fuller Inquiry examined whether arrangements across hospital and non-hospital settings adequately protect the security and dignity of deceased people. In its letter of 26 June 2026, NHS England identified 29 of the Phase 2 recommendations as requiring immediate consideration by NHS providers. The recommendations span security and access, Human Tissue Authority Designated Individual responsibilities, mortuary management, Board assurance, safeguarding, medical education, hospice settings and ambulance services.

SWYPFT does not operate a mortuary, body store, pathology or post-mortem facility, or ambulance service. Its direct exposure is therefore limited to the period following an inpatient death and before lawful transfer from Trust premises. The assessment applies the underlying principles of dignity, security, safeguarding and governance to that part of the pathway.

3. Evidence Considered

- Draft Procedure Following the Death of an Inpatient, developed in August 2026.
- Incident Reporting and Management Procedure (425), approved by the Trustwide Clinical Governance Group in April 2026.
- NHS England letter: Nottingham maternity review findings on post-death care and key actions required following the Fuller Inquiry, 26 June 2026.
- David Fuller Inquiry Phase 2 report, published by the Department of Health and Social Care.

The review considered both the controls set out in Trust procedures and the evidence that these are embedded in practice. The refreshed Procedure Following the Death of an Inpatient provides the current basis of assurance. Formal approval and implementation, supported by staff awareness checks, audit and exception reporting, will provide further assurance that the procedure is operating effectively.

4. Appraisal by Recommendation Theme

4.1 Security, access control, CCTV and audit (Recommendations 1-9)

These recommendations principally relate to the security of mortuaries and body stores, neither of which is operated by SWYPFT. The relevant consideration for the Trust is therefore the safe, secure and dignified care of a deceased person during the period following an inpatient death and before authorised transfer.

The Trust has refreshed the Procedure Following the Death of an Inpatient. This sets out the actions staff must take to ensure the safe, lawful and dignified care and transfer of a deceased person, including:

- arranging transfer to the family's chosen funeral director, a locally commissioned or contracted provider, or a destination specified by the coroner or police, recognising that the Trust does not operate a mortuary;
- ensuring that no transfer takes place until death has been verified and the necessary authority to release the deceased has been confirmed;
- confirming the identity of the deceased, completing the required release documentation and recording the transfer destination; and
- where a death is unexpected, unexplained or suspicious, protecting the scene and any potential evidence and ensuring that the deceased is not moved until the appropriate authority has been obtained.

Evidence that these requirements are embedded in practice will be obtained through completed release documentation, confirmation of transfer arrangements, staff awareness checks, incident reporting and audit.

4.2 Designated Individual responsibilities (Recommendations 10-12)

Recommendations 10–12 relate to organisations undertaking activities licensed by the Human Tissue Authority and to the statutory responsibilities of the Designated Individual for those activities. SWYPFT does not operate a mortuary, undertake post-mortem examinations or carry out any other relevant licensed activity. The recommendations are therefore not applicable to the Trust. This assessment and its rationale are reflected in the consolidated assurance assessment and the Board assurance statement at Appendix 1.

4.3 Mortuary management (Recommendations 13-14)

Recommendations 13–14 relate to the authority, capability and resourcing of mortuary management. As SWYPFT does not operate a mortuary or body store, these recommendations are not applicable to the Trust. The refreshed Procedure Following the Death of an Inpatient does, however, set out clear responsibilities for the care and transfer of a deceased person while they remain in the Trust's care. Operational responsibility sits with the nurse in charge and is supported by the ward manager, senior nurse, responsible consultant, on-call arrangements and Legal Services, according to the circumstances of the death.

4.4 Board assurance and reporting (Recommendations 15-18)

Recommendations 15–18 require the Board to maintain oversight of care after death, receive appropriate assurance and ensure that any gaps are addressed. These requirements apply to SWYPFT despite the Trust not operating a mortuary.

Oversight is provided through established patient safety, clinical governance and Learning from Healthcare Deaths arrangements. The refreshed Procedure Following the Death of an Inpatient requires all inpatient deaths to be reported through Datix and reviewed through the appropriate learning response, with the Patient Safety Incident Response Framework and

Duty of Candour applied where relevant. Annual audit and exception reporting will provide further assurance and enable significant non-compliance, repeated concerns and overdue actions to be escalated through established governance routes.

The Board can take reasonable assurance from these arrangements and from the refreshed procedure. This remains subject to formal approval and implementation of the procedure, confirmation of local transfer arrangements, staff awareness checks, annual audit and exception reporting. Appendix 1 sets out the proposed Board assurance statement for approval and submission to NHS England.

4.5 Safeguarding and speaking up (Recommendations 19-21)

Recommendations 19–21 are fully applicable and require clear safeguarding oversight and accessible routes through which concerns can be raised and acted upon. The Chief Nurse and Director of Quality and Professions is the Executive Lead for Safeguarding, Executive Lead for the Procedure Following the Death of an Inpatient and the executive responsible for Freedom to Speak Up. These aligned responsibilities provide a clear line of executive accountability for safeguarding people after death, overseeing the Trust's care-after-death arrangements and ensuring that concerns about practice or organisational culture are raised, escalated and addressed.

Staff report incidents and near misses through Datix and raise concerns through line management, specialist advisers or Freedom to Speak Up routes. The refreshed procedure directs escalation to the police, coroner, Legal Services and Mental Health Act Office according to the circumstances of the death and requires the Trust's significant incident checklist and memory capture to be completed where applicable following an unexpected death. The annual safeguarding report, Freedom to Speak Up reporting, relevant training and audit will provide assurance that these arrangements are understood and embedded in practice.

4.6 Medical education settings (Recommendations 24-25)

Recommendations 24–25 relate to the governance and security of settings in which deceased people are used for medical education. SWYPFT does not provide anatomical education or operating facilities for this purpose; the recommendations are therefore not directly applicable to the Trust. The refreshed Procedure Following the Death of an Inpatient does, however, set out the actions to be taken where a person has made prior arrangements to donate their body to medical science. This includes contacting the chosen institution, confirming that the donation has been accepted and arranging transfer in accordance with the institution's requirements. These arrangements provide a proportionate response to the limited circumstances in which this pathway may arise.

4.7 Hospice settings (Recommendation 27)

Recommendation 27 relates specifically to hospice settings and is therefore not directly applicable to SWYPFT. The underlying expectations are, however, relevant to the Trust's inpatient services. The refreshed Procedure Following the Death of an Inpatient requires deceased people to be cared for with dignity and respect and directs staff to communicate compassionately with families, recognise religious, cultural and spiritual needs, offer viewing before transfer where appropriate, return personal belongings and provide information and

support following a death. These arrangements provide a proportionate response to the intent of the recommendation within the Trust's service model.

4.8 Ambulance services (Recommendations 30-33)

SWYPFT is not an ambulance provider, and the ambulance-specific recommendations are therefore not applicable to the Trust. Where ambulance services support an incident response or transfer, the procedure requires appropriate liaison with the ambulance provider, police and coroner. Compliance with the provider-specific recommendations remains the responsibility of the relevant ambulance service.

5. Consolidated Assurance Assessment

The review confirms that most of the 29 recommendations relate to mortuary, Human Tissue Authority, medical education, hospice or ambulance services that SWYPFT does not provide. These recommendations are therefore either not directly applicable or have been considered in relation to their underlying principles.

The recommendations relating to Board oversight, safeguarding, speaking up and the safe, lawful and dignified care and transfer of deceased people are applicable to the Trust. The refreshed Procedure Following the Death of an Inpatient, supported by established governance, incident reporting and Learning from Healthcare Deaths arrangements, provides the current basis of assurance.

The Trust can take reasonable assurance that proportionate arrangements are in place. Further assurance will be provided through formal approval and implementation of the procedure, confirmation of local transfer arrangements, staff awareness checks, audit and exception reporting.

6. Actions to Strengthen and Evidence Assurance

The review did not identify a fundamental control failure. The actions below are required to complete implementation of the refreshed procedure, confirm local arrangements and provide evidence that the requirements are operating effectively in practice.

No.	Action	Lead	Timescale
1	Approve and issue the Procedure Following the Death of an Inpatient, completing the document control fields, named advice contact, associated documents and appendices.	Chief Nurse / procedure owner	30 September 2026
3	Complete the planned annual audit and report exceptions, themes and overdue actions through Care Group governance and the Clinical Governance Group.	Quality Governance Team	May 2027
4	Include assurance on care after death and the safeguarding of deceased people within the annual safeguarding report, with significant exceptions escalated through EMT and the Quality and Safety Committee.	Safeguarding and Quality Governance leads	August 2027

7. Overall Assurance Conclusion

Most of the 29 NHS-relevant Fuller Inquiry recommendations relate to facilities or services that SWYPFT does not provide. These have been assessed as not directly applicable, with the rationale recorded, while the underlying principles have been considered where relevant to the Trust's inpatient services.

For the recommendations that apply, the refreshed Procedure Following the Death of an Inpatient, supported by established patient safety, Learning from Healthcare Deaths, safeguarding, legal, Medical Examiner, coroner and Freedom to Speak Up arrangements, provides the current basis of assurance. Executive accountability is aligned through the Chief Nurse and Director of Quality and Professions, who is responsible for safeguarding, oversight of the procedure and Freedom to Speak Up.

The EMT can be assured that proportionate arrangements are in place to protect the dignity, security and respectful care of deceased people. This assurance remains subject to formal approval and implementation of the procedure, annual audit and exception reporting. The actions in section 6 will provide further evidence that the arrangements are operating effectively in practice.

8. Recommendations

The Trust Board is asked to:

- receive assurance that proportionate arrangements are in place to support the safe, lawful and dignified care and transfer of deceased people;
- endorse the actions in section 6 to complete implementation and provide further evidence that the arrangements are operating effectively in practice; and
- receive the assurance statement submission to NHS England in Appendix 1

Appendix 1: Board Assurance Statement for Submission to NHS England

The following statement is presented for Board approval and subsequent submission to NHS England.

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	Yes	The Trust does not provide mortuary services. However, the Procedure Following the Death of an Inpatient has been reviewed and refreshed and is progressing through the formal governance and approval process.
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	Yes	As the Trust does not provide mortuary services, most recommendations are not directly applicable. The Trust has nevertheless reviewed the relevant recommendations and refreshed its Procedure Following the Death of an Inpatient to strengthen assurance regarding the care of deceased people. Any identified actions will be monitored through the appropriate governance arrangements.
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	Yes	Executive accountability is clearly assigned. The Executive Lead for Safeguarding also provides executive oversight of the Procedure Following the Death of an Inpatient, supporting alignment with the NHS Safeguarding Accountability and Assurance Framework and clear escalation through established governance routes.
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	Not applicable	The Trust does not operate a mortuary or related storage facility. A procedure is in place to ensure the safe, respectful and appropriately governed care of deceased people pending transfer to the responsible external provider. Relevant arrangements are subject to oversight through established safeguarding, clinical governance and estates routes.
For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window, closing 8 September 2026, ensuring that the plan includes PAM sign-off from the Board prior to submission.	Yes	The NHS Premises Assurance Model self-assessment has been completed and submitted within the required timeframe, following the appropriate internal review and approval process.

Trust name	South West Yorkshire Partnership NHS Foundation Trust
Trust CEO/AO name	Mark Brooks
Date	1/09/26
Trust Chair name	Jayne Brown
Date	1/09/26

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29 September 2026
Agenda item 12.3

Private/Public paper:	**Public**		
Title:	**Medical Appraisal & Revalidation Annual Board Report & Annual Organisational Audit (Statement of Compliance)**		
Lead Director:	**Professor Subha Thiyagesh – Chief Medical Officer / Responsible Officer**		
Mission/values:	Ensuring that all medical staff are fit to practise and up to date supports the Trust's mission to enable people to reach their potential and live well in the community and demonstrates the Trust's commitment to delivering safe and effective services and being an environment that is a great place to work, and learn.		
Purpose:	The purpose of this paper is to inform the Trust Board of progress in achieving satisfactory medical appraisal and revalidation and to support the signing of the NHSE Designated Body Annual Board Report Statement of Compliance (Annex A), which is completed to complement the 2025-26 Annual Board report.		
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. Be the best we can be: Best Quality 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. We will be ambitious: 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	The Trust benchmarks against local and regional Trusts and uses this information to form any decisions to amend processes and policies that may affect other organisations locally, in particular those within the 2 Integrated Care Systems.		

based partnerships and partner organisation objectives at national regional or local level.	The Trust also collaborates with Barnsley Hospice to ensure objectives are aligned with regard to appraisal and revalidation processes due the Trust's Responsible Officer overseeing RO duties there also.
Any background papers / previously considered by:	Quarterly reports in the Integrated Performance Reports Previous Annual Board reports Reporting to PRC on Medical Compliance
Executive summary:	• 189 doctors had a prescribed connection with the Trust as of 31st March 2026. 7 of these are doctors working in Barnsley Hospice, and, in addition, there were two doctors working in the Trust not connected to our designated body due to being on the GP specialist register. One of the doctors undertook their appraisal with the Trust by special agreement, and the other undertook their appraisals outside of the Trust, as is usual practice. • It is important to note that not all doctors with a prescribed connection will be eligible for an appraisal during April 2025-March 2026. Reasons for this would include being on a short-term contract or being newly registered in the UK during this time period and therefore calculated figures may not add up to 100% of doctors with a connection as of 31st March 2026. Please also note that the number of doctors with a GMC connection will fluctuate throughout the reporting year. o Out of all Trust employed doctors (including our Chief Medical Officer/Responsible Officer) that were due to have their appraisal, all but 5 (97%) of these have successfully completed the appraisal process during the 2025/26 window, which is only a slightly lower percentage than last year. From these 5, 3 of the appraisals were due in March 2026 and so understandably will fall outside of the window when late. Two appraisals were deferred/cancelled due to adoption and sickness leave respectively. o To note there were 5 doctors who had their appraisals outside of the Trust within this reporting year, and one doctor had 2 appraisals within this reporting year. o Please note that quarterly reporting will pick up a higher number of late appraisals as the reporting window is for a shorter period of time, and doctors leave the Trust and new ones join across the year; however, NHS reporting is based on designated body connections as of 31st March and so the numbers will not add up compared to the annual report. Any late submissions were approved and understood, by either the Associate Medical Director (AMD) for Revalidation or Responsible Officer (RO) as appropriate. • 8 positive revalidation recommendations were made between 1st April 2025 and 31st March 2026. There were no revalidation due dates in relation to Barnsley Hospice doctors during this period. o There was one deferral during this period (included in the figures above), for a doctor requiring additional time to collect multisource feedback as they had not reached the minimum number during the 5-year revalidation cycle, although the positive recommendation was then made within the same reporting year.

	○ All of the positive recommendations led to revalidation of the doctors by the General Medical Council (GMC). <u>Risk appetite:</u> The Trust continues to have a robust governance system of reporting and investigating incidents including serious incidents. The following are areas of potential difficulty for the Trust: • The voluntary status of the appraisers and their importance to our system is noted annually. • The doctors ensure they have allocated time within their job plans to conduct the duties effectively using their Supporting Professional Activities (SPA) time for the medical appraiser duties in the Trust. • There is no formally appointed Deputy Responsible Officer currently, which is something that the team will be reviewing imminently to ensure there is a formal structure for cover arrangements covering all eventualities. <u>Mitigating factors:</u> • As above, appraisers are asked to ensure they have time allocated in their job plans for the medical appraiser role. • The workload of appraisers is regularly reviewed in the Appraiser Forum and the Revalidation Oversight Group. • Ensuring the Trust has sufficient appraisers to enable the maximum number of 7 appraisals for each appraiser per year to be maintained – this is monitored frequently and regular recruitment to this role is conducted. • All doctors are consistently requested to actively choose their appraiser as soon as their current appraisal has been completed, and no later than 6 months prior to their next appraisal, and regular notifications are sent by way of reminders. • There is continued engagement with doctors to encourage them to take up such an important additional leadership role • There is an appointed AMD for Appraisal and Revalidation who provides leadership within the revalidation field. <u>Improvements/Achievements:</u> The appraisal team continue to review processes and put improvement measures in place based on a number of factors, including but not limited to; feedback from appraiser forums, any patterns of challenges or delays, and any updates Nationally. Please see below some key improvements to highlight, and the rest will be listed in the full report: • Recruitment of new appraisers, and ongoing monitoring to ensure there is sufficient availability for appraisals to continue to take place within the timescales in order to meet compliance • Excellent engagement in appraiser training and development sessions • Robust governance of processes, including monitoring of each doctor's minimum data set, which is essentially a checklist of all evidence required for a doctor's appraisal. • 99% of the doctors either agreed or strongly agreed that they would be happy to have the same appraiser again • We were able to make 100% of positive revalidations in this reporting year. • A new approach to reflections in appraisals has been communicated to doctors in terms of ensuring reflections on all red and amber incidents within

	the team a doctor is working in, and ensuring themes, learning and impact are reflected upon, not specific details of the incidents. <u>Next Steps (2026-27 Actions)</u> • Continue to monitor L2P in terms of ensuring doctors are pro-active when requesting their next year's appraiser in a timely manner • To continue to conduct annual in-person appraiser training development sessions for all appraisers to attend by way of refresher training, following excellent feedback during previous development sessions. As an outstanding action from previous years, there is still a commitment to record a session by the AMD to use during introduction to appraisal meetings for new starters within the Trust. This will complement the already robust sessions that take place periodically. • Monitor compliance in terms of completion of the new Declaration of Independent Practice forms that should be uploaded to each doctor's appraisal on an annual/ongoing basis. • Since assurance about a doctor's fitness to practice as a medical educator takes place through appraisal, capturing a doctor's participation in relevant CPD activity for this role will be strengthened, with a new standardised proforma covering a 5-year cycle (eventually to be included in L2P). In addition, in order to facilitate CPD requirements for this role, the revalidation team will work with the Trust medical education team to enhance the Trust offer of in-house medical education CPD opportunities.
Recommendation:	**Trust Board members are asked to:** **APPROVE** this report noting that it will be shared with NHSE, alongside the Statement of Compliance and recognise that the resource implications of medical revalidation are likely to continue to increase year on year, and with the added pressures of financial constraints, the stability of the medical appraisal processes should be prioritised.

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

MEDICAL APPRAISAL / REVALIDATION
ANNUAL BOARD REPORT 2025-26

1. Introduction

The Medical Appraisal and Revalidation services in the Trust are managed and maintained by the Appraisal and Revalidation Team, led by the Responsible Officer (RO) in the Trust, who is also the Trust's Chief Medical Officer, and also consists of the Associate Medical Director (AMD) for Revalidation, the Business Manager and Medical Directorate Coordinator (administrative support).

To complement the Medical Appraisal and Revalidation functions, appropriate clinical governance and assurance meetings take place periodically throughout each year and consist of members from the above team, members within the Trust outside of the Medical Directorate, including lay membership, Chief Nurse and Director of Quality and Professions as well as People Directorate representatives.

In addition, the current arrangement is that the Responsible Officer for Southwest Yorkshire Partnership Foundation Trust (SWYPFT) is also RO for the medical workforce within Barnsley Hospice. An annual Service Level Agreement (SLA) is in place to support this process.

As advised in the last report, SWYPFT purchased and officially adopted the services at Cheswold Park Hospital from 1st October 2024 as part of a funded agreement through NHS England. CPH medical professionals therefore became linked to the Responsible Officer and Designated body at SWYPFT since then, and transition has taken place across all aspects of governance.

The purpose of this annual report is to provide formal, high-level assurance to the Trust Board and NHS England that the organisation is fully compliant with its statutory and regulatory duties as a Designated Body. This will further support the signing of the NHSE Designated Body Annual Board Report Statement of Compliance (Annex D), which will be completed to complement the 2025-26 Annual Board report.

2. Executive Summary

2.1 189 doctors had a prescribed connection with the Trust as of 31st March 2026. 7 of these are doctors working in Barnsley Hospice, and, in addition, there were two doctors working in the Trust not connected to our designated body due to being on the GP specialist register. One of the doctors undertook their appraisal with the Trust by special agreement, and

the other undertook their appraisals outside of the Trust, as is usual practice.

2.2 It is important to note that not all doctors with a prescribed connection will be eligible for an appraisal during April 2025-March 2026. Reasons for this would include being on a short-term contract or being newly registered in the UK during this time period and therefore calculated figures may not add up to 100% of doctors with a connection as of 31st March 2026. Please also note that the number of doctors with a GMC connection will fluctuate throughout the reporting year.

- Out of all Trust employed doctors (including our Chief Medical Officer/Responsible Officer) that were due to have their appraisal, all but 5 (97%) of these have successfully completed the appraisal process during the 2025/26 window, which is only a slightly lower percentage than last year. From these 5, 3 of the appraisals were due in March 2026 and so understandably will fall outside of the window when late. Two appraisals were deferred/cancelled due to adoption and sickness leave respectively.
- To note there were 5 doctors who had their appraisals outside of the Trust within this reporting year, and one doctor had 2 appraisals within this reporting year.
- Please note that quarterly reporting will pick up a higher number of late appraisals as the reporting window is for a shorter period of time, and doctors leave the Trust and new ones join across the year; however, NHS reporting is based on designated body connections as of 31st March and so the numbers will not add up compared to the annual report. Any late submissions were approved and understood, by either the Associate Medical Director (AMD) for Revalidation or Responsible Officer (RO) as appropriate.

2.3 8 positive revalidation recommendations were made between 1st April 2025 and 31st March 2026. There were no revalidation due dates in relation to Barnsley Hospice doctors during this period.

- There was one deferral during this period (included in the figures above), for a doctor requiring additional time to collect multisource feedback as they had not reached the minimum number during the 5-year revalidation cycle., although the positive recommendation was then made within the same reporting year.
- All of the positive recommendations led to revalidation of the doctors by the General Medical Council (GMC).

3. Purpose of Paper

This report is presented to the Board:

3.1 For assurance that the statutory functions of the RO role are being appropriately and adequately discharged.

3.2 To inform of progress in medical appraisal and revalidation during 2025/26.

4. Background

4.1 2025/26 was the fourteenth year of medical revalidation. Launched in 2012 to strengthen the way that doctors are regulated, the aim is to improve the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical profession.

4.2 The e-appraisal web-based system that the Trust continues to utilise has been renamed recently as Patchwork, although the platform used continues to be referred to as L2P.

4.3 Each doctor must have a Responsible Officer (RO) who must oversee a range of processes including annual appraisal, and who will at five-yearly intervals make a recommendation to the GMC in respect of the doctor's revalidation.

4.4 The RO is appointed by the Board of the organisation, termed a Designated Body, to which the doctor is linked by a Prescribed Connection.

4.5 The RO for SWYPFT is also the appointed RO for Barnsley Hospice through a Service Level Agreement.

4.6 Provider organisations have a statutory duty to support their RO in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards/executive teams will oversee compliance by:

4.6.1 Monitoring the frequency and quality of medical appraisals in their organisation.

4.6.2 Checking there are effective systems in place for monitoring the conduct and performance of their doctors.

4.6.3 Confirming that feedback from service users/patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors.

4.6.4 Ensuring that appropriate pre-employment background checks (including pre-employment for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4.7 Compliance with the Responsible Officer Regulations forms part of the Care Quality Commission inspection.

5. Governance

5.1 Trust's Appraisal and Revalidation Team

- Responsible Officer – Professor Subha Thiyagesh
- Associate Medical Director for Revalidation – Dr Mike Ventress
- Business Manager, Medical Directorate – Michelle Goth
- Medical Directorate Coordinator – Tracy McCaffrey
- People Directorate Representatives with responsibility to support Revalidation via People Relations Team

5.2 Main Tools Utilised Centrally

- Patchwork/L2P (web based) – e-appraisal system
- Datix incident reporting system) – provision of incident, complaints and compliments data
- Electronic Staff Record (ESR) Manager Self-Service – provision of sickness data and mandatory training
- GMC Connect (web based) – designated body list

5.3 Designated Body List

The Business Manager and Coordinator ensure that the designated body list of doctors is accurate. The formal list of the Trust's prescribed connections is recorded on the GMC Connect portal. As individual doctors are able to add themselves to this list, it is regularly checked to ensure that all the prescribed connections are appropriate. To facilitate this, a regular starters and leavers report is provided from the Electronic Staff Record (ESR)

5.4 External Oversight

The Trust is subject to the oversight of the NHS England Revalidation Team. The Medical Directorate Business Manager, with the support of the Appraisal and Revalidation Team, completes the Annual Organisational Audit/Statement of Compliance (Annex D) along with quarterly reports to the Board and continues to submit quarterly reports that are included in the Integrated Performance Report (IPR)

5.5 Internal Oversight

5.5.1 The AMD, Business Manager and Coordinator meet fortnightly to oversee the day-to-day running of the appraisal and revalidation processes.

5.5.2 The RO, AMD and Business Manager meet monthly to ensure that there is regular communication with the RO and that any issues are highlighted and acted upon, and to formally consider those doctors with a revalidation recommendation required within the following 12 months. Where a meeting is not possible, and if there are any urgent matters to discuss, email and telephone conversations take place to ensure matters are dealt with in a timely manner.

5.5.3 The RO and Business Manager meet with the CEO and Medical Lead of Barnsley Hospice on a quarterly basis to seek assurance that governance processes are in order and so that appropriate and relevant information-sharing discussions can take place.

5.5.4 The Revalidation Oversight Group, which meets 3 times per year has the aims:

- To advise the Responsible Officer of delivery of appraisal and revalidation processes and overall direction in terms of strategic, policy and performance.
- The group has a volunteer lay member to provide independent scrutiny and service user input.

5.6 Independent Verification

5.6.1 Independent verification is required to be undertaken every 5 years. Following a successful peer review with Leeds and York Partnership NHS Foundation Trust, a similar sized mental health Trust, in December 2022, the next review will be scheduled for 2027, in line with NHS England guidance.

6 Medical Appraisal

6.1a NHSE Compliant Appraisal Data

Annual Compliance Report for NHS England (Annex C, Annual Organisational Audit)

Designated Body:	**South West Yorkshire Partnership Teaching NHS Foundation Trust**
Start date of period:	1 April 2025
End date of period:	31 March 2026

AOA Reference	Item	Number of prescribed connections	Completed appraisals (1)	Optional completed appraisals (1a)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (2)	Total
2.1.1	Consultants	97	95	68	4	0	99**
2.1.2	Staff grade, associate specialist, specialty doctor	81	73	51	9	1	83**
2.1.3	Doctors on Performers Lists	0	0	0	0	0	0
2.1.4	Doctors with practising privileges	0	0	0	0	0	0
2.1.5	Temporary or short term contract holders	7	7	6	0	0	7**
2.1.6	Other clinicians with a prescribed connection	4	4	3	0	0	4**
2.1.7	**Total of 2.1.1 - 2.1.6**	189*	179	128	13	1	193**

The number of prescribed connections is as of 31st March 2026, and not a picture of the appraisal activity through the year.
****This figure is the total of columns 4, 6 and 7 above***

The NHS England rules have been applied as follows, based on a reasonable interpretation of the rules in terms of the L2P data.

For every clinician with a prescribed connection:

If the clinician had any appraisals with a meeting date in the reporting year, count those appraisals (see below).

Otherwise:

If the clinician had any appraisals with an appraisal month in the reporting year, count those appraisals (see below).

Otherwise the clinician had no appraisals in the reporting year or no appraisal dates set, so the clinician is counted in measure 2.

For every appraisal counted above:

If the meeting date was in the reporting year and the appraisal was signed off:

If the meeting was within the 3 months before the due date AND the submission was within 28 days of the meeting date AND the submission was in the reporting year, then both measure 1 and optional measure 1a.

Otherwise, just measure 1.

If the meeting date was in the reporting year and the appraisal was not signed off:

If the appraisal was on time, then measure 2.

If the appraisal was late and the reason was understood and accepted, then measure 2.

Otherwise, measure 3.

Otherwise, the meeting date was not in the reporting year:

If the meeting date was early (ie before the reporting year) and the appraisal was submitted early or on time, then measure 2.

If the appraisal was late and the reason was understood and accepted, then measure 2.

Otherwise, measure 3.

6.1b Appraisal Data – Barnsley Hospice (figures also included in the above NHSE report)

Number of doctors as of 31st March 2026 who have a prescribed connection to the Trust	7	
Number of completed appraisals during 2025/26:	8	100%*
Number of missed/ incomplete or late appraisals during 2025/26(see reasons in appendix 1):	0	0%
Number of doctors in remediation:	0	0%
Number of doctors in disciplinary processes	0	0%

**Please note one doctor had 2 appraisals within the window as the 2024/25 appraisal was slightly later than planned.*

6.2 Appraisers as of 31st March 2026

6.2.1 Number of appraisers – 29 (25 consultants, including 1 from Barnsley Hospice, 4 SAS doctors)

6.2.2 The role of the appraiser is available for all substantive and some fixed term doctors to apply for, including Consultants, SAS doctors and International Fellows. There remains an active and continuous recruitment process to identify doctors who may be interested in the role. The interested doctors apply and are selected following an interview process. The Trust supports the appraisers through active job planning by their respective medical clinical leads in ensuring time is allocated. There is no additional remuneration for the role; however, appraisers are allocated 0.5PA in their job plan for it.

6.2.3 Support activities undertaken:

- In-person medical appraiser forums were held on 15th May 2025, and 22nd January 2026, with a full day appraiser refresher training and development day held on 23rd October 2025.which was facilitated by the AMD, along with 3 experienced Trust appraiser trainers. In addition, a full day new appraiser training session was provided on 30th April 2025 for 3 new appraisers. Due to excellent feedback and increased attendance, the appraiser refresher training and development day will continue to be held in-person on an annual basis. The next session is scheduled for 9th October 2026.
- Continuous improvement of the appraisal process in the Trust is also an important topic for discussion, and areas of good practice and reasons for appraisals being referred back for further work are highlighted by the AMD.

6.3 Quality Assurance Processes

6.3.1 There is a portfolio minimum data set required for appraisal and the appraisers are required to check that this is uploaded or an adequate reason provided for non-inclusion. In addition to this, the Trust's Medical Directorate Coordinator performs additional checks at the point of submission of a completed appraisal to ensure that there is an uploaded or completed document for each element of the minimum data set.

6.3.2 The Trust utilises the multisource feedback tool embedded within L2P for most doctors. This automatically flags with the doctors

when they are required to undertake the colleague and patient feedback (required to be undertaken every 3 years, unless new to the Trust then required within first year). The reports are only released to the doctor if they have gained the minimum number of responses (and undertaken their self-assessments) or a request for release to the Appraisal and Revalidation Team is agreed under exceptional circumstances.

6.3.3 The alternative ACP360tool, that the Trust adopted to obtain feedback from services users within Learning Disabilities or their carers is used by doctors within that specialty, with no reported negative feedback from users. There has been minimal use of this tool so far due to the small number of LD doctors and the timescales for their feedback due dates, and usage and feedback will be monitored as usage increases.

6.3.4 The Appraisal and Revalidation Team inform the doctor if they are required to change their appraiser for their next appraisal (change is required after three consecutive appraisals with same appraiser). This occurs through automatic reminders to change appraiser through L2P and has continued to work successfully without issue.

6.3.5 The AMD reviews all submitted appraisals (excluding those where the AMD is the appraiser). Checks are made on appraisal inputs (appraisal portfolio), appraisal outputs (Personal Development Plan (PDP), appraisal summary and sign-off) and where appropriate, the AMD will request further work be undertaken prior to recommending to the RO that an annual appraisal is satisfactory. Those appraisals where the AMD was the appraiser are similarly reviewed by the RO.

6.3.6 The RO subsequently reviews completed appraisals on receiving the AMD's recommendation and either concurs or requests further clarification.

6.3.7 Each doctor is asked to provide feedback about the system and appraiser after their appraisal has been submitted (see section 6.6). This process is embedded in the L2P system. This feedback is combined with other objective measures and observations of the AMD who provides feedback in writing to appraisers on an annual basis. If any issues arise in the course of the year, the AMD will liaise with individual appraisers.

6.3.8 The reviews undertaken by the AMD and RO also often generate agenda items for the Medical Appraiser Forums, where particular themes are then discussed.

6.3.9 The appraisers receive further group feedback during Medical Appraiser Forum meetings.

6.3.10 Such issues are also discussed at the new appraiser and refresher training.

6.3.11 Due to previous issues of a minority of doctors leaving their request to have a particular appraiser until shortly before the appraisal meeting itself (which has meant appraisers may lack availability and therefore a delay in allocation or of the appraisal taking place), it has been agreed that appraisers should be chosen at least six months before the appraisal date, and doctors are advised to select next year's appraiser on L2P following their appraisal, in particular if the same appraiser is to be selected. A prompt is provided through L2P to this effect.

6.3.12 Doctors are asked to start collecting patient feedback at least a year in advance of the appraisal meeting, and in select specialities with limited patient contact or typically fewer patient responses, throughout the three-year feedback period.

6.3.13 Of note, in SWYPFT no doctor is appraised by their line manager, and this process was also adopted by Barnsley Hospice to ensure consistency throughout. Both policies have been updated accordingly to reflect this.

6.3.14 In 2023, an update to the Framework for Quality Assurance and Improvement from NHS England was introduced. This updated guidance is referred to in our most up to date Medical Appraisal Policy, and the Appraisal and Revalidation Team have an action plan in place in order to evidence application of this guidance within the Trust.

6.4 Access, security and confidentiality

6.4.1 The e-appraisal system (L2P) is required to be used by all doctors. No breaches to the system or individual portfolios were recorded during 2025/26.

6.4.2 Access to individual appraisals on L2P is restricted by login to the doctor, their appraiser, RO, Chief Medical Officer (CMO), AMD and the wider Appraisal and Revalidation Team, and any other person to whom the doctor provides access (via their own login).

6.4.3 Doctors are made aware via the L2P system that no patient identifiable information should be included in their appraisals. This is also stated in the Trust's Medical Appraisal Policy.

6.5 Clinical Governance

6.5.1 All doctors are provided with a PDF formatted record (including a nil response if appropriate) of incidents, complaints and sickness for their appraisal year from the Appraisal and Revalidation Team. This data is directly uploaded to the doctor's appraisal record on L2P. Doctors are required to reflect on their involvement in incidents and complaints included in the reports and any others of which they are aware, but which may not have been linked to them via Datix.

6.5.2 The minimum requirement for the appraisal portfolio is provided in a Portfolio Minimum Data Set, which is reviewed every year.

6.5.3 Doctors are required to complete a checklist prior to submitting their appraisal to their appraiser and where key information (predominately the minimum data set) is missing, they are required to provide a reason for its absence.

6.6 Appraisal feedback

Of the 160 feedback questionnaires completed by doctors after their appraisal, the following is a sample extract of questions used for:

Was your appraisal useful for:	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Your personal development	55% (43%)	39% (52%)	5% (3%)	0% (0%)	1% (1%)
Your professional development	58% (50%)	39% (45%)	2% (3%)	0% (0%)	1% (1%)
Your preparation	63% (55%)	35% (40%)	2% (4%)	0% (0%)	1% (1%)

for revalidation					
Promoting quality improvements in your work	**52% (44%)**	**43% (49%)**	**4% (6%)**	**0% (0%)**	**1% (1%)**
Improving patient care	**51% (45%)**	**40% (45%)**	**7% (8%)**	**1% (1%)**	**1% (1%)**

Number of hours	**<1**	**1-2**	**2-3**	**3-4**	**>4**
Duration of appraisal discussion	**6% (3%)**	**71% (69%)**	**14% (20%)**	**4% (3%)**	**5% (6%)**

	Strongly agree	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**
The appraisal process was satisfactory	**69% (66%)**	**28% (32%)**	**1% (0%)**	**1% (1%)**	**1% (1%)**
I was able to collect all the necessary supporting information from the organisation	**62% (58%)**	**34% (37%)**	**4% (4%)**	**1% (0%)**	**1% (1%)**

***() are the 2024/25 results.**

NB: 99% of the doctors either agreed or strongly agreed that they would be happy to have the same appraiser again.

6.6.1 Every appraisee is invited to give confidential feedback after their appraisal. Each appraiser receives this feedback on an annual basis, generated by L2P, which contains both free text comments and satisfaction scores, and which they can use for their own personal development as an appraiser. The AMD reviews these on an annual basis, both as aggregated results for the whole appraiser cohort and for individual appraisers. Any specific issues that arise are brought to the attention of appraisers by the AMD and appraisers receive a letter summarising their involvement in appraisal that year.

7. Revalidation Recommendations (1.4.25 to 31.3.26)

Number of recommendations	8 (including a positive recommendation after a deferral) *
Recommendations completed on time	8

Positive recommendations	8
Deferral requests	1(this was later submitted as a positive recommendation in the same reporting year
Non engagement notifications	0

**No Hospice doctors were due for revalidation during this period*

7.1 The Revalidation Review Group meet monthly and consider those revalidation recommendations due to be made in the following 12 months. This allows time for any further requirements to be actioned to enable a positive revalidation recommendation to be made.

7.2 All positive recommendations were approved by the GMC and the doctors subsequently revalidated.

See Appendix 3; Audit of revalidation recommendations

8 Recruitment and engagement background checks

8.1 Substantive and Fixed Term appointments

During 2025/26, the Trust employed 43 non-training doctors to include 14 consultants, 4 of which were appointed into an acting consultant post, and 19 specialty doctors, along with 1 Trust grade and 5 Locum Appointment for Specialty (LAS) posts to filling gaps in the various training rotations.

8.1.1 During the application and interview process, doctors are assessed to ensure they have the qualifications and experience in order to fulfil the duties of the post.

8.1.2 Where appropriate, Medical Staffing colleagues check the national database for Approved Clinician and Section 12 status. GMC registration is also checked.

8.1.3 Reference checks from the previous 3 years of employment are undertaken by Medical Staffing and the Appointing Officer confirms that they are satisfied with the references. The references will be checked for the correct dates and that the referee is the appropriate person.

8.1.4 Medical Staffing would normally meet with the doctor to verify their ID using the acceptable documents list. In some circumstances, copies are requested in advance, and the originals are then checked, copied, signed and scanned by the clinical lead or appropriate administrator on the doctor's first day.

8.1.5 The Medical Directorate requests information from the doctor's current/last RO, where the doctor has had one. This includes

information about the doctor's last appraisal date, whether there are any concerns about the doctor's practice, conduct or health and if there are any outstanding investigations. The information received is checked by the Trust's RO, prior to a final offer being made. Where this information is not received prior to the final offer being made*, the offer remains subject to satisfactory RO information or satisfactory Annual Review of Competence Progression (ARCP) outcome for those doctors joining the Trust straight from a training programme.

8.1.6 The Chief Medical Officer or delegate checks and approves the final offer letter prior to sending.

8.1.7 If a doctor is recruited with GMC conditions, further information from the GMC is requested.

8.2 Supporting New Doctors

All newly appointed doctors into a non-training post receive a welcome and introduction session to appraisal and L2P, the platform used by the Trust. These sessions are conducted by the AMD for Appraisal and Revalidation within a few weeks of a doctor joining the Trust. These are usually group sessions for new starters to the Trust, and the sessions are tailored to suit the doctors attending, bearing in mind any new doctors to the UK and NHS, such as our valuable international medical graduate workforce. There is ongoing support and guidance available for new doctors with the system support team (L2P) and the wider Appraisal and Revalidation team.

As part of minimum data set checks conducted by the appraisal team, any low health and wellbeing score is flagged in order that the AMD can make contact with the doctor to review whether any enhanced support is required, if that has not already been addressed prior to being made aware. Any additional developmental support can be put in place, or concerns escalated as appropriate as part of those ongoing checks.

8.3 Agency Locum appointments

8.3.1 Agency locum doctors do not have a prescribed connection to the Trust. Their connection is with their locum agency. It is the agency's responsibility to ensure their doctors are appraised and revalidated. However, the Trust's processes to engage locums do include appraisal and revalidation checks.

8.3.2 For any locum doctor who has not had an appraisal within 24 months, then it is recommended the doctor is not engaged.

8.3.3 If a booking is taken forward, a checklist is sent via email confirming the doctor has a DBS, Occupational Health clearance, Right to Work etc.

8.3.4 In line with the Trust guidance on booking locum doctors, the appropriate Clinical Lead is then required to undertake a telephone interview prior to commencement.

8.3.5 In line with Trust guidance on booking locum doctors, on their first day a locum doctor's identification should be verified through the checking of their passport or photo-card driving licence by the medical clinical lead or nominated person.

9. Monitoring Performance

9.1 Doctors are generally monitored through their team management structures.

9.2 In addition, selected elements of a doctor's performance are monitored via the appraisal system, including a Trust requirement for multi-source feedback from service users and colleagues on a three-yearly basis, or within 12 months for a new doctor commencing work in the Trust. Please note that this stipulation is more frequent than the 5-yearly expectation from GMC guidance and will continue to be included in the Trust's Medical Appraisal Policy.

~~9.3~~ Information in relation to whether a doctor has been linked to any incidents logged on the Trust (or Hospice) incident reporting system or whether they have been the subject of any complaints is also included within the appraisal process, primarily as an opportunity for reflection by the doctor. Investigations into complaints or serious incidents are managed through standard Trust (or Hospice) systems that fall outside of the appraisal process.

9.4 In the event that any concerns are raised about a doctor's practice, these are referred to the Responsible Officer, who can instigate various levels of investigation and/or take the issue to the Responding to Concerns Advisory Group, as appropriate.

9.5 The Responsible Officer has discretion to require specific information about a doctor's practice (outside of that ordinarily included in appraisal) to be included in and discussed at the appraisal.

10. Responding to Concerns and Remediation

10.1. The Trust has a Responding to Concerns and Remediation Policy which was reviewed and approved in August 2024. The next review of this policy is due by August 2027.

10.2. As at 31.3.26 the Trust has 2 trained Case Managers and 5 trained Case Investigators, all of whom are medical consultants, and conduct investigations as required in-keeping with MHPS process. Case investigators play a crucial part in responding to concerns about a doctor's practice. Their role is to examine relevant evidence in line with an investigation's terms of reference, determine findings of fact and produce a report.

The investigator will ask the practitioner for a response to the concerns raised, resolve any conflicts of evidence, determine the facts and produce a report which accurately captures all relevant details and findings. All investigators also have a duty to maintain confidentiality and ensure that the investigation is documented.

Case managers, (Chief Medical Officer and Associate Medical Director for Workforce & Operations) would oversee the investigation process, appoint investigators, ensure proper procedure and confidentiality, and facilitate the development of support or remediation plans for the doctor, focusing on a fair and effective resolution while protecting patient safety.

10.3. A Responding to Concerns Advisory Group meets monthly. It is chaired by the RO and is also attended by the Chief Medical Officer (currently both roles are held as one), Chief People Officer or Deputy, the AMD for Revalidation, Chief Nurse & Director of Quality and Professions or Deputy, and the Medical Directorate Business Manager or alternative cover as required. Relevant representatives may attend as and when required. This approach ensures a consistent and open view is taken across the Trust in the investigation and review of concerns in relation to doctors. The group's terms of reference are included in the Responding to Concerns and Remediation Policy.

10.4. Remediation, when identified, is carried out on an individual basis, being tailored to the individual's needs.

11. Improvements Implemented 2025-26

11.1 The number of appraisers continues to be monitored to ensure there is sufficient availability for appraisals to continue to take place within the timescales in order to meet compliance, and all appraisers are asked to encourage new doctors into the appraiser roles if there are qualities and interest highlighted in a doctor's appraisal. Further recruitment has taken place throughout the year to maintain an acceptable level of medical appraisers in the Trust.

11.2 The Trust now has an additional trained case manager in addition to the Chief Medical Officer.

11.3 Appraisers are now asked to conduct a minimum of 5 and a maximum of 7 appraisals per year, in order to ensure fairness of workload across the group of appraisers and to maintain their competence (historically, some appraisers have volunteered to do more than the maximum of 7 appraisals, where no other appraisers have been available). The current appraiser numbers mean that this figure is achievable. As appraiser or appraisee numbers increase or decline, this ratio will change accordingly.

11.4 A new approach to reflections in appraisals has been communicated to doctors in terms of ensuring reflections on all red and amber incidents within the team a doctor is working in, and ensuring themes, learning and impact are reflected upon, not specific details of the incidents.

11.5 A formal decision has been reached regarding doctors working purely on medical bank, in that if a doctor has no other medical primary role elsewhere, the doctor can be linked to the Trust's designated body and supported to conduct their appraisal in the Trust.

11.6 A new declaration of independent practice has been introduced for all doctors within the Trust. This is to be included as part of the minimum dataset for appraisal and will be reviewed/discussed at the appraisal (it will also separately be required for job planning).

12. Next Steps (2026-27 Actions)

12.1 Continue to monitor L2P in terms of ensuring doctors are pro-active when requesting their next year's appraiser in a timely manner

12.2 To continue to conduct annual in-person appraiser training development sessions for all appraisers to attend by way of refresher training, following excellent feedback during previous development sessions. As an outstanding action from previous years, there is still a commitment to record a session by the AMD to use during introduction to appraisal meetings for new starters within the Trust. This will complement the already robust sessions that take place periodically.

12.3 The number of appraisers will continue to be monitored to ensure there is sufficient availability, with expressions of interest sent out periodically to maintain and increase numbers, along with continuing to identify individuals expressing an interest or doctors with key qualities of a suitable future appraiser.

12.4 Monitor compliance in terms of completion of the new Declaration of Independent Practice forms that should be uploaded to each doctor's appraisal on an annual/ongoing basis.

12.5 Since assurance about a doctor's fitness to practice as a medical educator takes place through appraisal, capturing a doctor's participation in relevant CPD activity for this role will be strengthened, with a new standardised proforma covering a 5-year cycle (eventually to be included in L2P). In addition, in order to facilitate CPD requirements for this role, the revalidation team will work with the Trust medical education team to enhance the Trust offer of in-house medical education CPD opportunities.

13. Recommendations

13.1 For the Quality and Safety Committee to receive and approve for review and approval by The Trust Board

13.2 The Trust Board is asked to recommend for approval and submission to NHS England.

13.3 The Trust Board is further asked to recognise that the resource implications of medical appraisal and revalidation processes are likely to continue to increase year on year.

APPENDIX 1

AUDIT*OF LATE APPRAISALS DURING 2025/26

DOCTOR FACTORS	CONSULTANT PSYCHIATRISTS	SAS/TRUST GRADE/OTHER (including Hospice Staff)
Parental Leave during the majority of the appraisal period	0	0
Sickness Absence during the majority of the appraisal period	0	0
Prolonged Leave during the majority of the appraisal period	0	0
Suspension during the majority of the appraisal period	0	0
New starter	0	0
Postponed due to incomplete portfolio / insufficient supporting information	0	0
Lack of time of doctor	0	1 (submitted to appraiser 2 months' late due to change of post and workload)
Lack of engagement of doctor	0	0
Other doctor factor e.g. bereavement, sickness, or other time factors not applicable elsewhere	1 (sickness prior to the appraisal due date, appraisal held 1 month late)	1 (complex case where appraiser has struggled to contact doctor and additional supportive measures are in place – currently outstanding)

APPRAISER FACTORS	NUMBER	
Unplanned absence of appraiser	0	0
Lack of time of appraiser	0	1 (late submission from March 2026, currently outstanding due to workload)
Other appraiser factor (describe)	0	1 (late appraisal by 1 month due to sickness of appraiser who required time to catch up

ORGANISATION FACTORS	NUMBER	
Administration or management factors	0	0
Failure of electronic information systems	0	0
Insufficient numbers of trained appraisers	0	0
Other organisational factors (describe) – suspension of appraisal due to Covid-19	0	0

NB: It should be acknowledged that there is an expectation that due to busy schedules and staffing vacancies, there is a likelihood that some late submissions will continue and the Appraisal and Revalidation team will continue to monitor this to ensure support is in place for doctors struggling to participate in the appraisal process in a timely manner.

Appraisees are continually encouraged to request an appraiser early; in some cases the same appraiser can be requested immediately after completion of an appraiser. The Appraisal and Revalidation Team do not allocate appraiser; however, will step in to assist if a doctor is struggling to secure an appraiser within a timely manner.

Appraisers are also requested to accept or decline appraisal requests in a timely manner so that doctors can go on to request a different appraiser in good time.

There is likely to be some crossover of appraisal data for March 2026 appraisals as updates beyond 31st March will not be captured in the NHSE compliance report.

**Please note that the details stated above are as of 31st March 2026 when the annual reporting data becomes available. Quarterly reporting throughout the year will most likely reflect higher numbers due to staff turnover across the year, and data for doctors who have left the Trust prior to 31st March 2026 will no longer be captured in the annual report for that year.*

APPENDIX 2

QUALITY ASSURANCE AUDIT OF APPRAISAL INPUTS AND OUTPUTS

All appraisals are reviewed by the Medical Directorate Coordinator, followed by the Associate Medical Director for Appraisal and Revalidation, to include checks for the following appraisal inputs/outputs and omissions are flagged at an early stage:

All deficits were addressed satisfactorily after the appraisal had been referred back.

APPRAISAL INPUTS
Scope of work
Is continuing professional development compliant with GMC requirements?
Is quality improvement activity compliant with GMC requirements?
Has a patient feedback exercise been completed?
Has a colleague feedback exercise been completed?
Have all complaints been included and appropriately reflected on?
Have all significant events been included and appropriately reflected on?
Is there sufficient supporting information from all the doctor's roles and places of work?
Is the portfolio sufficiently complete for the stage of the revalidation cycle?

APPRAISAL OUTPUTS
Appraisal summary
Appraiser statement
PDP

APPENDIX 3

AUDIT OF REVALIDATION RECOMMENDATIONS (1st April 2025 to 31 March 2026)

Recommendations completed on time (within GMC recommendation window)	8 (including one deferral)
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	8

PRIMARY REASON FOR LATE/MISSED RECOMMENDATIONS	
No Responsible Officer in post	0
New starter / new prescribed connection established within 2 weeks of revalidation due date	0
New starter / new prescribed connection established more than 2 weeks of revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible Officer error	0
Inadequate resources or support for the Responsible Officer role	0
Other (describe). Appraisal and Revalidation team meeting was missed due to short notice bank holiday given in May 2022. This resulted in a 1-day late recommendation. There were no implications with regard to this short delay and the recommendation was still within the GMC accepted timeframe.	0
TOTAL (sum of late and missed)	0

APPENDIX 4

AUDIT OF CONCERNS ABOUT A DOCTOR'S PRACTISE

CONCERNS	HIGH LEVEL	MEDIUM LEVEL	LOW LEVEL	TOTAL
NUMBER OF DOCTORS WITH CONCERNS ABOUT THEIR PRACTISE IN THE LAST 12 MONTHS				
Capability concerns (as primary category)	0	0	0	0
Conduct concerns (as primary category)	0	0	0	0
Health concerns (as primary category)	0	0	0	0

REMEDIATION/RESKILLING/RETRAINING/REHABILITATION	
Number of doctors who have undergone formal remediation	0
Consultants (permanent, employed staff)	0
Staff grade, associate specialist, specialty doctor (permanent, employed staff)	0
Temporary or short-term contract holders	0

OTHER ACTIONS / INTERVENTIONS	
LOCAL ACTIONS	
Number of doctors who were suspended/ excluded (commenced or completed between 1.4.25 and 31.3.26)	0
Number of doctors who have had local restrictions placed on their practise in the last 12 months	0
GMC ACTIONS	
Number of doctors referred to the GMC between 1.4.25 and 31.3.26	0
Number of doctors who underwent or undergoing GMC Fitness to Practise procedures between 1.4.25 and 31.3.26	1 (ongoing from previous reporting year)
Number of doctors who had conditions placed on their practise by the GMC or undertakings agreed with the GMC between 1.4.25 and 31.3.26	1 (same doctor as above – please note this ended on 15th May 2025)
Number of doctors who had their registration / licence suspended by the GMC between 1.4.25 and 31.3.26	0
Number of doctors who were erased from the GMC register between 1.4.25 and 31.3.26	0

NHS Resolution ACTIONS	
Number of doctors about whom NHS Resolution has been contacted between 1.4.25 and 31.3.26	0
Reason for contacts:	
For advice	
For investigation	0
For assessment	0
Number of NCAS investigations performed	0
Number of NCAS assessments performed	0

Where 5 or more doctors have concerns about their practise in the year, a breakdown of appropriate protected characteristics will be provided

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29 September 2026
Agenda item 12.4

Private/Public paper:	**Public**		
Title:	**Annual report on the Social Responsibility and Sustainability (SRS) strategy and Green Plan**		
Lead Director:	**Dawn Lawson, Executive Director of Strategy, Inclusion and Change/Deputy Chief Executive**		
Mission/values:	This work is in line with the Trust mission and values		
Purpose:	To update the Equality Inclusion and Involvement committee on progress following the adoption of the Social Responsibility & Sustainability Strategy		
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):	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.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Following recent significant changes as ICB level, we are now awaiting details on how we will be expected to report and external governance will be provided. We are also fully engaged and active in all the relevant place-based groups, examples of which are included in the main report.		
Any background papers / previously considered by:	Previous Social Responsibility and Sustainability annual report (December 2025). Trust Green Plan 2025-2028 (as presented to Trust Board on 30.09.25).		
Executive summary:	The summary set out in the report demonstrates the breadth of work that is underway or planned to deliver the SRS strategy. The opening summary section of the report contains details on the overall progress of the strategy for which there are three primary drivers: 1. Delivery mechanisms, governance, and reporting 2. Strategy – commence work on headline initiatives. 3. Establish change approach.		

	We now have in place: • A good understanding of each of the listed priorities • Data on where progress has been made or otherwise • Refreshed measures where sustainability measures have become business as usual
Recommendation:	**Trust Board Members are asked to:** • **NOTE** the report and progress made since the last annual report in December 2025, the relationship between this report and the Green Plan for 2025-28 and the actions in relation to the increase in carbon emissions.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board Annual Report - September 2026
Social Responsibility and Sustainability (SRS) Strategy and Green Plan

1. Introduction

This paper provides the Trust board with a comprehensive update on the delivery of the Trust's Social Responsibility and Sustainability (SRS) Strategy and Green Plan. It outlines progress to date, presents a refreshed approach to strengthening delivery and measurement, and highlights key developments in relation to climate risk, adaptation planning, and regulatory expectations.

Since the adoption of the strategy in 2022, bi-annual reports have been given to the Equality Inclusion and Involvement committee. Following changes agreed at the April 2026 Trust board meeting, reporting has been moved to the newly established Transformation, Innovation and Sustainability Committee. This will ensure stronger alignment with the Trust's strategic change programme and emerging statutory sustainability requirements. The shift provides clearer oversight, a more integrated governance route, and a better fit with our commitment to system-wide transformation, enabling equality and inclusion impacts to be considered alongside innovation, service redesign and long-term sustainability.

The paper also sets out the next phase of work required to ensure the Trust continues to align with national NHS Net Zero commitments, Integrated Care System (ICS) priorities, and emerging Care Quality Commission (CQC) expectations. The Trust board is invited to note the progress made, endorse the proposed enhancements to delivery and measurement, and support the continued embedding of sustainability across Trust operations.

2. Background

The Social Responsibility and Sustainability (SRS) Strategy aims to maximise the value the South West Yorkshire Partnership Teaching NHS Foundation Trust delivers to local people, communities, and places. Emphasis is placed on supporting those who experience inequality, deprivation, or disadvantage, ensuring that the Trust's resources and influence are used to improve both health outcomes and wider determinants of health.

The strategy is aligned with the Trust's broader strategic objectives, as well as ICS priorities and the NHS Net Zero ambition. Delivery is structured around five headline initiatives, which provide a clear framework for action. These include partnerships, culture and civic role; the Trust's role as an employer; procurement of goods and services; management of environmental impacts, estates and assets; and engagement with less advantaged and diverse communities to ensure services are accessible, inclusive, and responsive.

3. Strategic Context and System Alignment

The Trust continues to operate within an evolving national and system context, where expectations around sustainability and social value are increasing. Alignment with ICS Green Plan priorities remains strong, and the Trust is actively contributing to place-based partnerships, including the Wakefield Strategic Social Value Group and the Barnsley 2040 programme.

These partnerships are supporting a broader shift towards collaborative, system-led approaches to social value, sustainability and resilience. There is an increasing expectation that organisations demonstrate measurable outcomes, contribute to shared Net Zero targets across Scope 1, 2, and 3 emissions, and play an anchor institution role in supporting local economic and community resilience.

The SRS strategy and Green Plan continue to be developed and delivered in a context of evolving system and local dynamics, both of which introduce a level of uncertainty that we are actively managing. At system level, recent changes to Integrated Care Boards, alongside ongoing national direction, have created some ambiguity regarding their future role and priorities, and the extent of their influence on planning and delivery. In parallel, local political changes are shaping priorities and decision-making frameworks, with potential implications for alignment, pace, and resource allocation. While these factors may affect the operating environment, we are maintaining close engagement with system partners and local stakeholders to ensure the SRS strategy and Green Plan remain responsive, resilient, and aligned to agreed expectations.

4. Progress to Date

Progress has been made across all five headline areas of the SRS strategy, with increasing maturity in both delivery and engagement. Within partnerships and civic leadership, the Trust has strengthened its involvement in system-wide initiatives, contributing to the development of shared priorities and influencing local strategies on sustainability and social value. This work is beginning to position the Trust as an active and credible partner in place-based transformation around this agenda.

In relation to workforce and organisational culture, sustainability is increasingly being embedded within leadership discussions and organisational development. A structured Green Team support offer has been developed, providing services with accessible resources and practical guidance to act at a local level. While awareness of sustainability issues continues to grow across the workforce, further work is required to embed sustainability within formal objectives, leadership responsibilities, and appraisal processes.

Clinical leadership will be enhanced through the introduction of a Clinical Lead for Sustainability. This role is currently under discussion and if progressed it will strengthen clinical engagement and supporting the integration of sustainability into care delivery. Progress has also been made through Greener Allied Health Professional (AHP) initiatives, which are helping to reduce waste, promote prevention, and support lower-carbon models of care.

In the procurement and supply chain, the Trust has continued to align with NHS Net Zero supplier requirements and now incorporates sustainability considerations into all purchasing decisions. Early work to reduce reliance on single-use items has been undertaken where clinically appropriate, and further development will take place to embed social value consistently within procurement frameworks.

Progress within estates and environmental management has focused on improving energy efficiency and reducing environmental impact. Initiatives such as the NHS uniform programme are supporting more sustainable approaches through reduced waste and improved lifecycle management, although the main emphasis remains on higher-impact areas such as energy use and infrastructure with ongoing work around the introduction of solar power and installing LED lighting systems.

5. Living our values excellence – social responsibility and sustainability

The Trust continues to embed the aims of the strategy and green plan through the *"living our values excellence – social responsibility and sustainability"* award, which spans environmental improvement, social value, community engagement, and reduction in health inequalities. The awards also support awareness, engagement, and the scaling of best practice across services.

Winner: *Trustwide Facilities Team – QI Inpatient Food Waste Project*
This project used 10 months of detailed tracking and analysis of food waste and meal uptake to drive improvement, alongside a shift to patient-led meal ordering. It reduced inpatient food waste from 2.515 tonnes (May 2024) to 1.325 tonnes (August 2025), a **47% reduction**, while ensuring waste is repurposed into green energy.

Runner-up: *Fleet Management Team – Road to Zero Fleet Initiative*
Over five years, the team increased low-emission vehicles in the fleet from **7% (2020) to 60%**, supported by targeted staff engagement and decision-making tools. This has reduced fleet emissions by **over 400 tonnes of CO_2 annually**.

All four nominations were strong and illustrate increasing alignment with strategic priorities, including greener clinical pathways, waste reduction, resource efficiency, and community impact, alongside growing staff ownership at all levels. Further development of the awards will focus on stronger alignment to the measurement framework, enabling clearer demonstration of impact and tighter linkage to organisational KPIs.

6. Rationale for Measures Refresh

While progress has been made, there is a clear need to refresh the SRS strategy delivery framework to ensure it remains fit for purpose. This reflects several factors, including updated national NHS requirements on Net Zero delivery, changing expectations from ICS partners, and emerging regulatory focus. Also, encouragingly several of the initial areas of focus have now become business as usual, thus no longer requiring ongoing measure.

The current approach requires strengthening in terms of measurement, with a shift from activity-based reporting towards outcome-based delivery supported by clear baselines and defined trajectories. In addition, the Trust must ensure it is adequately prepared to meet climate-related reporting requirements and demonstrate resilience to environmental risks. This refresh therefore represents a transition towards a more structured, measurable, and accountable approach to sustainability and social value. Appendix 1 provides a list of refreshed measures; it would be useful if Trust board could consider supporting these so we can develop further.

As well as the 5 headline initiatives, there will also be continued focus on cross-cutting measures such as sustainability reporting in governance structures, climate change risk assessment (CRRA) maturity, and climate adaptation plan delivery.

Once the measures have been agreed, baseline figures will be validated and refined through 2026/27 and ongoing, as part of embedding the refreshed measurement framework. The measures will be integrated into existing governance and performance management processes, ensuring that sustainability is embedded within routine organisational oversight, rather than treated as a standalone agenda.

7. Climate Change Risk Assessment (CRRA)

The Trust is now required to assess and disclose climate-related risks as part of its annual reporting obligations. Initial work has identified several key risks, including the impact of extreme heat on vulnerable service users, potential flooding risks to estate infrastructure, and disruption to supply chains.

As the 2026 assessment is now complete, further work will take place to strengthen the Trust's Climate Change Risk Assessment for 2027, thus ensuring that risks are clearly defined, quantified where possible, and incorporated into the Trust's broader risk management framework. This will also support readiness for future reporting requirements and ensure compliance with national expectations.

8. Climate Adaptation Plan Framework

In response to emerging regulatory expectations, Trust responsibilities and risk management, a framework for a climate adaptation plan has been developed. (Appendix 2) This represents an important step in moving from risk identification to active resilience planning. The plan sets out a framework on how the Trust will maintain safe and effective services in the face of climate-related challenges, including extreme weather events. It also includes actions to strengthen infrastructure resilience, protect vulnerable populations, and ensure continuity of care during periods of disruption. This work is critical in demonstrating that the Trust is not only addressing carbon reduction but also preparing for the operational impacts of climate change. Following recent approval from the Transformation, Innovation and Sustainability committee, work on developing a full climate adaptation plan is now underway.

9. Green Plan and Carbon Reduction

Delivery of the Trust's Green Plan continues, with a focus on reducing carbon emissions and improving environmental performance. Work is aligned with the NHS Net Zero trajectory, covering emissions across estates, travel, and supply chain. Key areas of focus include improving energy efficiency within the estate, reducing travel through digital and remote service delivery, and addressing supply chain emissions through procurement practices. While progress is being made, continued effort is required to ensure that carbon reduction plans are fully implemented and deliver measurable outcomes.

To support the implementation of the recently refreshed Trust green plan, the carbon reduction steering group recently approved a green plan implementation plan (Appendix 3) and accompanying carbon reduction plan (Appendix 4), both of which will help support turning sustainability ambitions into clear, actionable outcomes. They provide a structured approach to reducing environmental impact, ensuring compliance with regulations, and supporting organisational commitments to net zero and responsible resource use. We are including guidance on EV charging to support our wider sustainability ambitions and ensure our facilities are aligned with evolving environmental standards. This helps future-proof our

sites by promoting low-emission transport options for staff, visitors, and service users. (Appendix 5)

The Green Plan sets out broader environmental goals—such as energy efficiency, waste reduction, sustainable procurement, and biodiversity—while the Carbon Reduction Plan focuses specifically on measuring, managing, and reducing greenhouse gas emissions. Together, they ensure a coordinated approach, aligning day-to-day operations with long-term sustainability targets and avoiding fragmented or ineffective efforts. Together, these plans and monitoring mechanisms ensure that sustainability commitments are not just statements of intent but are actively delivered, measured, and improved over time.

10. Social Responsibility

Across the Trust, community-based approaches already contribute significantly to our social responsibility ambitions through partnership working, social value, workforce inclusion and neighbourhood delivery. Examples include a partnership with Mirfield Community Centre that both secured a local delivery base and helped sustain an important community asset, and collaboration with Project Colt, which created wider community connections, volunteering opportunities and access to local support networks.

Another example is a service user who, after an ADHD diagnosis and eight years out of work, progressed from attending a course to volunteering and ultimately gaining employment within the Trust. Further evidence includes the development of Mindful Maker CIC, where a former learner went on to establish a successful community interest company that now delivers wellbeing activities back into local communities.

Partnership working is also helping to improve inclusion and reduce inequalities. Through work with Ravensthorpe Community Centre, local Community Champions are being supported to co-design and deliver culturally relevant wellbeing courses, strengthening community leadership while improving access to services. Overall, evidence suggests there is an opportunity to build on these established approaches to further support the Trust's objectives around prevention, social value, workforce development, inclusion, community resilience and its role as an anchor institution.

11. Governance and assurance

Governance arrangements for sustainability have continued to develop, with clear executive ownership and increasing integration within organisational structures via the SRS steering group and the carbon reduction steering group. Sustainability is becoming more embedded within performance management, risk frameworks, and strategic planning processes. Further work will focus on strengthening reporting arrangements, improving data quality, and aligning with national benchmarking and maturity frameworks. This will ensure that the Trust can demonstrate robust oversight and provide assurance to both internal and external stakeholders.

12. Supporting Initiatives

A range of supporting initiatives have been developed to enable delivery at all levels of the organisation; this includes the well-received regular green team newsletter. A newly developed green team introduction pack will be launched in early October. This will provide practical guidance to teams and services on how they can contribute to sustainability objectives. These resources are designed to support local ownership, encourage innovation, and ensure that sustainability becomes part of everyday practice across the Trust.

13. Next Steps

The next phase of work will focus on finalising and implementing the refreshed measurement framework, embedding sustainability within business planning and reporting cycles, implementing a system of sustainability impact assessments and delivering the climate adaptation plan. Further development of the Climate Change Risk Assessment will be undertaken to ensure compliance with reporting requirements and strengthen organisational resilience. Continued alignment with ICS priorities and national policy will remain essential, alongside ongoing efforts to integrate sustainability into all aspects of Trust activity.

14. Recommendations

The Trust board is asked to:

- **RECEIVE and NOTE** the progress made in delivering the SRS Strategy and Green Plan.

Appendix 1

Refreshed Measures

Proposals for refreshed Measures and Delivery Approach

In conjunction with headline initiative leads, a revised set of draft measures is being developed across the five headline initiatives to support improved oversight and accountability. These measures will be underpinned by baseline data, enabling the Trust to track progress over time and demonstrate impact.

The refreshed framework will focus on key areas such as workforce engagement, sustainable procurement, carbon emissions, and community engagement, ensuring that each initiative is supported by clear metrics. Delivery will be driven through a Quality Improvement (QI) approach, allowing for iterative progress, local ownership, and continuous learning.

Refreshed Draft SRS Measures and KPIs

1. **Partnership, culture and civic role**

Problem	To reflect the aims of the new People strategy/SRS strategy
Measure 1	% of employees living locally
Measure 2	% of employees residing in deprived areas
Measure 3	Workforce stability and recruitment
Monitoring	Data dashboards, audits, governance reviews, and PDSA cycles
Lead Area	People directorate

There will also be continued focus on active sustainability/social value partnerships at place/system level, contribution to place based strategies, increasing staff awareness and supporting green teams.

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2. **Our Role as an Employer**

Problem	To increase alignment level of alignment with the SWYPFT SRS strategy and Trust Green Plan.
Measure 1	Total number of sustainability impact assessments
Measure 2	Level of patient electronic communications at Folly Hall (3P's)
Measure 3	Level of travel costs for delivery of prescriptions/medicines
Monitoring	Data dashboards, audits, governance reviews, and PDSA cycles
Lead Area	Strategy and change/Pharmacy

There will also be continued focus on staff completing sustainability awareness training, sustainability included in leadership objectives, staff participation on sustainability objectives, staff travel - % using active/low carbon travel.

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3. Procurement of good and services

Problem	Sustainability commitments are not consistently measurable or monitored
Measure 1	Our Procurement team are currently developing a joint policy within the WYICS Procurement Collaborative with Oliver Golledge as the Sustainability Lead. Relevant measures will be determined by that.
Measure 2	As above
Monitoring	Contract governance, reporting, reviews, and PDSA learning
Lead area	Procurement

There will also be continued focus on social value weightings, supplier alignment with NHS zero requirements, reduction in single use items and the inclusion of sustainability in business cases.

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4. Management of environmental impacts, estate and assets

Problem	Waste prevention and segregation are inconsistent and insufficiently measured
Measure 1	Level of food waste sent to generate energy (tonnes)
Measure 2	Level of waste separated for specific recycling streams (tonnes)
Monitoring	Data dashboards, audits, governance reviews, and PDSA cycles
Lead Area	Estates & Facilities

There will also be continued focus on total carbon emissions (Scope1 & 2), selected scope 3 emissions (e.g. travel, procurement hotspots, energy use intensity (kWh/m), waste volume.

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5. Engagement with Less Advantaged and Diverse Communities

Problem 1	To support more horticultural, wildlife and other green projects. Continue to build on Caring Garden Fieldhead and “Grow your own” project at the Kendray hospital site.
Measure 1	Continue to look for more funding opportunities and different ways of funding this work.
Measure 2	Work with trust staff to ensure support, recruit more Creative Minds Champions
Monitoring	Creative Minds Team
Lead Area	Creative Minds, Arts & Health programme and SRS steering group

☐

Problem 2	Answer further development Good Mood Football, links with Miners Welfare project and Learning Disability Fun days
Measure 1	Continue to look for more funding opportunities and different ways of funding this work.
Measure 2	Work with trust staff to ensure support, recruit more Creative Minds Champions
Monitoring	Good Mood Sports Steering Group and SRS steering group
Lead Area	Creative Minds Good Mood Sports programme

There will also be continued focus on engagement with underserved groups, co-production in service design, sustainability initiatives targeting inequalities and alignment with population health priorities.

Appendix 2

Framework for SWYPFT Climate Adaptation Plan (Aligned to SWYPFT Service Structure)

Aims

- Introduce measurable outcomes and performance indicators.
- Strengthen governance and accountability arrangements.
- Adopt a more formal risk-based approach, including risk ownership.
- Include funding and resource considerations to support implementation.
- With the nature of our Trust, place more emphasis on the mental health impacts of climate change, vulnerable groups and workforce resilience.

1. **Strategic Framework**

1.1 **Purpose**

To ensure SWYPFT can deliver safe, high-quality mental health, learning disability, autism, forensic, community and specialist services under increasing climate-related pressures.

1.2 **Statutory Drivers (Mandatory)**

• NHS England Climate Adaptation Framework
• NHS England requirement for Trust-wide Climate Change Risk Assessment (CCRA)
• CQC Quality Statements: Safe Environments, Governance, Sustainability
• Civil Contingencies Act (EPRR duties)
• UKHSA Heatwave & Cold Weather guidance
• Health & Safety at Work Act
• NHS Premises Assurance Model (PAM)

1.3 **Strategic Objectives**

1. Protect service users and staff from climate-related harm.
2. Maintain continuity of clinical services during climate disruption.
3. Strengthen estates, digital systems, supply chains and workforce resilience.
4. Embed climate risk into governance, quality assurance and emergency planning.
5. Deliver a realistic, phased adaptation programme aligned to SWYPFT's Green Plan.

2. **Trust-wide Mandatory Adaptation Measures**

These apply across all SWYPFT services.

2.1 **Climate Change Risk Assessment (Mandatory)**

• Complete NHS England CCRA every 3 years.
• Include risks to estates, digital, workforce, medicines, supply chain, transport, vulnerable service users.
• Integrate into Board Assurance Framework and Major Incident Plan.

2.2 **Heatwave & Overheating Controls (Mandatory)**

• Overheating risk assessments for all buildings.
• Temperature monitoring in clinical areas.
• Ventilation compliance with CQC Safe Environments.
• UKHSA Heatwave Plan compliance.
• Medication storage temperature controls.

2.3 **Flood Risk Management (Mandatory)**

• Flood-risk mapping for all sites.
• Protect critical infrastructure above flood levels.
• Water supply continuity planning.
• Evacuation and access-route planning.

2.4 **EPRR Integration (Mandatory)**

• Severe weather plans for heat, cold, storms, flooding, air quality.
• Staff recall and communication protocols.
• Updated Major Incident Plan with climate-risk scenarios.

2.5 **Supply Chain Resilience (Mandatory)**

• Identify climate-vulnerable suppliers.
• Alternative suppliers for critical medicines and equipment.
• Compliance with NHS Net Zero Supplier Roadmap.

2.6 **Digital & Data Resilience (Mandatory)**

• Server-room cooling and flood protection.
• Redundant connectivity for remote care.
• Cyber-resilient backup systems.

3. Operational Adaptation Measures by SWYPFT Service Area

This section mirrors SWYPFT's real service structure.

3.1 **Acute & Rehabilitation Inpatient Services**

(Beechdale, Stanley, Sandal, Nostell, Elmdale, etc.)

Mandatory

• Temperature monitoring in all wards.
• Overheating mitigation where temperatures exceed safe limits.
• Ventilation compliance with CQC Safe Environments.
• Water safety management under changing climate conditions.
• Flood-risk assessment for each inpatient site.
• Business continuity for heatwaves, storms, power outages.
• Safe medication storage during extreme heat.

Highly Recommended

- Passive cooling retrofits (shading, reflective films).
- Air-quality monitoring during pollution or wildfire events.
- Heat-stress protocols for staff.

3.2 **Forensic Services (Newton Lodge)**

Mandatory

- Secure-environment temperature controls.
- Overheating and ventilation compliance.
- Flood-risk mitigation for secure infrastructure.
- Continuity planning for security systems during power disruption.
- Safe-working protocols for staff during extreme weather.

Highly Recommended

- Resilient perimeter systems (storm-resistant fencing, drainage).
- Enhanced cooling for high-risk areas (seclusion, medication rooms).

3.3 **Community Mental Health Services (Barnsley, Wakefield, Calderdale, Kirklees)**

Mandatory

- Severe weather travel protocols for staff.
- Remote-care capability during disruption.
- Prioritisation pathways for vulnerable service users (SMI, frailty, respiratory).
- Safe-working guidance for heatwaves and storms.
- Temperature-safe environments in community bases.

Highly Recommended

- Portable cooling/heating equipment for bases.
- Air-quality alerts integrated into clinical risk planning.

3.4 **CAMHS (Inpatient & Community)**

Mandatory

- Safe-temperature environments for young people.
- Heatwave and cold-weather protocols for clinics and home visits.
- Continuity plans for school-based services during extreme weather.
- Medication temperature compliance.

Highly Recommended

- Trauma-informed communication around climate anxiety.
- Cooling and shading improvements in therapy rooms.

3.5 **Learning Disability & Autism Services**

Mandatory

- Heat-risk assessments for LD inpatient and residential settings.
- Evacuation and flood-response plans tailored to communication and mobility needs.
- Medication temperature-control compliance.
- Safe-environment monitoring for sensory-sensitive service users.

Highly Recommended

- Accessible climate-risk communication tools.
- Additional hydration and heat-stress monitoring during heatwaves.

3.6 **Older People's Service (OPS)**

Mandatory

- Enhanced heat-risk protocols (older adults are high-risk).
- Cold-weather planning for home-based care.
- Hydration and heat-related symptom monitoring.
- Continuity planning for memory services and care homes.

Highly Recommended

- Proactive welfare checks during extreme weather.
- Air-quality alerts for COPD-risk patients.

3.7 **IAPT / Talking Therapies**

Mandatory

- Safe-temperature therapy rooms.
- Remote-care continuity during weather disruption.
- Staff travel safety protocols.

Highly Recommended

- Air-quality and heatwave adjustments to appointment scheduling.

3.8 **Specialist Services (Perinatal, Eating Disorders, Gender, Veterans)**

Mandatory

- Temperature-safe clinical environments.
- Continuity planning for vulnerable cohorts.
- Medication storage compliance.

Highly Recommended

- Climate-risk screening for high-risk groups (e.g., dehydration risk in ED).

3.9 **Estates & Facilities**

Mandatory

• Overheating, ventilation and water-safety compliance.
• Flood-risk mapping and mitigation.
• Backup power testing for critical areas.
• HVAC resilience for extreme temperatures.
• Compliance with NHS PAM climate-risk sections.

Highly Recommended

• Green infrastructure (shade, tree planting).
• Sustainable drainage systems (SuDS).

3.10 **Digital & IT**

Mandatory

• Server-room cooling resilience.
• Flood protection for digital infrastructure.
• Redundant communication channels for emergencies.

Highly Recommended

• Cloud-based backups for climate-resilient data storage.

3.11 **Workforce**

Mandatory

• Heat-stress and cold-stress protocols.
• Severe weather travel guidance.
• Safe working conditions under Health & Safety law.

Highly Recommended

• Climate-risk training for clinical and non-clinical staff.
• Psychological support for climate-related stress.

3.12 **Pharmacy & Medicines Management**

Mandatory

• Temperature-controlled storage compliance.
• Supply chain continuity for critical medicines.
• Risk assessments for heat-sensitive medicines.

Highly Recommended

• Stockpiling essential medicines during forecasted disruptions.

3.13 **Procurement & Supply Chain**

Mandatory

• Climate-risk assessment of suppliers.
• Compliance with NHS Net Zero Supplier Roadmap.
• Alternative suppliers for critical items.

Highly Recommended

• Localised procurement to reduce transport disruption risk.

3.14 **Transport & Fleet**

Mandatory

• Severe weather travel plans.
• Business continuity for patient transport.

Highly Recommended

• EV fleet transition with heatwave-resilient charging planning.

4. Monitoring & Assurance

Mandatory

• Annual reporting through the Green Plan.
• Board oversight of climate-risk mitigation.
• CQC evidence for Safe Environments & Governance.
• Integration into EPRR assurance processes.

Highly Recommended

• Quarterly adaptation progress reviews.
• ICS-level collaboration on shared risks.

5. Implementation Timeline

0–12 months (Mandatory focus)

• Complete CCRA.
• Update Major Incident Plan.
• Overheating and flood-risk assessments.
• Temperature monitoring rollout.
• Supply chain risk review.
• Staff severe-weather protocols.

12–36 months

• Estates upgrades (ventilation, shading, drainage).
• Digital resilience improvements.
• Expanded remote-care capability.
• ICS-wide climate-risk coordination.

36+ months

• Long-term estate redesign for climate resilience.
• Full integration of climate-risk into capital planning.

Appendix 3

SWYPFT Green Plan – Implementation Plan

1. Purpose and Strategic Alignment

The Green Plan serves as the Trust's organisation-wide sustainability strategy, guiding reductions in carbon emissions, air pollution, and waste, and embedding sustainable practice into all operations. It supports NHS Net Zero commitments (2040 for NHS Carbon Footprint, 2045 for Carbon Footprint Plus) and aligns with the SRS Strategy (2022–2027) and Trust Strategy (2024–2030).

2. Governance & Programme Structure

2.1 Establish Oversight

- **Executive-level ownership** via Trust Board, Transformation, Innovation and Sustainability committee, Executive Management Team and Carbon Reduction steering group.
- Reinforce the Sustainability Steering Group, including estates, procurement, digital, clinical, workforce, comms, and service-user voices.
- Ensure governance aligns with SRS governance and new Trust Strategy governance.

2.2 Delivery Team

- Sustainability Change Manager (lead).
- Trust board lead.
- Carbon Reduction steering group.
- SRS steering group.
- Comms team.
- Green Team as site champions across the Trust.

2.3 Reporting Mechanisms

- Quarterly dashboard to EMT, biannual reporting to the Board via TISC
- Annual public report linked to SRS Strategy performance.

3. Implementation Phases

Phase 1 – Foundation (Months 1–6)

3.1 Baseline & Data

- Confirm or refresh environmental baselines: energy, water, waste, business travel, fleet emissions, procurement categories.
- Use carbon baseline methodologies from earlier plans.

3.2 Prioritisation

- Apply Trust Green Plan targets in:
    - General sustainability.
    - Carbon reduction.
    - Air pollution.
    - Waste reduction.

3.3 Engagement

- Relaunch Green Team programme with locality-based action groups.
- Conduct on-site roadshows and digital engagement sessions as used in wide strategy engagement (#allofusconversation).

Phase 2 – Delivery (Months 6–36)

Organised around the Trust's **10 sustainability domains** from the Green Plan.

4. Detailed Action Areas

4.1 Corporate Approach

Objectives: Embed sustainability into decision-making, policies, risk management, procurement, and leadership.

Actions:

- Integrate sustainability metrics in business cases.
- Mandatory sustainability impact assessment for all capital and service redesign projects.
- Align to national NHS sustainability drivers and local ICS strategies.

4.2 Asset Management & Utilities (Energy, Water, Estates)

Objectives: Improve energy efficiency, reduce utility consumption, decarbonise estate.

Actions:

- Expand building energy audits and implement LED upgrades, insulation improvements, and heat decarbonisation.
- Increase use of green electricity tariffs where feasible.
- Deliver decarbonisation roadmap (aligned with the 2025–2028 plan).
- Install smart monitoring across sites.

4.3 Travel & Logistics

Objectives: Reduce emissions from staff travel, fleet, and logistics.

Actions:

- Roll out staff e-bike loan scheme (already planned).
- Transition pool fleet to EVs.

- Expand EV charging infrastructure on sites.
- Increase use of virtual consultations and remote working where clinically appropriate.

4.4 Adaptation & Resilience

Objectives: Prepare for climate risks affecting service delivery.

Actions:

- Complete climate risk assessments for all main sites.
- Integrate adaptation measures into Estates plans (flooding, heatwaves, ventilation).
- Update Business Continuity Plans to reflect climate-related disruption.

4.5 Capital Projects

Objectives: Ensure new builds and refurbishments are aligned with Net Zero and biodiversity principles.

Actions:

- Apply BREEAM/Net Zero building standards.
- Use low-carbon materials and construction processes.
- Include landscaping plans that enhance biodiversity.

4.6 Greenspace & Biodiversity

Objectives: Enhance therapeutic and ecological value of green spaces.

Actions:

- Expand tree planting efforts (building on 2,000 trees already planted).
- Create biodiversity corridors and pollinator-friendly sites.
- Develop outdoor therapeutic spaces.

4.7 Sustainable Care Models

Objectives: Reduce carbon intensity of clinical services.

Actions:

- Review high-carbon clinical pathways (e.g., inhalers, single-use items).
- Promote community care, digital care, and preventive models (aligned with NHS "three shifts": hospital → community, analogue → digital, sickness → prevention).

4.8 Our People

Objectives: Build a culture of sustainability across the workforce.

Actions:

- Create sustainability training modules for induction and ongoing learning.
- Empower the Green Team to lead local action projects.
- Reward schemes for sustainability innovation.

4.9 Sustainable Use of Resources (Waste & Procurement)

Objectives: Reduce waste, increase circularity, and decarbonise supply chains.

Actions:

- Ensure zero waste to landfill continues (current achievement).
- Increase recycling rates Trust-wide.
- Rationalise procurement categories focusing first on high-emission items.
- Embed social value into procurement processes.

4.10 Carbon & Greenhouse Gas Management

Objectives: Monitor, report, and reduce emissions in line with NHS Net Zero targets.

Actions:

- Annual emissions calculation using consistent baselining.
- Track progress toward interim targets (80% by 2028–2032 for direct emissions).
- Publish annual progress reports.

5. Communication, Engagement & Equality

Approach

- Continue strong community and staff engagement.
- Provide regular sustainability communications via intranet, Teams channels, newsletters.
- Ensure equality impacts are assessed for every sustainability initiative, following SRS and Green Plan guidance.

6. Measurement & Key Performance Indicators

KPIs aligned to national NHS guidance and Trust targets:

- Total carbon emissions (Scopes 1–3).
- % reduction in electricity, gas, water consumption.
- % waste recycled & % waste to landfill (maintain at 0%).
- Number of staff using active / low-carbon travel schemes.
- Procurement categories with carbon/sustainability criteria applied.
- Biodiversity metrics (tree count, habitat areas).
- Staff engagement participation numbers.

7. Risks & Mitigations

Risk	Mitigation
Funding limitations	Maximise national NHS decarb grants; align with capital programmes.
Workforce capacity	Use Green Team to distribute ownership; embed responsibilities into roles.
Behaviour change challenges	Use SRS culture programmes and targeted communications.
Estate limitations	Prioritise high-impact sites; develop phased decarbonisation.

8. Timeline Overview (2026–2029)

Year 1: Baseline refresh, governance strengthening, engagement relaunch, priority quick wins.

Year 2: Major estate decarb projects, fleet transition, procurement reform rollout.

Year 3: Embedding sustainable clinical pathways, nature recovery projects, digital care expansion.

Year 4+: Continuous improvement aligned with Net Zero horizons 2030, 2040, 2045.

Appendix 4

SWYPFT Carbon Reduction Action Plan – Summary (2025–2030)

Purpose
To deliver the Trust's commitments under NHS Net Zero, the SWYPFT Green Plan, and the Sustainability & Resilience Strategy (SRS) by reducing carbon emissions across all operations while improving resilience, efficiency, and quality of care.

1. Strategic Goals

- Net Zero for direct emissions by 2040 (80% reduction by 2028–2032).
- Net Zero for indirect emissions by 2045 (80% reduction by 2036–2039).
- Deliver a refreshed Board-approved Green Plan by July 2025.
- Embed sustainability into governance, estates, clinical care, procurement, and workforce culture.

2. Priority Action Areas (2025–2030)

A. Governance & Leadership

• Establish Sustainability & Net Zero Sub-Committee.

• Carbon impact assessments required for all business cases.

• Annual public reporting on carbon reduction progress.

Timescale: 2025–ongoing.

B. Estates & Energy

• Full energy audits; LED lighting; insulation upgrades.

• Transition from gas to low-carbon heating (heat pumps/hybrid).

• Expand solar PV and procure 100% renewable electricity.

• Improve water efficiency and climate resilience.

Timescale: Audits 2025; major upgrades 2026–2030.

C. Travel & Fleet

• EV charging infrastructure across key sites.

• Electrify 100% of Trust fleet by 2030.

• Reduce staff travel emissions via digital consultations and active travel.

Timescale: 2025–2030.

D. Procurement & Supply Chain

• Apply NHS Sustainable Procurement Framework.

• Require suppliers to commit to Net Zero by 2045.

• Reduce single-use plastics and increase recycling.

Timescale: 2025–2030.

E. Medicines & Clinical Care

- Eliminate desflurane; expand low-carbon inhaler use.
- Improve waste segregation and recycling.
- Embed low-carbon care pathways (digital follow-ups, prevention).

Timescale: 2025–2028.

F. Digital Transformation

- Expand virtual care and remote monitoring.
- Reduce paper use by 70% by 2030.
- Improve data centre energy efficiency.

Timescale: 2025–2030.

G. Workforce & Culture

- Mandatory sustainability training for all staff.
- Green Champions network across all services.
- Annual sustainability engagement events.

Timescale: 2025–ongoing.

H. Climate Adaptation & Resilience

- Climate risk assessments for all sites.
- Update emergency and continuity plans.
- Implement flood, heatwave, and infrastructure resilience measures.

Timescale: 2025–2027.

3. Key Metrics

- Annual CO_2e reduction.
- % renewable energy used.
- % fleet electrified.
- Waste recycling rate.
- Supplier compliance with sustainability standards.
- Staff training completion.

4. High-Level Timeline

- 2025: Governance in place; audits; desflurane eliminated; digital baseline.
- 2026–2027: Major estate upgrades; fleet transition; procurement compliance.
- 2028: Green Plan refresh; low-carbon pathways embedded.
- 2029–2030: Full fleet electrification; major heat decarbonisation; 30% supply chain reduction.

Appendix 5

Electric Vehicle (EV) Charging Guidance

This guidance sets out how electric vehicle (EV) charging infrastructure provided by SWYPFT is installed, accessed, and used.

If the initial draft is approved by EMT, the final draft will also include guidance on: -

- Governance arrangements, ownership and operational responsibilities.
- Clearer booking, allocation and fair-use arrangements where demand exceeds capacity.
- How charger usage, utilisation and carbon benefits will be monitored and reported.
- Include principles for future expansion and demand management as EV uptake increases.
- Providing greater transparency around charging costs, pricing and cost recovery.
- Expanding EV-specific fire safety requirements and emergency procedures.
- Data protection considerations where charging systems collect user information.
- Visitor and contractor access.
- A process for reporting issues, resolving disputes and addressing misuse.
- Guidance review intervals.

The guidance supports the Trust's commitments to:

- Reduce carbon emissions from staff and business travel.
- Promote sustainable transport choices.
- Support the transition to low-emission vehicles.
- Ensure safe, fair, and efficient use of Trust assets.

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2. Scope

This policy applies to:

- All SWYPFT staff.
- Contractors and partners where access is explicitly permitted.
- Trust-owned vehicles and fleet vehicles.
- All EV charging points located on SWYPFT premises.

This policy does **not** create an entitlement to an EV charging space.

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3. Policy Principles

EV charging provision will be:

- **Safe** – compliant with electrical, health, and fire safety standards.
- **Fair** – transparent access and prioritisation rules.
- **Efficient** – maximising charger availability and minimising misuse.
- **Supportive of Net Zero** – prioritising business and operational needs.
- **Pragmatic** – scaled in line with demand and infrastructure capacity.

---

4. Eligibility and Priority of Use

4.1 Eligible vehicles

- Fully electric (BEV) and plug-in hybrid vehicles (PHEV).
- Vehicles must be actively charging to occupy EV bays.

4.2 Priority order

When demand exceeds capacity, priority is as follows:

1. **Trust fleet and pool vehicles.**
2. **Staff using EVs for business travel during the working day.**
3. **Staff commuting in private EVs.**
4. **Visitors or partners (where signage or local rules permit).**

---

5. Access and Use Rules

- EV bays are **for charging only**, not long-stay parking.
- Vehicles must be moved promptly once charging is complete.
- Charging is **first-come, first-served**, unless a local booking system is in place.
- Users must not unplug another vehicle without explicit permission.
- Idle charging (remaining plugged in unnecessarily) should be avoided.

Local site rules may introduce time limits, signage, or booking arrangements.

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6. Payment and Costs

- Charging arrangements may include:
  - Free charging (where formally approved).
  - Pay-per-use charging.
  - Salary sacrifice or fleet-linked charging models.
- Charging arrangements will **not constitute a taxable benefit** unless HMRC guidance changes.
- Costs, if applicable, will be communicated clearly at each site.

---

7. Safety and Responsibilities

All users must:

- Follow on-site safety signage and instructions.
- Use only the installed charging equipment (no extension leads).
- Report faults, damage, or hazards immediately.
- Ensure charging cables do not create trip hazards.

The Trust reserves the right to suspend access if safety is compromised.

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8. Installation and Expansion

EV charging infrastructure will be installed based on:

- Site electrical capacity and safety.
- Current and projected demand.
- Business travel and fleet requirements.
- Value for money and carbon reduction impact.

The Trust will review provision periodically as part of its Green Plan and Estates Strategy.

9. Enforcement

- Misuse of EV charging bays may result in:
    - Loss of EV charging access.
    - Parking enforcement action under local site rules.
- Persistent misuse by staff may be addressed via line management.

10. Equality and Inclusion

The Trust will consider:

- Reasonable adjustments for disabled EV drivers.
- Fair access across different sites and staff groups.
- Accessibility when installing new infrastructure.

11. Monitoring and Review

The policy and associated infrastructure will be reviewed to ensure:

- Alignment with NHS Net Zero objectives.
- Compliance with legislation and guidance.
- Effective uptake and fair access.
- Continued value for money.

12. Related Documents

- SWYPFT Social Responsibility and Sustainability Strategy.
- Green Plan.
- Travel and Expenses Policy.
- Fleet Management Policy.
- Parking Policy.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29 September 2026
Agenda item 12.5

Private/Public paper:	**Public Board**		
Title:	**Board Assurance Framework for Winter Planning**		
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 all front-line 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 the oversight of the planning for winter to support the West and South Yorkshire partners with winter pressures.		
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):	2.4 - Increased demand of services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes. 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. 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. 5.1 - Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.		

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships.	The self-assessment for winter pressure preparedness is part of the approach to assess and support the health care system across both West and South Yorkshire ICBs. The self-assessment is SWYPFT's own assessment of the capabilities, support, gaps and challenges.
Any background papers / previously considered by:	
Executive summary:	**Executive overview** The 2026/27 Winter Planning Board Assurance Statement has been completed to provide the Board with oversight of the Trust's readiness to maintain safe, resilient services during seasonal pressure. The self-assessment dashboard records an overall rating of 4 - Substantial assurance. Section B records 28 of 36 applicable assurance points, with full assurance shown for prevention, flow/occupancy/discharge, infection prevention and control, leadership and operational grip, and the mental health-specific requirements. **Key strengths and controls** • Established vaccination processes, respiratory infection prevention and staff health and wellbeing arrangements, including inpatient vaccination in line with Infection Prevention Control (IPC) guidance. • Seven-day patient flow and senior leadership arrangements, supported by estimated discharge dates, criteria-led discharge, OPEL escalation and regular system escalation meetings. • Business continuity, mutual aid, severe weather, infrastructure and industrial action arrangements have been reviewed, with on-call medical, nursing and director leadership available. • Mental health resilience arrangements remain in place for NHS 111, crisis alternatives, crisis and home treatment, liaison psychiatry, Section 136 pathways and frequent attender planning. • QIA completed and reviewed. **Residual risks, gaps and qualifications** • Workforce plans are based on rotas as per capacity and demand. The use of the bank will be assessed and agreed within services where required. • The community hospital-at-home pathway is described as fragile because it relies on acute trust medical support. • The wider support to transition people Clinically ready for discharge **Conclusion and Board attention** The assessment demonstrates a strong operational base for winter within the limits of the operational resource commissioned and available. Prior to national submission, the return needs to be agreed at Trust Board, and the final assessment will be completed by the Senior Responsible Owner (SRO) taking account of any feedback from Trust Board members, with Chief Executive and Chair approvals. The national submission deadline is 30 September 2026.

Recommendation:	**Trust Board members are asked to:** • **RECEIVE** and **SUPPORT** the Trust's self-assessed Board Assurance Framework for Winter Planning for 2026/27.

Winter Planning 26/27
Board Assurance Statement (BAS)

1. Purpose
The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement
Please include the Trust / Provider name at the top of the tab.
This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist
This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026.**

Winter Planning 26/27
Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):	
If Other, write Provider/Trust Name:	
Contact details (email, phone number):	South West Yorksire Partnership Trust
Date:	01/07/2026

				Please complete these sections		
Assurance statement				**Confirm (Y/N)**	**Additional comments or qualifications (optional)**	**Blockers/Support requirements (optional)**
Governance and executive leadership						
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.				
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.			Qiality impact assessemnt was review on 18.9.26 by QIA group	
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.			there are daily and weekly meeting with the system partner on flow, escaltions and support	
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.			there has been several exercises that the trust have been involved in. the latest was the system wide excerise orgnasied by the trust to test our response from the wider system on 25.6.26. Although this was not winter planning this evidence the planning and response . We have also been in	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.			Adele Fox	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.			This is via our EPRR arrangements with adele Fox as AEO and Adarin Snarr and depouty AEO . Boht have undertalekn all trianing required.	

Winter Planning 26/27
Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Please complete these sections

Section B: 26/27 Winter Plan checklist			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	Staff vaccination program groups established – local team coordination Trust wide Flu and vaccination program led by a lead practitioner with peer vaccination and patient vaccination program embedded. Occupational health supporting staff/locality leads for each area of the Trust vaccinations for flu. Roll out plan learning from previous years ESR flag - need to check with HR	
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	Range of H&WB support available – Occupational health, range of physical activities, MSK support, Health and wellbeing checks, weight management, menopause support.	
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	Vaccination for inpatients as per IPC guidance.	
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	Support to house bound / vulnerable patients where required	
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	SWYPFT inpatient and community improvement workstreams Weekly escaltion meetings with ICB All age liaison team 7 day senior leadership team support mitigation of system pressures linked to mental health Clear escalation protocols shared with acute trust partners Made and barriers to discharge meetings Use of OPEL cards and escalation processes Care closer to home work to improve bed capacity on MH wards Extended patient flow team working Full offer in place for NRS / NNS / UCR / SRU / NRU – 7 days per week	
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: •coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes	Senior on call 7 days a week Patient flow planned Estimated Discharge dates criteria led discharge	
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	Christmas is usualy BAU as is occupancy reduciton.	
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	Barsnley Health and Welbeing support acute hositals and YAS to aviod addmission where possible	

	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	Barsnley Frailty pathway works closly with acute trust to support discharge	Community hosital at home is relaint on acute trust medical support therfore is fragile
Capacity					
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	As per normal rota – zero tolerance on agency and overtime, reduced bank % usage. Business continuity plans in place for cross cover etc.	
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	E-rostering plans in place. Annual leave is carefully planned at the beginning of the year, allowing fair distribution without excessive depletion of workforce. Management of leave / study leave to ensure service coverage	
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.		NA	
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	All RTT pathways have a winter plan to support increased demand and BCP all reviewed	
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	All ppans have been reviewed and up to date to ensure we respond best we can with in our capaity and capabilities	
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	GIRTH reccomdation re 12 hour breach and frequent attenders are in place with all acute colleagues this is in collabaraition with the OPEL action cards and mulit agency care plans in place for all Attenders	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.		NA	
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	Patient flow meeting 3 x daily. Esclation routes to execuitve Trio for support ICB escaltion meetings daily to support CRFD barriers	
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.		NA	
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	all busineess contunuity plans have been revieewed and updated SOP in place for escaltion beds	
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	yes Chief Nurse has oversight of IPC	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	Those teams that require FIT testing are up to date with training. If training is required for other teams we have a group of professionals able to mobilse at pace t	
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	ALL staf require to use fit testing are trained as required	
Leadership and operational grip					
	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	All areas have robust on call director, medic and arrangements. MH acute have weekend and BH seniour leadership and patient flow.	

6	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	OPEL dashboard and Pt flow dashboard.	
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes	All BCP are in place and reviewed , incldiug mutial aid	
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	All have been reviewed including updates	
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes	All EPRR plans have been updated and are responsive to requirements	
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes	all updated under EPRR requiremnts	
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes	Health and wellbieng plans in place, Emploee assitance prgrame professioanl nurse advocate	
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes	This is BAU	
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Yes	Place based frequent attenders groups monitor and address issues	
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.	Yes	This is BAU	

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

Trust / Provider Name:	South West Yorkshire Partnerships Teaching Trust
Provider CEO name:	Mark Brooks
Date reviewed:	29.9.26
Provider Chair name:	Jane Brown
Date reviewed:	29.9.26

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Adele Fox , Chief Operating Officer. Adele.fox@swyt.nhs.uk

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

yes

Please confirm date reviewed

1.9.26

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 4 - Substantial assurance

		Rating
Section B	Prevention	**5 - Full assurance**
	Flow, occupancy and discharge	**5 - Full assurance**
	Capacity and community	Awaiting assessment
	UEC Flow	Awaiting assessment
	Infection Prevention and Control (IPC)	**5 - Full assurance**
	Leadership and operational grip	**5 - Full assurance**
	Specific actions for Mental Health Trusts	**5 - Full assurance**

[illegible]

The quality impact assessment tool has been designed to support teams/services to assess any potential impact on quality of care of proposed changes within services. This may be, for example, significant staffing restructures, environmental changes, restructuring of services (such as the older peoples transformation), removal and/or down banding of a post, introduction of new posts within services, changes to service provision [this list in not exhaustive].

All questions may not need to be answered but all should be considered when assessing a potential impact on quality. Please consider the impact and identify how an impact can be mitigated and identify a risk rating.

Where a risk is rated as significant (amber or red), further information may be required and the table in appendix 1 should be completed for this domain only.

Further support can be provided by the quality governance team: QualityGovernanceTeam@swyt.nhs.uk.

Completed QIA's should be sent to the quality governance team.

[illegible]

Directorate/Care group: Trust wide	**Service: Trust wide**
Completed by: Adele Fox, Chief Operating Officer	**Date: 2 September 2026**

Service change (describe)	This QIA assesses the quality implications of the Trust's Winter Plan and Board Assurance Framework (BAF) for 2026/27. It does not propose a reduction or material change to commissioned services. The plan brings together existing prevention, flow, workforce, infection prevention and control, emergency preparedness, escalation and mental health resilience arrangements to maintain safe care during seasonal and system pressure.

Data (include any data to support QIA)	The BAF records substantial overall assurance. Evidence includes: a Trust-wide vaccination programme; inpatient vaccination arrangements; daily and weekly system escalation; three-times-daily patient flow oversight; seven-day senior leadership and on-call cover; OPEL and patient-flow dashboards; reviewed business continuity and EPRR plans; escalation-bed procedures; mental health crisis, liaison psychiatry and Section 136 resilience; and place-based oversight of frequent attenders. Areas requiring continued assurance are sustained workforce resilience, high mental health bed occupancy and discharge delays, reliance on system partners, fragility of Hospital at Home medical support, confirmation of the ESR frontline-worker flag, and safe activation of surge capacity.	
Will there be changes to the oversight and accountability requirements?	No fundamental change to statutory or Board accountability is proposed. Winter delivery will require enhanced operational grip through existing governance: routine performance and quality oversight, OPEL escalation, executive and clinical on-call arrangements, EPRR command arrangements, IPC governance, system escalation meetings and Board reporting. Exceptions, emerging quality risks and any use of surge capacity should be escalated through the agreed governance route.	
Where will responsibilities sit?	Executive accountability sits with the Chief Operating Officer as Executive Winter Sponsor and Accountable Emergency Officer. Operational delivery sits with care-group and service leadership teams, supported by patient flow, clinical, nursing, medical, workforce, IPC, estates, digital, occupational health and EPRR leads. System dependencies and barriers to discharge are managed jointly with the ICB, local authorities, acute providers, community partners and primary care through established escalation arrangements.	
Overall rating and score: Please refer to ratings table below. This will be the average score overall.	**Overall residual rating: 7 (Amber / moderate risk)**	The plan is expected to protect quality and improve operational readiness, but it cannot remove all risk during periods of sustained demand. Residual risk remains in relation to bed occupancy and flow, staffing capacity and skill mix, delayed discharge, system partner dependencies, infectious disease outbreaks and the safe use of escalation capacity. The rating

		assumes all mitigations are maintained, monitored and escalated promptly.

Quality Impact Assessment (QIA) Table

The rating score is defined as a combination of the likelihood and impact of the change.

Impact score- represents the potential impact if the change were to occur.

Likelihood score- reflection of how likely it is that the impact described will occur with mitigations in place.

Rating Matrix		**Likelihood**				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Impact	(1) Improves quality	1	2	3	4	5
	(2) Neutral impact	2	4	6	8	10
	(3) Potential impact	3	6	9	12	15
	(4) Negative impact	4	8	12	16	20
	(5) Extreme impact	5	10	15	20	25

Domain	If we make this change it will…	Impact on quality	Mitigating actions	Rating score
Safe	Improve the environment including IPC in which service users are treated	Positive: Provides advance IPC, estates and cohorting arrangements to support safe care during outbreaks and pressure.	Maintain environmental risk assessments; IPC oversight; PPE and fit-testing assurance; escalation-bed SOP; rapid review if capacity is reconfigured.	**4**
	Promote a safe approach to service user care and/or helps to prevent harm to service users	Positive with residual risk: Strengthens safe care through on-call cover, escalation triggers, patient-flow oversight and tested EPRR arrangements. Risk increases if demand exceeds available capacity.	Daily operational review; OPEL escalation; executive, medical and nursing on-call; incident reporting; clinical review of any temporary capacity.	**9**
	Support risk management and safety systems	Positive: Supports consistent identification, escalation and management of operational and clinical risks.	Use OPEL and patient-flow dashboards; care-group risk review; Board and committee oversight; clear exception reporting.	**6**
	Reduce safety risks for service users	Positive with residual risk: Aims to reduce avoidable harm caused by delayed access, delayed discharge, out-of-area care and unsafe occupancy.	Three-times-daily flow meetings; criteria-led discharge; estimated discharge dates; escalation of CRFD barriers; frequent-attender care plans.	**9**
	Positively impact partner organisations	Positive with dependency risk: Supports shared management of flow, urgent care and vulnerable cohorts, but delivery depends on timely action by system partners.	Daily/weekly system escalation; agreed escalation routes; local authority and acute-partner involvement; record unresolved dependencies as risks.	**9**

Domain	If we make this change it will…	Impact on quality	Mitigating actions	Rating score
	and any aspects of shared risk			
	Improve medical devices / medicines safety	Neutral/positive: No change to device arrangements. Medicines and vaccination safety are supported through existing pharmacy, IPC and clinical governance processes.	Apply medicines governance, cold-chain and vaccination recording requirements; monitor incidents and uptake.	**4**
Effective	Improve service user experience	Positive with residual risk: Should improve experience by maintaining access, reducing avoidable delay and supporting care closer to home. Pressure may still affect privacy, choice and continuity.	Monitor complaints, PALS themes, restrictive practice, out-of-area placements, delayed transfers and service-user feedback.	**6**
	Reduce impact on variation in care provision	Positive: Standardised escalation, OPEL action cards and pathway oversight should reduce unwarranted variation.	Use common thresholds, daily review and clinical escalation; audit application across care groups and localities.	**4**
	Deliver positive outcomes of care (including patient and clinical reported	Positive: Supports safe access, continuity and discharge, with expected benefit to clinical outcomes.	Monitor safety incidents, readmissions, length of stay, CRFD, delayed discharges and clinical outcome indicators.	**6**

Domain	If we make this change it will…	Impact on quality	Mitigating actions	Rating score
	outcome measures)			
	Allow for implementation of evidence-based practice	Positive: Uses established IPC, EPRR, discharge, flow and urgent mental health arrangements.	Keep procedures current; test plans; capture learning from exercises, incidents and OPEL escalation.	**4**
Caring	Allow staff time to care for people	Mixed: Clear escalation and senior decision-making can protect time to care, although sustained pressure may reduce direct-care time.	Safe-staffing reviews, acuity-based decisions, redeployment controls, leadership visibility and rapid escalation of gaps.	**9**
	Support individualised care	Positive with residual risk: Maintains clinical review and crisis planning; system pressure may constrain placement and pathway choice.	Clinical prioritisation; personalised crisis/relapse plans; care planning and equality review; escalate exceptions.	**6**
	Promote patient choice and control over their own care, treatment and wellbeing	Mixed: The plan aims to preserve choice and care closer to home, but extreme pressure could reduce options or increase out-of-area care.	Monitor out-of-area placements and pathway exceptions; involve service users and carers in decisions; senior authorisation for deviations.	**9**

Domain	If we make this change it will…	Impact on quality	Mitigating actions	Rating score
	Improve the wellbeing of staff	Mixed: Wellbeing support and clear leadership are positive, but prolonged pressure, vacancies and additional workload may adversely affect staff.	Occupational health and EAP; supervision; Professional Nurse Advocate support; leave management; regular staffing and wellbeing review.	**9**
Responsive	Improve the timeliness of any stage of the service user pathway	Positive with residual risk: Improves operational response and decision-making, but timeliness may deteriorate if demand exceeds capacity.	Daily flow oversight; seven-day leadership; urgent pathway prioritisation; CRFD escalation; deployment of surge measures when safe.	**9**
	Support delivery of service performance including national and local performance targets	Positive: Supports delivery of local and national expectations through real-time oversight and winter-specific controls.	Monitor agreed KPIs and trajectories; exception reporting; restore performance plans where standards deteriorate.	**6**
	Promote the principle of Right Care, Right Place, Right Time	Positive: Supports Right Care, Right Place, Right Time through admission avoidance, home-first approaches, crisis alternatives and care closer to home.	Maintain community and crisis capacity; strengthen discharge pathways; escalate partner delays and capacity constraints.	**6**

Domain	If we make this change it will…	Impact on quality	Mitigating actions	Rating score
Well Led	Align with the Trust's vision, values, and strategic objectives	Positive: Aligns with safe, effective, person-centred care, system partnership and operational resilience.	Maintain Board assurance, quality governance review and alignment with strategic objectives.	**4**
	Have an impact on the staff working within the service and align with the 7 elements of the NHS people promise	Mixed: Provides clear roles and support, but may require flexible deployment and increased intensity of work during escalation.	Consult and communicate changes; apply safe redeployment principles; monitor workload, fatigue, sickness and staff experience.	**9**
	Positively impact on the way in which staff are expected to work. E.g. number of hours, impact on workload	Mixed: More coordinated working is expected, but peak demand could increase hours, workload and management span.	Roster review, senior cover, escalation thresholds, rest and wellbeing arrangements, and approval of exceptional working.	**9**

Domain	If we make this change it will…	Impact on quality	Mitigating actions	Rating score
	Positively impact the recruitment and retention of staff	Mixed: Good support and planning may aid retention; sustained pressure and vacancies could worsen recruitment and retention.	Recruit to establishment subject to approvals; reduce avoidable temporary staffing; monitor turnover, vacancies and exit themes.	**9**
Equality impact	Involve and engage service users, staff, public, and other stakeholders	Positive: System and internal partner engagement informs delivery; no specific service reduction is proposed.	Continue staff-side, service-user, carer and partner engagement as plans are tested and refined.	**4**
	Be co-produced with partners and people who use services	Positive with gap: The BAF reflects system working. Further direct co-production should be evidenced where operational changes affect pathways or access.	Record engagement and co-production; involve service users and carers in material pathway or escalation changes.	**6**
	Support fair access and the principles of the Equality Delivery System	Neutral/positive: The plan seeks to maintain fair access and prioritise vulnerable and high-risk cohorts.	Use equality and population-health information; monitor access and outcomes by protected characteristic and deprivation where available.	**4**
	Result in a more accessible service	Neutral: No planned reduction in accessibility. Extreme pressure could create temporary barriers or delays.	Maintain reasonable adjustments, accessible communication and alternative routes to urgent help; monitor access complaints.	**4**

Domain	If we make this change it will…	Impact on quality	Mitigating actions	Rating score
	Take into account the needs of all service users, staff, public, and other stakeholders	Positive with residual risk: The plan considers vulnerable patients, long-stay inpatients, housebound people, carers and staff, but local impacts require ongoing review.	Dynamic EQIA review; monitor differential access and outcomes; escalate disproportionate impact and implement targeted action.	**6**

Any other comments

Panel notes	
Key residual risk	Sustained demand may exceed funded bed, community and workforce capacity, with consequences for safety, experience, flow and staff wellbeing.
System dependency	Timely discharge and admission avoidance depend on capacity and response from local authorities, acute providers, primary care, community services and the ICB.
Assurance gap	Confirm the ESR frontline-healthcare-worker flag and evidence vaccination recording arrangements before final Board approval.

Conditional controls	Any additional capacity or altered staffing model must have a documented clinical, workforce, IPC, estates and equality risk assessment before activation.
Review requirement	Treat this as a live QIA. Review following winter exercises, material OPEL escalation, serious incidents, outbreaks, workforce deterioration or changes to the plan.

Please forward all completed QIA's to qualitygovernanceteam@swyt.nhs.uk

Appendix 1 (NHS England Quality impact Assessment Tool)

The table below is for amber or red risks only. Please complete only relevant sections only.

NQB domain	Impact			Description of impact Summarise the main impact (positive or negative) on the domain. State N/A if the impact is assessed as neutral. If impact is negative undertake risk scoring and mitigations planning	Evidence to demonstrate impact	Initial assessment			Mitigations Proposed mitigations to reduce any negative impacts. Please re-score risk of impact once expected mitigation are accounted for.	Revised assessment			KPIs Outline KPIs which will be used to monitor positive and negative impacts on domain.
	Positive	Neutral	Negative			Consequence	Likelihood	Risk score		Consequence	Likelihood	Risk score	
Patient safety	X		X	The plan improves preparedness and escalation. Negative impact could arise if occupancy, staffing, outbreaks or surge arrangements exceed safe thresholds.	OPEL and patient-flow dashboards; IPC and EPRR plans; escalation-bed SOP; on-call arrangements.	4	4	16	Daily flow and acuity review; safe-staffing escalation; IPC assessment; executive/clinical authorisation of surge capacity; incident learning.	3	3	9	Safety incidents; staffing fill/acuity; occupancy; OPEL level; outbreaks; restrictive practice; out-of-area placements.

Clinical effectiveness	X		X	Timely access, discharge and continuity may deteriorate during sustained pressure, affecting pathway effectiveness.	Criteria-led discharge, estimated discharge dates, urgent pathways, crisis and liaison arrangements.	3	4	12	Daily multidisciplinary flow review; prioritisation of highest clinical need; escalation of CRFD barriers; maintain crisis and community alternatives.	3	2	6	Access and waiting times; length of stay; CRFD/delayed discharge; readmission; crisis response; clinical outcome measures.
Experience	X		X	The plan supports care closer to home and timely access. Extreme pressure may reduce choice, privacy, continuity and carer experience.	Care closer to home work; crisis alternatives; frequent-attender plans; patient-flow oversight.	3	4	12	Shared decision-making; reasonable adjustments; senior review of out-of-area care; monitor feedback, complaints and pathway exceptions.	3	3	9	Complaints/PALS; service-user and carer feedback; out-of-area placements; waiting times; equality-related access concerns.
Well led	X		X	Clear governance is in place, but sustained escalation may increase workload and test clarity of accountability.	Executive Winter Sponsor; AEO arrangements; on-call structures; Board	3	3	9	Defined command and escalation; twice-daily or daily executive review when required;	2	3	6	OPEL compliance; actions closed; on-call issues; BCP activations; governance exceptions; overdue risks.

					assurance; EPRR plans.				documented decisions; Board exception reporting.				
Sustainable	X		X	The plan uses existing capacity. Prolonged pressure may require extra staffing, temporary capacity or mutual aid and may expose fragile partner-dependent pathways.	BCPs, mutual aid, cross-cover arrangements, community pathways and system escalation.	4	3	12	Cost and capacity controls; pre-authorised escalation options; impact assessment before additional capacity; active management of partner dependencies.	3	3	9	Temporary staffing and premium spend; mutual aid use; capacity opened; service disruption; partner-related delays.
Equitable	X		X	The plan aims to protect vulnerable and high-risk cohorts. Pressure could disproportionately affect people requiring adjustments, transport,	Risk stratification, support for vulnerable/housebound patients and crisis-relapse planning.	3	3	9	Dynamic EQIA; monitor differential access/outcomes; maintain reasonable adjustments and accessible communication; targeted action	2	2	4	Access and outcomes by protected characteristic/deprivation where available; reasonable-adjustment failures; equality complaints.

				advocacy or specialist pathways.					where inequality emerges.				
Workforce	X		X	Peak demand, sickness and vacancies may affect safe staffing, skill mix, workload, fatigue and wellbeing.	E-rostering; leave management; recruitment to establishment; wellbeing support; BCP cross-cover.	4	4	16	Daily safe-staffing review; controlled redeployment; escalation for additional resource; senior clinical cover; wellbeing, rest and supervision arrangements.	3	3	9	Fill rates; vacancies; sickness; turnover; bank/agency use; overtime; incidents linked to staffing; wellbeing indicators.
Performance	X		X	The plan supports performance, but sustained pressure may affect access, flow, RTT and urgent-care standards.	Winter plans for RTT pathways; dashboards; flow meetings; escalation routes.	3	4	12	Daily exception management; recovery actions; prioritisation by clinical risk; system escalation for blocked pathways.	3	2	6	RTT/access trajectories; waiting times; flow; discharge; occupancy; 12-hour breaches where applicable.

Strategic Objectives	X			The plan supports safe care, partnership working, resilience and delivery of national winter requirements.	BAF completion; Board assurance; system engagement; operational and EPRR governance.	2	2	4	Maintain alignment through Board review, quality governance and post-exercise learning.	2	1	2	Board assurance actions; delivery milestones; exercise learning completed; strategic risks updated.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29 September 2026
Agenda item 12.7

Private/Public paper:	**Public**		
Title:	**NHS Oversight Framework 2026/27**		
Lead Director:	**Adrian Snarr – Director of finance, estates and resources**		
Mission/values:	This report aligns to all Trust values.		
Purpose:	To provide Trust Board with an update on the Trust performance measures for the NHS Oversight Framework for 2026/27.		
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 strategic risks		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships.	The Trust performance management framework and reporting provide the ICBs with assurance that the Trust has an effective performance management system to contribute to the delivery of the ICB's strategic priorities and delivery plans.		
Any background papers / previously considered by:	Papers to Finance, Investment and Performance Committee June and July 2026		

Executive summary:	NHS England published the framework, methodology and full technical guidance on 11 June 2026. The main changes compared to the 2025/26 framework include: • Alignment of the approach to delivery segmentation for ICBs and providers • Clearer recognition of highly capable, high performing providers, including those that are awarded advanced foundation trust status and benefit from lighter-touch oversight • Update oversight metrics aligned to the NHS Medium Term Planning Framework, including new metrics for mental health, community, and ambulance trusts • Refinement of the delivery segmentation methodology to make tracking of improvement and deterioration easier • Establishing a stronger link between the oversight response model and delivery segmentation, organisational capability, and other considerations around engagement intensity, support, potential incentives, and consequences. • A greater number of metrics are applicable to the Trust during 2026/27. 25 scoring metrics (increased from 12 in 2025/26) and 5 contextual applicable metrics. The process for determining a segmentation will be undertaken as follows: • Calculation of an average metric score - each organisation receives a score for its delivery against a range of metrics. Each metric has an agreed scheme for scoring between 1 and 4. The individual metric scores are then averaged to produce an overall score for each organisation. There are some changes to how metrics are scored this year: • Target and spread - a defined target or benchmark is set and every organisation achieving that level scores 1.00. Remaining organisations are scored evenly between 2.00 and 4.00 based on their relative performance. • Banded scores - specific criteria are defined and converted to a performance band. • Floor and spread - a defined lower acceptable limit is set and every organisation failing to achieve that limit scores 4.00. Remaining organisations are evenly scored between 1.00 and 3.00 based on their relative performance. • Even spread - there is no defined performance threshold, organisations are ranked evenly between 1.00 and 4.00 based on their relative performance. • Segmentation - each organisation's overall score is then benchmarked against the rest of the country using defined rules to translate the score into a segment of 1, 2, 3, or 4. • Overrides - there is a single override within the segmentation methodology. Any organisation determined to be in financial deficit is automatically prevented from being allocated to segment 1 or segment 2 until the deficit has been satisfactorily resolved. Performance is based on existing national data flows such as the mental health services dataset (MHSDS), community services data set (CSDS), national staff survey, electronic staff record, NHSE Trust finance submissions, CQC national service users survey.

	As reported in the Chief Executives report this month, the Trust has retained its segment 1 rating in the Quarter 1 NHS Oversight Framework (NOF) ratings. The Trusts performance against the 25 individual metrics in the 2026/27 framework can be seen in the Integrated Performance report (agenda item 11.1)
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** the update on the NHS Oversight Framework for 2026/27.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29 September 2026
Agenda item 13.1

<table>
<tr><td>Private/Public paper:</td><td colspan="3">Public</td></tr>
<tr><td>Title:</td><td colspan="3">South Yorkshire Integrated Care System (SY ICS) Update including Mental Health, Learning Disability and Autism Provider Collaborative (MHLDA)</td></tr>
<tr><td>Lead Director:</td><td colspan="3">Mark Brooks - Chief Executive
Dawn Lawson – Executive Director of Strategy, Inclusion and Change/ Deputy Chief Executive</td></tr>
<tr><td>Mission/values:</td><td colspan="3">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.</td></tr>
<tr><td>Purpose:</td><td colspan="3">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.</td></tr>
<tr><td rowspan="3">Strategic aims:</td><td>Live Our Values</td><td>✓</td><td rowspan="3">The Trust's partnership working at system and Place supports it to be the 'Best Partner' and to achieve its ambitions.</td></tr>
<tr><td>Be the best we can be:
• Best quality
• Best partner
• Best value
• Best place to work and learn</td><td>✓</td></tr>
<tr><td>Be ambitious</td><td>✓</td></tr>
<tr><td>BAF Risk(s):</td><td colspan="3">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.</td></tr>
</table>

	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	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 28th July 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.
Recommendation:	**Trust Board members are asked to:** • **NOTE** the SY ICS and Barnsley Place updates.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29th September 2026
Agenda item – 13.1
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 2nd September 2026.</u> Key agenda items included: • Story Telling: Stroke Survivor, Rotherham - Stroke Awareness Week. • Questions from the public. • Chief Executive's update report. Key updates included: o Yorkshire Ambulance Service has been selected as one of the second wave of applicants to be assessed for Advanced Foundation Trust Status. o Baroness Casey's Independent Review into Social Care- The Prime Minister announced in early July that he has asked Baroness Casey of Blackstock to bring forward her an independent review on Adult Social Care, which will recommend how to reform the adult social care system. On 29 July, baroness Casey launched a Big Conversation on Care, which will run until April 2027. o The new Secretary of State for health and social care, Yvette Cooper, visited Sheffield's Newfield

	Green Neighbourhood Mental Health Centre on 6 August 2026 to announce funding over the next two years to create 100 new community-based centres like Newfield Green. The funding will also support the introduction of 59 additional mental health emergency departments, including Barnsley and Sheffield. o Dr Richard Jenkins has been appointed as Interim Chief Executive of Doncaster and Bassetlaw Teaching Hospitals (DBTH) for an initial period of up to 12 months. This is alongside his existing role as Joint Chief Executive of Barnsley Hospital NHS Foundation Trust and The Rotherham NHS Foundation Trust. Further changes to the leadership teams in Barnsley and Rotherham have been made to facilitate this move. o In July, consultants across England voted in favour of industrial action over pay and pensions. Although no dates have been announced, they now have a mandate for strike action over the next 12 months. o Barnsley Hospital has officially opened a new Frailty Same Day Emergency Care (SDEC) service on 20 July, which will help to improve care for older people. The purpose-built facility provides a dedicated, person-centred alternative to the Emergency Department for some of the hospital's most vulnerable patients. • South Yorkshire Board Assurance Framework and Corporate Risk Register. • Response to the national maternity review. • South Yorkshire – Delivering our Performance Objectives. Key updates included: o Urgent Community Response (UCR) continues to be a system strength across South Yorkshire. Performance remains well above the national standard, with 91% of referrals responded to within two hours in July 2026, compared to the national target of 70% and a national average of 86%. o There has been a slight increase in the number of children and young people accessing services in June 2026 of 150, almost achieving plan. The ICB continues to support the rollout of Mental Health Support Teams in Schools (MHST) and access via digital provision such as Kooth. o The ICB has been placed in enhanced scrutiny by NHS England for non-delivery of the Talking Therapies ambitions and the ICB has had a deep dive with the National NHS England Mental Health portfolio and is tasked with agreeing a recovery plan by the end of September 2026. In June the completion numbers were above plan,

	and improvement and recovery performance was close to target. • 2025/26 ICB Annual Accounts and Annual Report were agreed. • ICB Running Cost Reductions Organisational Change Programme Update: The results of a peer review conducted with West Yorkshire will be available at the next meeting. The majority of organisational change programme is expected to be completed by the end of September. • NHS South Yorkshire Month 4 Finance Report. At month 4 the ICB has recorded a deficit of £1.8m which is entirely related to the fact deficit support funding for the second quarter has not yet been confirmed. • Letters received from NHS England regarding Delivering the SYICB 2026/27 Financial Plan and the details of NHSE's annual assessment for the ICB for 2025/26 • Corporate Assurance Report. • Board Meeting Dates for 2027/28.
Date of next meeting	Next meeting scheduled for 4th November 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 and Trust Chair
Items discussed	Update from meeting held on 4th September 2026. Key agenda items included: • Updates were provided on key priority programmes regarding out of area bed placements, eating disorders and adult secure services. • Financial approach and priorities were discussed. • Collective response to national and regional drivers.
Date of next meeting	Next meeting to be confirmed.

4. South Yorkshire Eating Disorder Joint Committee (EDJC)

Member	Director of Strategy, Inclusion and Change/ Deputy Chief Executive
Items discussed	Update from meeting held on 14th September 2026. Key agenda items included: • SY Avoidance Restrictive Food Intake Disorder (ARFID) Proposal. • Community Children and young people's eating disorders (CYP ED) Services: Benchmarking, sharing learning and identifying opportunities scoping proposal.

	• Lived Experience Plan – Draft Engagement Strategy.
Date of next meeting	Next meeting Monday 12th October 2026

5. Barnsley Place

Barnsley Provider Partnership (BPP)

Member	Chief Executive
Items discussed	Update from meeting on 20th August 2026 Key agenda items included: • Discussion on the role of the Health Commissioner and how it may impact on Barnsley. There was a discussion in relation to South Yorkshire priorities. Prevention was agreed as a priority with a focus on Chronic Obstructive Pulmonary Disease (COPD), substance misuse, homelessness and alcohol. • Consultation on proposed Multi-Neighbourhood Provider (MNP) and Single Neighbourhood Provider (SNP) contracting models to support neighbourhood health services- it was agreed that each organisation will submit their own responses to the national consultation, and will share responses to identify areas of agreement and difference.
Date of next meeting	Next meeting to be confirmed.

Barnsley Community Health and Care Alliance

Member	Chief Executive, Chair, and Director of Strategy, Inclusion and Change/ Deputy Chief Executive
Items discussed	There has been no further meeting of the Barnsley Community Health and Care Alliance since the last report to Trust Board.
Date of next meeting	Next meeting to be confirmed.

Barnsley Health and Wellbeing Board

Invited observer	Director of Strategy and Change/Deputy Chief Executive
Items discussed	The meeting scheduled for 23rd July 2026 was cancelled. 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?CommitteeId=143
Date of next meeting	Next meeting scheduled for 12th November 2026.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29 September 2026
Agenda item 13.2

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	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through Place based partnership		

Integrated Care System/Integrated Care Board/Place based partnerships.	arrangements and provider collaboratives, and also developments and discussions in progress where relevant.
Any background papers / previously considered by:	Strategic discussions and updates on the West Yorkshire Health & Care Partnership developments and place-based developments have taken place regularly at Trust Board. The last update was received by Trust Board on 28 July 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.

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.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29th September 2026
Agenda item 13.2

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.

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	The next meeting of the West Yorkshire Integrated Care Board is 22nd September 2026.
	
	Key agenda items include:
	
	• Public Questions.
	• Board Assurance Framework.
	• Chair's Report.
	• Chief Executive's Report.
	• Finance and performance update.
	• West Yorkshire Joint Capital Resource Plan 2026/27.
	• Corporate Risk Register.
	• Committee 'AAA' (Alert, Advise, Assure) Reports.
	  ○ Quality, Safety and Experience – 8 September 2026.
	  ○ Finance, Commissioning and Performance – 1 September 2026.
	  ○ Audit and Risk – 15 September 2026 (verbal).
	  ○ Bradford District and Craven – 21 August 2026.
	  ○ Kirklees – 12 August 2026.
	  ○ Wakefield – 19 August 2026.
	  ○ Yorkshire and Humber Joint Committee for Specialised Commissioning - 24 August 2026.
	• Strategic Commissioning and Planning.
	• Neighbourhood Health.
	• Freedom to Speak Up Annual Report.
	• Corporate Policies.
	  ○ Risk Management Policy, Strategy and Framework.
	  ○ Standards of Business Conduct.
	  ○ Conflicts of Interest.
	  ○ Fit and Proper Persons (FPP).
	• Changes to the Operational Scheme of Delegation.
	• Changes to the Financial Scheme of Delegation.
	• Quality, Safety and Experience Committee Terms of Reference.

Date of next meeting	Next meeting scheduled for 15th December 2026
Further information:	Integrated Care Board : West Yorkshire Health & Care Partnership

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.wyhpartnership.co.uk/meetings/partnershipboard Meeting papers are available here:

	https://www.wypartnership.co.uk/meetings/partnershipboard/papers

West Yorkshire Mental Health, Learning Disability and Autism Partnership Board

Members	Chief Operating Officer and Medical Director.
Items discussed	The West Yorkshire Mental Health, Learning Disability and Autism Partnership Board meetings scheduled for the 11th August and 17th September were cancelled.
Date of next meeting	Next meeting scheduled for 15th October 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	Update from meeting on 19th August 2026 Key agenda items included: • Terms of reference- these were approved. These reflect that the meeting will continue to be held in public rather than in private. • Neighbourhood health plan- a presentation was shared outlining the work that has taken place to develop the neighbourhood health plan. • Section 75 Partnership Agreement (Wakefield Place and Wakefield Council)- this was supported.
Date of next meeting	Next meeting scheduled for 10 November 2026
Further information	Meeting papers are available here: Committee meetings - Wakefield District Health & Care Partnership (wakefielddistricthcp.co.uk)

Wakefield Mental Health Alliance

Member	Deputy Director of Partnerships, Planning and Governance (Chair) Associate Director of Operations, Mental Health Care Group
Items discussed	Update from meeting on 22nd July 2026 Key agenda items included: • Mental Health Alliance Dashboard Report. • Mental Health Community Panel Quarter Report Q1: April 2026- June 2026. • Update on Memory Service.

	• Future of the Mental Health Alliance- feedback was received on the proposed merger of the Mental Health Alliance and Learning Disability and Neurodiversity Alliance. The revised terms of reference, work plan and draft dashboard were received. • Update on the Wraparound service. <u>Update from meeting on 19th August 2026</u> Key agenda items included: • Mental Health Alliance Dashboard. • My Mental Health Wakefield- the 'My Mental Health Wakefield' website has been shaped by lived experience feedback through Healthwatch, alongside statutory and VCSE input. The website aims to provide a simple, accessible guide to mental health support across Wakefield. A demonstration was given of the new website • The proposal to merge the Mental Health Alliance and Learning Disability and Neurodiversity (LD ND) Alliance was further discussed. The Alliance supported the merger so, pending agreement by the LD/ND Alliance this will be taken forward. An initial face to face meeting will be arranged.
Date of next meeting	Next meeting scheduled for 23 September 2026

Wakefield Health and Wellbeing Board

Member	Chief Executive (deputy - Programme Director for Mental Health Transformation- Wakefield)
Items discussed	<u>Update from meeting on 15 September 2026</u> Key agenda items included: • Urgent items. • Public questions. • Ageing Well. • Health Protection Report. • Carers Update. • JSNA (Joint Strategic Needs Assessment) indicators. • Final Better Care Fund s75 partnership agreement. • Better Care Fund 20206-27 NHS England approvals letter. • Overview and Scrutiny Papers for information.
Date of next meeting	Next meeting scheduled for 24th November 2026
Further information	Papers and draft minutes are available at: <u>www.wakefield.gov.uk: Browse meetings - Health and Wellbeing Board</u>

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	The meeting scheduled for 13th August 2026 was cancelled. Therefore there has been no further meeting since the last update to Trust Board.
Date of next meeting	Next meeting scheduled for 12th November 2026
Further information	Further information and meeting minutes can be found here: Calderdale Cares Partnership Board Papers - Calderdale Cares Partnership

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 were 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	There has been no further meeting of the Calderdale Health and Wellbeing Board since the last meeting of Trust Board
Date of next meeting	Next meeting is scheduled for 14th 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	Update from meeting on 12th August 2026 Key agenda items included: • Terms of reference for approval. • Kirklees Better Care Fund Section 75 Partnership Agreement 2026/27 (Kirklees Place and Kirklees Council). • Community Investment Schemes Decisions Report- this provided assurance to the Kirklees ICB Place Committee regarding the exercise of deploying the delegated 4.2% community investment allocation and implementing previously approved mental health investment. This included a proposed development of a business case for a Children and Young People's Hospital at Home and Rapid Response service using the remaining delegated Community Investment allocation.
Date of next meeting	Next meeting scheduled for 11th November 2026
Further information	Further information and papers are available at: Kirklees Integrated Care Board Committee - NHS Kirklees HCP

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	Update from meeting on 10th September 2026 Key agenda items included: • CLiK survey- the outcomes of the CLiK (currently living in Kirklees) survey were shared. The aim of the survey is to gather data about Kirklees residents that can't get via other means.

	• Overall health related behaviours have improved, though financial pressures have worsened and differences between places and groups have widened.
Date of next meeting	Next meeting scheduled for 5th November – Picture of Kirklees Event

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.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29 September 2026
Agenda item 13.3

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	✓	Please be explicit as to what strategic aims the paper support and why. Please remove as appropriate
	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 based partnerships and partner organisation objectives at national regional or local level.	The paper provides an update on the work of the 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 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 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:** **RECEIVE** the updates provided within the paper.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29 September 2026
Agenda item 11.3

Specialised NHS-Led Provider Collaboratives and Alliances - Update

1. Introduction

The purpose of this paper is to provide an update to the Trust Board on the Specialised NHS-Led Provider Collaboratives, focusing on developments that are of importance or relevance to the Trust. The paper includes updates on the West Yorkshire and South Yorkshire & Bassetlaw Provider Collaboratives where the Trust is a Co-ordinating Provider or partner, and an update on the national Phase 2 Provider Collaboratives.

2. Phase 1 Provider Collaboratives

In **West Yorkshire**, Provider Collaboratives have been established for national Phase 1 services:

- Adult Low and Medium Secure Services - co-ordinated by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT).
- Children and Young People Mental Health (CYPMH) inpatient services (Tier 4) - co-ordinated by Leeds and York Partnership NHS Foundation Trust (LYPFT).
- Adult Eating Disorder Services - co-ordinated by LYPFT.

In addition to being Co-ordinating Provider for Adult Secure, the Trust is a partner in both the Adult Eating Disorder and CYPMH Provider Collaboratives.

The Adult Eating Disorder Collaborative went live on 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:

- 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 functions and improved coordination of secure beds across WY, SY and H&NY.
- A new executive oversight group co-chaired by SWYT SRO and Humber and North Yorkshire SRO have been established to support the implementation of the regional work, improving collaboration. This has been established in the context of the potential lead provider contract and associated KPI indicated by NHSE post March 2027.
- The WY PC continue to experience the highest number of patients cared for in secure services, at 275 since the PC went live. This is because of demand, and recent slowing of discharges. The main pressure continues to be on the medium secure male 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. Providers across Wy have been requested to develop discharge plans and a thematic review of reasons for the slowing of discharges it to be developed t inform system improvements.
- The total numbers waiting for secure care has reduced in recent months.
- The overall number of OOA cases increased to 57 and has remained at this level for the last 5 months. This is the highest number since 2022, whilst some cases are within their natural clinical flow, some are OOA purely due to no 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 operational activity pressures continue to have a financial pressure on the West Yorkshire Adult Secure collaborative due to increased expenditure on OOA placements and EPCs. The deficit is expected to be £1.2m by the end of the year, with the year-to-date deficit £497k.

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 financial position, year to date is a surplus of £67k. On commissioning activity, this forecasted position is unlikely to materially change as we have factored in a 3 month 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 financial position, year to date, a surplus of £594k is reported. Underspends against the EPC and secure budgets are driving the surplus position. After risk share repayments and allocation of monies for a business proposal (agreed at board), the amount held in the investment reserve stands at £1416k and will be made available for investment against the developmental service specifications and/ or held to manage future financial risk.

The current forecast for 2026 / 27 is a surplus of £679k. On commissioning activity, this forecasted 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 (+10) with 163 patients in inpatient treatment in total, this is 9 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 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 SYB in 2026/27.
- As at the end of August 2026, 20 patients were out of area (+3), 7 patients were within natural clinical flow (0 movement) and 4 are appropriate for repatriation (+2). Of the 4 patients appropriate for repatriation both will be prioritised for beds as they become available with Wathwood. Forest Lodge and Cygnet Sheffield.
- 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.

- 2026/27 Annual Quality Reviews have been undertaken at Cheswold Park Hospital, Amber Lodge, Wathwood and Cygnet Sheffield to date. There were no immediate quality or patient safety concerns to escalate, and all providers remain in Routine Monitoring.

- Consideration is being taken on the 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 and a further event in July 2026 to hear proposals from RDASH and SHPU on how the expansion could be managed alongside existing services, work continues to agree clinical models, delivery plans and financial positions. This work is continuing at pace with an agreed position expected by the end of October 2026 following all relevant governance is followed.
- 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 and work continue in strengthening the wider regional joint working.
- Negotiations are ongoing with Providers on 26/27 contract terms with 4 out of 5 now finalised and the remaining 1 being in final stages of agreement for 26/27.

The SYB Provider Collaborative is reporting a deficit position of £1.5m as at month 5 for 2026/27, this is primarily driven by;

- An increase in demand for inpatient services which has increased costs for both in area providers and out of area providers with a forecast pressure over £2m. 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 £266k pressure in relation to higher than national inflation within both multi-site provider uplifts and out of area Provider Collaboratives that the SYB Provider Collaborative do not negotiate. This is being monitored and reported to NHS England regional team as on 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 full £90,000 funding from central NHSE and £103,000 from FCAMHS surplus investment fund.

5.2 Perinatal Mental Health

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.

At month 3, 2026/ 27 the PMH PC has reported £22k deficit with an annual forecast deficit of £88k. The 2025/26 deficit was £289k and was funded by LYPFT. The 2026/27 forecast deficit has reduced due to growth of £132k being added to the contract. It will be discussed in the Finance & Contracting group how the deficit should be funded with a proposal coming to PC Board. On commissioning activity, this 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

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29 September 2026
Agenda item 15.2

Private/Public paper:	**Public**
Title:	**Research & Development Strategy update: 2026 - 2031**
Lead Director:	**Prof Subha Thiyagesh**
Mission/values:	The R&D strategy is an enabling strategy which is grounded in the ambition to support the central aim of the Trust to enable people to reach their potential and live well in their community. **R&D Aim:** We will do this by establishing the Trust as a centre for evidence-based practice, co-production and a leader in staff, service user and carer research participation. Using our Trust values and behaviours, our approach to help deliver our aim is to ensure everyone (service users, carers, staff and the public we serve) have an opportunity to get involved, lead and support research activity. Under the banner **#AllofusinResearch** there is a commitment within the strategy to help build sustainable research capacity and capability across the **life course of services.** This will create opportunity that builds research capacity and capability across **all** of our place areas and clinical teams.
Purpose:	To review / comment / approve the updated R&D strategy for 2026 -31
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):	
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at	The strategy provides a framework for the Trust to contribute (through representation) and support (through research delivery) to the wider ICB, ICS and place-based research and innovation aspirations. The strategy consolidates its strategic support for the Research hubs in our place areas as well as continuing a focus upon challenging health inequalities, building inclusive engagement strategies (EDI work) and actioning the aspirations within the NHS 10-year plan and Life Sciences Plan (which are key delivery items for the ICB and ICS). The strategy capitalises on our Teaching Trust status and looks to develop the Trust's research portfolio in joint areas of research enquiry (with ICB, ICS and

national regional or local level.	other strategic bodies regionally and nationally) such as increasing commercial research, research in genomics, AI – large language model processing /data models and wider health sciences.
Any background papers / previously considered by:	EMT – 7 July 2026 Quality and Safety Committee - 8 September 2026
Executive summary:	This five-year strategy continues the journey to build a dynamic and integrated research culture within the Trust and consolidate the gains made in the last three years. The strategy sets out a clear ambition to position the Trust as a regional and national leader in mental health research, innovation, evidence-based practice and coproduction with a strong emphasis on collaboration, inclusion, and real-world impact across the life course. The R&D department is a strategic enabler across the Trust, providing the expertise, governance, and infrastructure needed to embed high-quality research. The department provides technical, methodological, and academic expertise to support the evidence base in identifying best practice, challenging health inequalities and driving continuous improvement. It ensures the Trust meets its legal and regulatory responsibilities for conducting safe, high-quality, and well-governed research within the NHS. The strategy builds on significant progress made since 2022 and leverages the successful attainment of Teaching Trust status to consolidate the development of a life course approach to our research portfolio, while simultaneously maintaining our involvement in several multi-million-pound research bids. The Strategy therefore adopts a whole-system, inclusive approach under **#AllofusinResearch** and is guided by 3 core strategic themes and several objectives which culminate into a number of ambitions. The ambitions and objectives will be delivered through the R&D operational plan (RDOP) which provides a broad framework for KPIs and milestones for each of the objectives (these will include or reference the linkage to Trust strategic objectives and those identified by the NIHR RRDNs). These will be reviewed at a monthly R&D operational meeting chaired by the head of research with escalations and oversight at the senior leadership team meeting. The overall implementation, monitoring and evaluation of the Trust's R&D strategy will be managed by the Trust R&D team on behalf of the chief medical officer and Trust board. An annual progress report / quality account and update will be provided to respective Trust governance teams alongside representation to the EMT and to the Trust board highlighting updates in the R&D operational plan. **R&D Strategic Themes:** 1. **Workforce & Organisational Development** o Strengthen research skills, embed R&D across the Trust, and Leverage Teaching Trust status to improve quality, learning, and value.

	2. **Research & Innovation Leadership** o Promote participation, leadership, and innovation in research that delivers meaningful outcomes. 3. **Partnerships & Networking** o Expand collaboration with academic, industry, and community partners to increase impact and capacity. **Strategic Objectives** • Strengthen presence in regional and national research forums which share good practice and challenge health inequalities and support wider inclusion. • Fully integrate R&D into clinical, operational, and governance systems within the Trust providing opportunity to all. • Increase research capacity and workforce capability by Developing clinical academic career pathways and funding opportunities • Expand research into priority (national /local) areas including commercial research, AI, genomics, digital health, and life sciences. • Build capability in data, AI, and digital innovation to support prevention and service improvement and value for money. **Five-Year Ambitions (2026–2031)** • Develop and deliver a self-sustaining pipeline of "home-grown" research and talent (backed by a clear clinical academic pathway). • Establish a mental health research centre in Wakefield. • Achieve a balanced, high-performing NIHR portfolio, including commercial studies. • Lead place-based and community-driven research across the Trust's geography. • Integrate research, audit, quality improvement, and innovation into a coordinated system. • Position the Trust as a leading national provider of mental health research. **Dissemination** An annual or bi-annual R&D conference will be held to showcase innovations, share best practice, and enhance networking across all stakeholders. **Development of Strategy & EIA:** The strategy has been developed in consultation with staff, service users/ carers (through our Research involvement group) and key academic, NIHR research partners. The EIA further lists key examples of good practice and highlights the department's commitment to ensuring equity of service and support.
Recommendation:	**Trust Board members are asked to:** **APPROVE** the Research and Development Strategy.

South West Yorkshire Partnership Teaching
NHS Foundation Trust

Research and development strategy

2026 - 2031

With **all of us** in mind.

Contents

Foreword

I am pleased to introduce our research strategy which sets out our ambitions for the next five years of building and leading an innovative research active trust. This strategy consolidates the gains made by the R&D dept and helps to structure the ongoing development and specialisation of research and innovation. The last three years have seen the department exponentially grow and build a sustainable foundation in research design, delivery and coordination. The extensive relationships with academia and industry partners continues to support new opportunities and helps the trust maintain its position within the region as one of the top mental health recruiters. The successful development of our dedicated research facility alongside our teaching trust status will enable new and exciting research to be undertaken and led by the trust.

One of our values here at South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) is 'relevant today and ready for tomorrow'. We strongly collaborate, support and listen to the voices of our service users, carers, staff and partners across the systems that we deliver care – thus helping us to set the right objectives, priorities and addressing the inequalities which has become increasingly clear exists across the systems.
We believe the clear and practical objectives and priorities provide a pragmatic approach to continuous improvement on our journey to providing the highest quality of care we can across our communities. I would like to particularly thank our fantastic team who have contributed to the development of this strong strategy.

Prof. Subha Thiyagesh, chief medical officer/director of research and development

As a Teaching Trust, Research and Development is fundamental to achieving our Trust strategic aims: by living our values, being the best we can be and supporting the ambitions for the communities we serve. It is through research that we challenge current practice, generate new knowledge, embrace innovation, and ensure that the care we provide is informed by the best available evidence.
Research is not a separate activity undertaken by a few; it is a vital part of a high-performing healthcare organisation. Evidence consistently demonstrates that organisations actively engaged in research deliver better outcomes for patients, foster a culture of continuous improvement, and are better able to attract, develop and retain talented staff. Research enables us to better understand the needs of our diverse communities, develop and evaluate new treatments and models of care, reduce health inequalities, and improve the quality, safety and effectiveness of the services we provide.
This Research and Development Strategy sets out how we will strengthen research capability and capacity across our organisation and with our partners. It reflects our commitment to enabling more staff to become research active, expanding opportunities for patients and service users to participate in research, and ensuring that the benefits of innovation reach the communities we serve.

Mark Brooks
CEO

As Chair of the Trust, I am proud to introduce this Research and Development Strategy, which reflects our commitment to improving the lives of the people and communities we serve through high-quality research and innovation. In mental health, learning disability and community services, research plays a vital role in helping us better understand people's needs, develop more effective interventions, reduce inequalities, and ensure that care is informed by the best available evidence.
This strategy sets out our ambition to build a strong and inclusive research culture across the Trust—one that encourages curiosity, supports innovation, and creates opportunities for staff, patients, service users, carers and communities to be actively involved in research. By embedding research into everyday practice, we can improve outcomes, enhance experiences of care, and contribute to the development of services that are compassionate, effective and responsive to the needs of our population.
Through collaboration with universities, NHS partners, voluntary and community organisations, and the people who use our services, we will strengthen our research capability and extend the impact of our work.

Jayne Brown
Chair

“Taking part in research and the research involvement group has helped me build my confidence and learn new skills. I started as a participant in a project then went on to help support a study and now I am involved in a few projects where I help with how the project is started and how it runs. I am loving it.”

Research involvement group member

1. Executive summary - about the strategy

This five-year strategy continues the journey South West Yorkshire Partnership Teaching NHS Foundation Trust (the Trust) has been undertaking to build a dynamic and integrated research culture. The strategy builds upon the successful gains made in the last three years in establishing the profile and credibility of the Trust as a key research partner regionally and nationally with academic institutions, industry and other NHS providers.

As a key driver of the Teaching Trust accreditation, the department provides guidance and assurance to the Trust that it is meeting its legal duties to undertake and lead research within the NHS setting ensuring that any research being undertaken is of high quality, safe, relevant and has the appropriate oversight.

Providing opportunity through the NHS for people to get involved in research is enshrined within the NHS Constitution (2021) and is the strategic driving force of change in the 10-year NHS 'Fit for the Future' plan (2025) and Life Sciences Sector plan (2025) announced by the Department of Health and Social Care.

Our ambition

The ambition of the research and development department and this strategy is to support the central aim of the Trust to enable people to reach their potential and live well in their community. We will do this by establishing the Trust as a centre for evidence based practice, co-production and a leader in staff, service user and carer research participation.

Our approach

Using our Trust values and behaviours, our approach to help deliver our aim is to ensure everyone (service users, carers, staff and the public we serve) have an opportunity to get involved, lead and support research activity. Under the banner **#AllofusinResearch** there is a commitment to help build sustainable research capacity and capability across the **life course of services** i.e. creating opportunity that builds research capacity and capability across **all** of our place areas and clinical teams.

Our support for the Trust's strategic aims

The research and development department is an enabling department whose support, guidance and insight can be felt across the Trust and its strategic aims. The department provides a framework and evidence base to allow the Trust to identify and explore **what is "best" and to be ambitious in its aspirations for the staff and people we serve.**

The department provides technical and methodological support as well academic support through its academic partnerships enabling the Trust to critically evaluate, measure and design services which are relevant and support the needs of the populations we serve. It provides support for the delivery of the Trust strategy and clinical strategy, and is a key driving force in maintaining our Teaching Trust accreditation, alongside supporting the delivery of outstanding, person-centred, safe and sustainable care. It ensures we are relevant today and ready for tomorrow, allowing the Trust to identify best practice and best place to work and learn.

The department is a vehicle in attracting investment and high caliber, research-active staff who are motivated to support innovative clinical care practice. The department utilises its expertise in community engagement, data/ AI machine learning and wider technology to help address health inequalities and provide evidence in understanding short term and long-term investment efficiencies and value for money.

What we have achieved so far

The research and development department has become a recognised regional and national research partner managing a complex and emerging pipeline of research activity, with over 52 studies delivered in 2025.

Between 2019 – 2025 the department has grown exponentially, starting with six staff in 2019 and by 2025 holding 31 staff. The department also has over twenty volunteers who are actively working across the life course.

Key examples of success over the course of the last strategy:

- We are the only mental health trust across the North of England that has established research divisions which map across clinical specialities and care groups providing a 'life course approach to study delivery'. This 'sustainable' structure has helped build research capacity and capability across our place areas and clinical teams. It has also led to year-on-year increase in participation of service users, staff and carers in research activity, with over 800+ recruited in 2025.

- The department continues to integrate within the Trust's structure. It is a recognised specialist team that contributes to several strategic clinical and governance meetings, providing knowledge and guidance on research practice.

- Established a research and innovation group to facilitate communication and co-ordination of activity between different teams involved in research, evaluation, clinical audit, quality improvement and learning.

- Supported the senior executive team to successfully attain NHS Teaching Trust status and build a working relationship with over 36 higher education institutions across the UK.

- Supported numerous competitive NIHR grants totalling over £18m (**as a delivery partner**) and gained uplift in funding from the NIHR Research Delivery Network (RDN) which attracted a minimum of £450k in direct income (staff costs) and over £1.25m in infrastructure money.

- This investment contributed to the Trust improving our overall R&D ranking from 25 out of 26 to being in the top three (i.e. 3 out of 26) specialist mental health Trust recruiters within the region.

- Identified as the **lead NHS mental health trust partner** in the following multi-million-pound research bids:
    - £1.25m – Research funding secured to develop a new research centre at the Fieldhead site in Wakefield
    - £11m – Research funding secured to support the University of Huddersfield in developing a new mental health research centre.
    - £5m – Research funding secured to support Wakefield Council in developing a health determinants research collaboration

    - £9.5m – Research funding secured to support the University of Durham's investigations in to hidden experiences of mental health through the Wellcome Discovery platform

- Established a process to engage communities in our place areas and develop joint activities to increase participation in research

- Established a process for clinical colleagues to engage with research either as a principal investigator or through the development of clinical academic roles

Our focus for the next five years

Moving forward into the next five years our strategy is to ensure we can deliver on the projects we are currently supporting, while also developing our life course approach and establishing clearer opportunities through our Teaching Trust partnership.

The strategy has three broad themes supported by several objectives which will form part of an annual delivery plan. The objectives and the annual delivery plan will be reviewed and key performance indicators identified to ensure the objectives are met through the course of the strategy.

This strategy will continue to build on the key success of the previous strategy and will increase our focus on:

- Approaches that actively challenge health inequalities while ensuring patient safety and choice

- The use of artificial intelligence (AI) and digital health to innovate clinical care pathways as well as improving timely support for individuals with mental and physical health conditions

- Capitalise on the Teaching Trust status to build opportunities for clinical academic roles. This will also support the development of home-grown research activity led by staff, service users and carers that is meaningful and impactful for the communities and people we serve

- We will aim to support prevention as well as effective place-based treatment in line with the NHS 10-year plan

- We will continue to create a balanced NIHR portfolio that delivers on the national KPIs and includes a focus on commercial research

- In line with our Trust values, we will adopt a holistic and a systems-based approach to understanding the challenges faced by individuals experiencing mental health and physical difficulties. This will enable us to investigate and ensure the Trust is at the cutting edge of research inquiry by bringing together the following key research fields:

    - The physiological and biological (pathophysiology underpinnings of disease through multi-omics using biogenetics and biomarkers) alongside the wider social, psychological, economical, cultural and historical factors.

- We will continue to build our partnerships (internationally, nationally and regionally) and strengthen our place-based networks. This will ensure we are creating the right opportunities which are meaningful and help deliver our Trust strategic ambitions.

Consultation and development of strategy

The strategy has been developed through feedback with clinical teams and through the Trust strategy group. Feedback has also been gained though our research involvement group and wider academic delivery partners across the region.

2. About South West Yorkshire Partnership Teaching NHS Foundation Trust

South West Yorkshire Partnership Teaching NHS Foundation Trust provides community, mental health, learning disability and wellbeing services to over 1.2 million people across Barnsley, Calderdale, Kirklees and Wakefield. We also provide specialist secure mental health (forensic) services for the whole of Yorkshire and Humber. There are around 600 inpatient beds spread across 40 wards in the trust.

We employ nearly 5000 staff in both clinical and non-clinical support services. In the complex landscape of systems and place-based structures, partnership working and the relationships we build are integral to the success of the research strategy.

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

The Trust successfully gained Teaching Trust status in 2025 working closely with our academic partner University of Leeds. The attainment of this status helps the Trust become a leading partner in the development of next generation of health professionals and clinical and research practices.

NHS
South West Yorkshire Partnership Teaching
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Our purpose

We help people reach their potential and live well in their community

Our values

- We put the person first and in the centre
- We know that families and carers matter
- We are respectful, honest, open and transparent
- We improve and aim to be outstanding
- We are relevant today and ready for tomorrow

If you require a copy of this information in any other format or language please contact the Trust.

With **all of us** in mind.

Figure 1: Trust purpose and values

Trust strategy

The Trust has developed an ambitious overarching strategy which was updated in summer 2024. It sets out the future direction of the organisation for the next five years – our purpose and values, as well as our strategic ambitions and outcomes (Figure 2).

Figure 2: The relationships between our strategy and our partnerships

The Trust has a current overall Care Quality Commission rating of good, and we are proud of the recognition of our caring and kind staff as well as our delivery of well-led services. Through the implementation of our clinical strategy, we hope to build on our good rating, address the areas for improvement that have been identified and strive to be outstanding.

Our clinical strategy has been developed to help us to achieve that vision and to drive the delivery of our strategic aims (Figure 3):

- **Strategic aim one:** We will live our values
- **Strategic aim two:** We will be the best we can be
- **Strategic aim three:** We will be ambitious

Figure 3: Strategic aims

3. Background and current context

3.1 Introduction and importance of research: NHS 10 Year Plan and The Life Sciences Plan

Research is vital in providing the evidence we need to ensure treatments are safe, effective and fit for purpose, as well as enabling transformation of services and development of new approaches to care.

Research development and delivery are central tenants of the NHS Fit for the Future 10-year plan (2026) and Life Science Sector plan (2025), with research investment of over £2billion in the next 10 years. As a result, it is imperative to establish an efficient, research ready workforce and research accessible service to fulfil the requirements within these plans.

Evidence arising from research is central to informing the design and delivery of services, professional training, and helps to develop innovation and new ways of working. The NHS Constitution (2021), NHS Long Term Plan (2019) and NHS Fit for the Future includes research activity as a key vehicle in improving current and future health and social care outcomes or prospects of the population.

Research activity and impact is also a key outcome identified by the Care Quality Commission and a milestone in clinical practice for all regulated staff with the health and social care sector.

There is a strong evidence base that shows research-active organisations, and engagement of clinicians in research, leads to improved healthcare performance and outcomes for NHS users as well as supporting retention of NHS staff.

3.2 What does the research and development (R&D) department do?

The research and development (R&D) department is a single point of access for all research related enquiries and ensures research within the trust is of high quality, safe, and relevant to Trust services and service users. The R&D department is jointly funded by the Trust and the National Institute of Health Research (NIHR) through its Local Research Delivery Network (RDN). The Trust funding supports the infrastructure of the department and the external RDN funding in principle covers the delivery aspect of the team i.e. to undertake and deliver NIHR studies locally.

The department has delegated responsibility to manage the governance processes for all NHS research being undertaken within the Trust. This includes supporting colleagues and research staff to navigate the NHS ethics application process which is administered by the Health Research Authority (HRA).

The department provides bespoke support and guidance to staff, service users, and carers who are involved in the various stages of a research project. Advice and information is also provided to researchers from external partners and academic institutions who are collaborating on projects and may require governance support including research passports, letters of access and training in Trust-specific activities. Through its clinical research officers (delivery team) and research assistants, the department also provides support in assessing feasibility, setup and delivery of local, national or international research studies that are on the NIHR portfolio. The NIHR portfolio is a national listing of studies currently being set up / delivered within NHS and social care settings.

The department provides specialist knowledge and guidance on research methodology, ethics and support for the development of research literature and research competitive bid development.

Is it research, an audit, or a quality improvement project?

The department provides clarification and bespoke guidance on governance related queries. Through partnership working with other corporate services, the team ensures projects have the appropriate governance approvals whether it is an audit, involvement project, quality improvement or service evaluation.

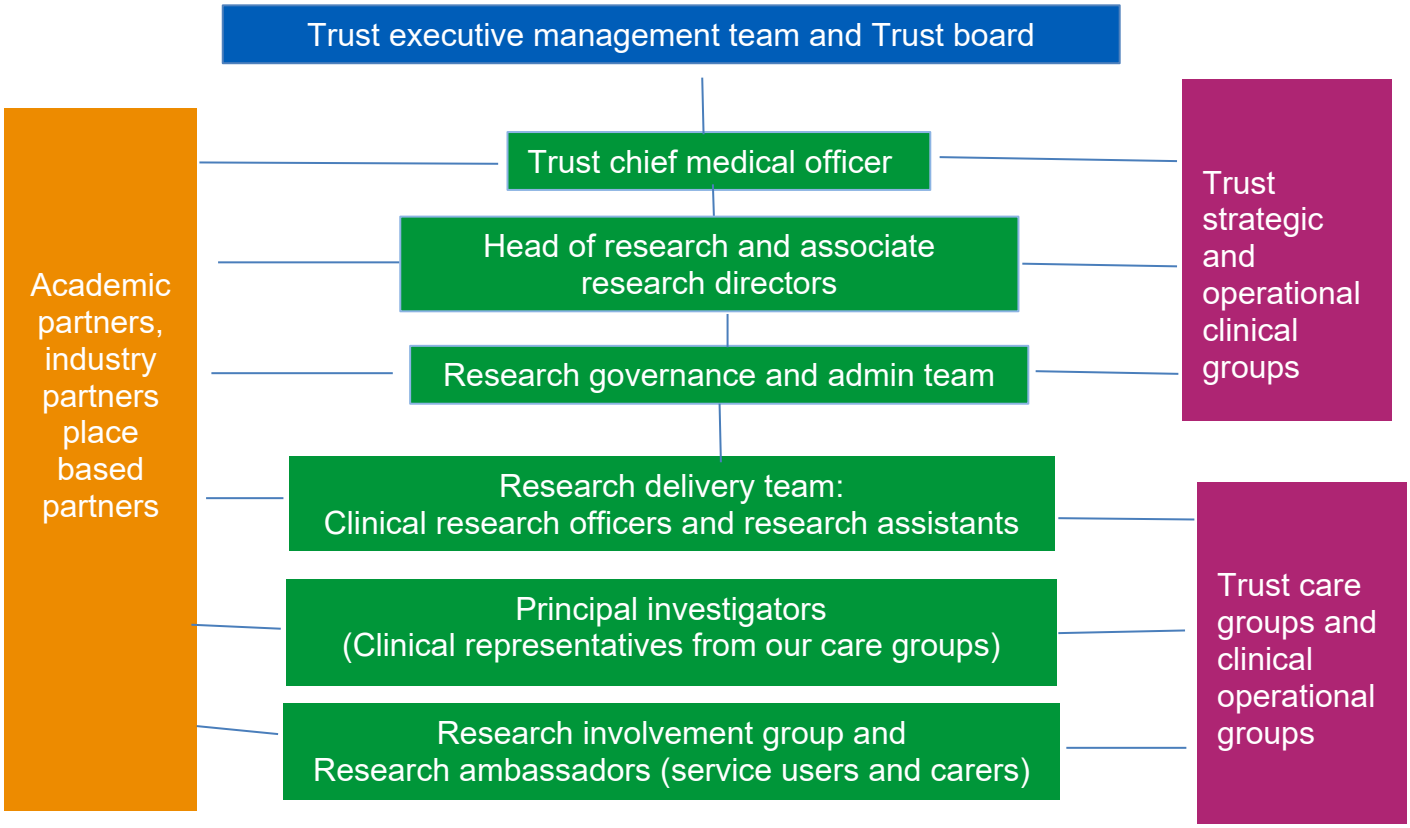
There is a strong relationship between audit, quality improvement, service evaluation and research as they all can support Innovation and lead to service improvement:

Research, however, can be defined as the detailed and systematic study of a subject area to discover **new information or reach a new understanding** of that subject, using rigorous and scientifically grounded methods.

Research involves developing a hypothesis and then systematically investigating and testing that hypothesis. Research activity can be replicated, and its findings can be generalisable. Research activity within the NHS must go through external ethics and governance approval which is managed by the R&D department.

3.3 Who is in the team and how do they link to the rest of the Trust? R&D workforce

The R&D department is strategically hosted within the medical directorate with direct linkage to other strategic and operational groups within the Trust. It is a growing team which currently includes a head of research, associate R&D research directors, associate medical director, clinical research officers and research assistants. The wider R&D Trust family also includes staff, service users and carers who are actively engaged in or leading research as principal investigators (PI) or collaborators.



Further details on the R&D team structure and Delivery Team structure are provided in Appendix 1 and 2.

Appendix 3 provides information about the R&D linkage with Digital innovation & process mapping highlighting the distinction between stage 1: digital innovation activity which is Research based & stage 2 which is implementation based

Appendix 4 highlights cross collaboration between corporate and clinical services with R&D.

3.4 R&D accountability

The department is hosted within the medical directorate and is accountable to the Trust board. The department contributes towards the annual reporting and CQC reporting for the Trust. Through its senior leadership team, the department is also represented in a number of Trust governance and assurance meetings.

The department is also benchmarked against national metrics managed by the National Institute of Health Research (NIHR). The higher-level objectives set by the NIHR focus on 'recruitment and delivery' of studies on the NIHR portfolio, a key performance indicator which provides national ranking and funding support.

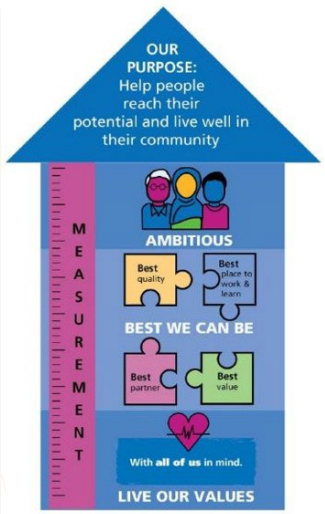
The higher-level objectives are reviewed nationally by the Department of Health and Social Care and are reported annually by the NIHR CRN (https://www.nihr.ac.uk/about-us/who-we-are/our-research-performance/clinical-research-network-performance.htm).

3.5 R&D linkage to Trust strategy

- The R&D department is an **"ENABLING"** department whose support, guidance and insight can be felt across the Trust and its overarching strategic aims.
- R&D activity provides a framework and evidence base to allow the Trust to identify and explore **what "Best" is and to be ambitious in its aspirations for the staff and people we serve.**
- R&D is a key enabler for the delivery of the Teaching Trust activity and is integral to the clinical, digital and sustainability strategies

Supporting the Trust Strategy

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust



R&D Support & Influence

Our strategic aims:

1. We will live our values
2. We will be the best we can be
3. **We will be ambitious**

Supporting the Trust Strategy: R&D linkage: We will be the best we can be

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

R&D Support & Influence

Key linkage:

Provide the opportunity via innovative research activity to build new and strengthen partnerships

Support the evidence base, Measurement of how we say we are the best.

Supporting the Trust Strategy: R&D linkage: We will live our values

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

R&D Support & Influence

Key linkage:

Relevant for Today & Ready for Tommorow

"We have developed new ways of working and delivering care that focus upon learning, research and improvement"

Supporting the Trust Strategy:
R&D linkage: We will be Ambitious

South West Yorkshire Partnership Teaching NHS Foundation Trust

Key linkage:
Utilising research to provide innovative ways of working in our neighbourhoods & addressing health inequalities.

Building innovative partnerships and investment to support our ability to deliver wider NHS priorities around prevention, digital development and community care pathways

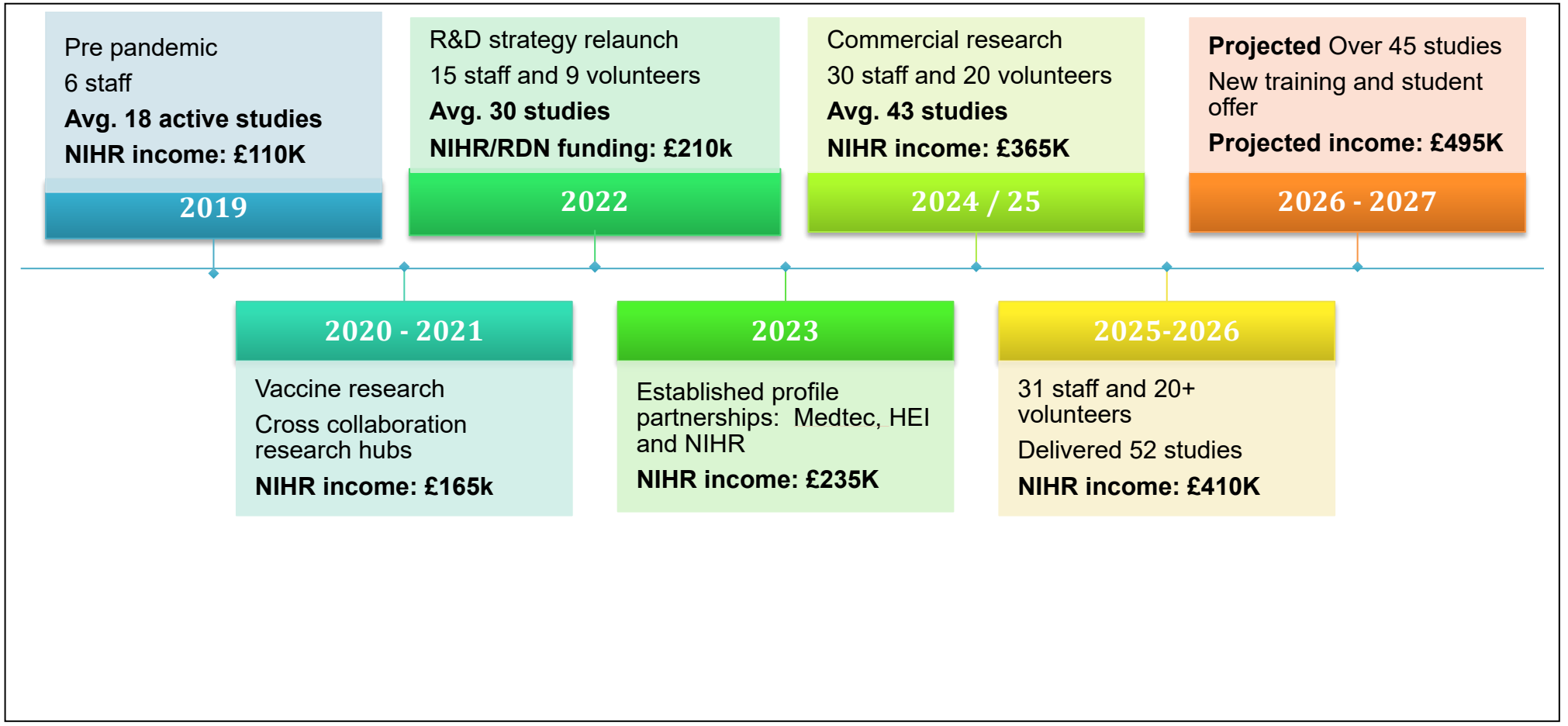
- The R&D team provide strategic guidance and support in helping establish key measurement standards, and allow the development of clinical academic research activity to be supported throughout the Trust.

- The department offers opportunity to host and develop innovation and build investment into clinical services through research grants and research partnerships with industry. This allows us to be the best we can be and creates an environment which helps us manage the acuity of services in a different way.

- Through our partnerships with academia, industry and the communities we serve we are relevant today and ready for the future by helping support new and novel approaches to service delivery and training.

3.6 What have we achieved so far? R&D strategic development and timeline: 2019 – 2026

During the past seven years, the R&D team has made significant progress to be ranked in the top three specialist mental health trusts within the region and become one of the top recruiters to NIHR studies. This has allowed our service users and staff to benefit from the opportunity to get involved in research.



- Sustained core funding from the NIHR (year on year increase) due to the ambition, drive, tenacity and determination of the team and clinical colleagues supporting the team.
- Regarded as one of the top recruiting sites with over 800+ participants recruited into studies each year
- NIHR infrastructure funding: Only mental health trust (outside of London in 2024) to receive £1.25m for dedicated research resource building to enhance our ability to deliver complex, bio marker, genetic and commercial research.

3.7 Key highlights of success and impact in the last 3-year strategy

Developed a Trust research innovation group in 2024 to co-ordinate and manage activity between services and teams

We are part of the lead NHS providers and partner with the University of Durham in a **£9.6m** Wellcome Grant looking at the hidden experience of mental health

Developed partnerships with over **36** university and academic partners

2022-2025 Established track record of NIHR and wider funding with involvement in grants totalling over £26m out of which direct R&D investment in trust i.e. staffing support for study delivery is around **£3.8m**

Successfully supported and are the Lead NHS partner in the NIHR investment of **£11m** of a new mental health research centre at University of Huddersfield

Main NHS partner with the University of Leeds developing their innovation and research activity in mental health as part of the Teaching Trust partnership

We are a leading provider and host to the NIHR Ethnic Minorities into Research (EMRI) collaboration project in west Yorkshire. The EMRI project supports true engagement across the region by creating training and engagement opportunities in the communities we serve

We are a co-ordinating partner within the region in the development of the Department of Health and Social Care **Research Engagement Network (REN)**

We are a key partner in co-ordinating research in our place areas through our **research hubs**. The hubs bring together health, social care and the voluntary/ faith business sector

Created a new **divisional structure** within the trust to support a growing pipeline of studies and clear progression plans for staff

We are a key partner in a **£5m** NIHR funded project with Wakefield council looking at the wider determinants to health and well being (NIHR HDRC programme)

We said by end of 2025 we would be on track:		**& We did:**
• **The Trust will have** an effective platform to engage, disseminate and build collaboration with services users, carers, staff and wider public who may have an interest in the research activities undertaken by the Trust	⟹	• We have successfully built a number of shared databases which identify volunteers and staff service users who would like to be involved in Research. • Working with the Clinical teams and our Power BI team we have developed efficient ways to support clinical case load screening.
• **Where the Trust will aim** to achieve year-on-year significant gains in the LCRN Annual Targets; facilitated by an efficient approval process allowing a reduction in the time it takes to assess feasibility, set up and delivery of new research activities	⟹	• Through dedicated recruitment strategies, engaging with our communities and our clinical teams we have maintained our recruitment targets (minimum 550) and have achieved all the national Key performance targets set by the NIHR / NHS England
• **Where the Trust will have** increased the diversity and complexity of portfolio studies further providing assurance for an increase in core funding element attributed by the LCRN to the Trust	⟹	• By building a research platform that covers the whole life course the Trust has increased the number of interventions studies and is building its capacity for commercial and drug studies.
• **Where the Trust will be** actively involved in the local and regional partnerships enabling it to lead the place-based research activities within its geographical footprint i.e. will support the research hubs in each of the 'places' (Wakefield, Barnsley, Kirklees and Calderdale)	⟹	• The Trust currently co lead the research hubs with its partners through which the Trust is involved in large regional studies, public health and primary care studies. The trust also co-host the NIHR EMRI network and support innovation projects in the Voluntary community sector.
• **Where the Trust will have** its own appropriately trained research active workforce including a robust R&D department allowing incremental increases in the number of principal investigators (PIs) and collaborators	⟹	• The department has sequentially grown the number of principle investigators with over 100+ colleagues trained alongside over 100+ volunteers, community connectors and research active staff.

The people we have worked with said:

"The R&D department is dynamic and supports staff to be adventurous. The team are very helpful and always happy to look at ideas and help with new projects."

Early intervention team manager

"Research is exciting. I enjoy working with the team and enjoy the work we do going in to the community."

R&D research volunteer

"Working with the research team is a new experience. Every day you learn something new, it never gets boring and never gets overwhelming. The team are open and good at supporting one another."

Core team, Kirklees

"The R&D team are friendly and supportive; they work with the whole team to support and make the research project accessible to all."

Peer support worker, Barnsley

"The research department at the Trust have become a leading partner within the Yorkshire and Humber regional research delivery network (RRDN). They are recognised and respected as leaders in community engagement, recruitment to specialist studies as well as being a true open partner with other Trusts in the region."

Yorkshire and Humber RRDN

"The research department are key partners in building our local research activity in Barnsley, they have supported the council to become more research aware and have helped me personally develop my skill and interest in research. We jointly support the research activity in Barnsley through the research hub."

Public Health – Barnsley Council

3.8 Local and national drivers for change - NHS 10 Year Plan and Life Sciences Plan

Mental health research and delivery as a key NHS priority

Mental health research is highlighted both nationally and regionally as a key priority within the NHS and social care structures and is referred to as a key pledge within the NHS 10 Year Plan. The shift between hospital to community, analogue to digital and sickness to prevention are underpinned by the focus on research innovation to drive these changes and new ways of working.

The Life Sciences and Health Sector plan will boost research investment to over £12billion over the course of its tenure. However, the resourcing and capacity of mental health trusts to undertake research activities has been limited due to restricted investment. A key national driver for change is to address this investment imbalance by developing innovative ways of working. This includes building upon established and new partnerships which enhance the Trust's opportunity to develop research activities with commercial and non-commercial organisations.

The introduction of key reporting features and an increased reference to research activity of NHS trusts within the CQC assessments framework provides the inertia to develop and sustain a highly efficient and responsive R&D department.

- **Geographical profile and diverse populations**

The diverse social and cultural population the Trust serves, which covers four distinct local authority areas combined with specialist care services, makes it a key partner for enhanced research enquiry.

The Trust's understanding of its local populations, including the awareness of social inequality, deprivation and wider health and social carer barriers places the Trust in a unique position to develop and engage with partners and service users to identify bespoke research activity. The value-based approach to care means that the Trust has an established reputation to support innovative research, clinical activity and places the service user and carer at the centre of its work.

- **Collaborative approaches to research**

Prior to the pandemic, partner organisations within the RDN would be focused on individual delivery of studies with limited focus on joint working. However, the pandemic has driven the need for research organisations to collaborate and build effective pathways to manage and deliver research across the range of specialisms including urgent public health and vaccine research. The success of this collaborative model has now been adopted for the delivery of a range of research study specialisms including mental health and wider public health and social research. This process has also prompted the RDN to look at research delivery as a whole system rather than just individual partner organisations.

- **Integrated care systems and place-based research**

The collaborative model of research delivery has further gained momentum through the development of the integrated care systems which place a focus upon place-based research activity. Place-based research activity can be defined as research which serves the needs of the population in a specific area. The Trust has opportunity to develop placed based research initiatives in four distinct geographical areas providing vital research infrastructure in two Integrated Care systems.

- **Academic partnerships & development of life course research**

The Trust is ideally placed with its clinical services to provide research activity across the life course, enabling it to be involved in research activity from perinatal to end of life care. This opportunity, coupled with the extensive academic links and recognition to deliver research, enables the Trust to build a secure and sustainable platform.

Building on our success and managing the challenges:

Key challenges and drivers for change within the new strategy are:

- To ensure a consolidation and maintenance of the gains made, especially in a changing national NHS context.

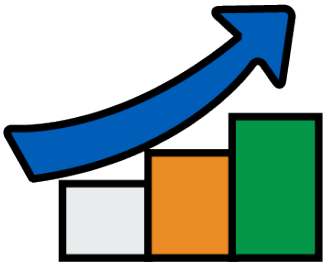
- To utilise the Teaching Trust status to encourage and develop a sophisticated clinical academic pathway for all. Ensuring a greater connection and support to our clinical teams who may struggle with accessing research and training opportunities.

- To build a clearer communication and dissemination plan and to celebrate the successes and partnerships we have developed.

- To support with greater depth Trust priorities and to ensure that research opportunities and projects align with priorities.

- To utilise the skills and partnerships to challenge health inequality, service delivery and service provision.

4. #AllofusinResearch: R&D aims and objectives 2026 – 2031



Our aim

The R&D department aims to support the development and promotion of an innovative and vibrant research culture which establishes the Trust as a centre for evidence base practice, co-production, and a leader in staff, service user and carer research participation.

Our approach

Our approach to help deliver our aim and to support the Trust objectives focuses upon enabling research capacity and capability across the life course, helping us to build a systematic and sustainable approach to research activity.

Values and themes

To help us deliver this aim, three overarching themes which echo the values of the Trust have been identified:

1. **Workforce and organisational development**
   Developing the specialist skills and knowledge base to ensure opportunity, capacity and integration of R&D activity throughout the Trust. Utilising the Teaching Trust status to support the Trust's ambitions of best place to work and learn, best quality, and value for money

2. **Leading change through opportunities in research and innovation**
   Providing opportunity to all to lead, participate, co-produce and influence research. Developing opportunities that have real value and change for the people we serve, enabling them to reach their potential and live well in their communities.

3. **Development of partnership opportunities and networking**
   Building collaborative partnerships to increase capacity and capability, leading us to be ambitious for our neighbourhoods, communities and promoting effective change.

Strategic objectives – the themes are supported by the following objectives:

1. **Maintain the Trust's profile** in regional, and national research and innovation forums to ensure it's at the forefront of emerging social policy and health and social care research. **Ensure learning from R&D is applied and disseminated** to improve services and reduce health inequalities.

2. **Continue to integrate R&D** and innovation into technical, clinical and operational activity within the Trust, providing a governance and assurance framework for research and innovation activity.

3. **Increase capacity and capability** of the Trust's workforce and stakeholders, including service users, carers and staff to engage in all aspects of R&D. Supporting a diverse and mature research pipeline across the life course.

4. **Facilitate the development of opportunities** for undergraduate, postgraduate, professional, and wider NIHR/academic clinical fellowships that build an internal pipeline of research-active and qualified staff who support the diverse portfolio of studies.

5. **Provide opportunity through our academic (Teaching Trust and wider academic) partnerships** and commercial partners to develop an active research pipeline that highlights our life sciences activity and builds specialisms in genomics, AI, creative health and wider determinants to health and long-term conditions.

6. **Enable the Trust to move from analogue to digital** and build the Trust's capacity and capability to curate and unlock the use of data, AI, machine learning, and algorithms to promote research and innovation across the life course and support the preventative agenda.

What change and growth will look like in the next five years

5. Five-year (2026 – 2031) ambition statements

- As a Teaching Trust **we will have an established pipeline of "home grown" studies and specialities which will enable us to be the best we can be.**

- The Trust, with its academic partners, will develop clinical academic and research delivery careers pathways, competitive grant writing capabilities and project development process to enable agile response to funding opportunities. This will involve a particular focus on innovative research encompassing a systems biology approach to understand the pathophysiology of physical and mental ill health, including the use of **multi-omics, artificial intelligence and digital health research.**

- As a Teaching Trust we will enhance the dedicated research facility at Wakefield which will host the genetic and biomarker study development within the region. The new centre will also be a driving force for creative health approaches to mental health in line with the Trust's ambitions.

- The Trust will aim to achieve a balanced NIHR portfolio with year-on-year targets set by the RRDN and achieve time and target for research set up and delivery, with a developed pipeline of commercial and interventional studies as a priority. This will increase the diversity and complexity of portfolio studies as well as non-portfolio studies in line with the **NHS Life Sciences Plan (2025).**

- The Trust will actively support the local and regional partnerships enabling it to lead place-based research activities within its geographical footprint (Wakefield, Barnsley Kirklees and Calderdale). It will continue to engage, disseminate and build collaboration with service users, carers, staff and the wider public.

- The Trust will have a co-ordinated and integrated mechanism to share good practice and capitalise on the skill between R&D, clinical audit, quality improvement, service evaluation and innovation.

- The Trust will continue to lead and develop its community engagement activities and will use this resource to actively challenge health inequalities while ensuring patient safety and choice.

- The Trust will have a co-ordinated approach in developing commercial research and establishing itself as a key national provider of mental health research.

6. Yearly priorities and milestones (example of an operational plan)

	Activity (years 1-2)	Activity (years 2-5)
1	• Establish a mental health research centre at Fieldhead in Wakefield using NIHR infrastructure award to equip with appropriate resource and staffing. • Develop a clinical academic and research delivery career pathway, and research funding collaboration with the University of Leeds ensuring the Trust is the lead NHS partner within competitive research funding bids. • Sequentially increase the number of peer reviewed publications and dissemination articles in relation to the work we are doing with academic partners	• Target AI, multi-omics and digital health research centre pipelines utilising the mental health research centre at Fieldhead with the ambition of hosting our multi-omics research activity. • Support a year-on-year increase in the number of peer reviewed publications, grant awards and higher education degrees undertaken by Trust staff.
2	• Prioritise the commercial pipeline of studies across the life course utilising our divisional structure. • Confirm R&D representation at appropriate Trust level governance meetings and provide appropriate feedback on activity progress, including any risk factors and their respective mitigation process. • R&D where appropriate will be identified as standing items on the agenda for the operational meetings reporting on study opportunity and delivery. • Create a mechanism to proactively increase the complexity and diversity of the research portfolio including identifying studies which fit with the diverse specialisms of the trust. • Achieve an annual increase in the percentage of Trust patients participating in research studies linked to the RDN annual target.	• Develop opportunities for research staff to work across teams, collaboratively building a resilient skills mix. • Support the development of joint training opportunities and collaborate on the set up of an annual research conference. • Develop a stronger partnership with Power BI and data led approaches to ensure commercial research can be responded to in a timely manner
3	• Develop an annual communication and engagement plan with the communication team, with a clear digital and social media action plan. This will include targeted communication around research studies and career development opportunities for staff, to raise the profile of the R&D team with the purpose of engaging staff within and external to the Trust.	• The use of an annual communication and engagement plan, working with the communications team.
4	• Co-produce a framework for hosting, managing and reporting on research and audit activity within the organisation	• Provide a systematic process of recognising, reporting, and managing research and audit to enable i) results to be disseminated efficiently and effectively, ii) results to be implemented using an evidence-based framework and iii) improved connections between research and audit.

	Activity (years 1-2)	Activity (years 2-5)
	• Consolidation and stabilisation: Ensure that regional and national NIHR / RDN changes are mitigated. Identify and manage risk in relation to national funding formula • Understand and implement, through the Teaching Trust activity and the digital/ clinical Trust strategy, the impact and changes of the Life Sciences Plan and the NHS 10 Year Plan. Creation of clinical academic pathways. •	• Ensure the Trust has representation on the regional and national NIHR and RDN steering group. • Establish extensive partnerships with industry and Medtech to support and drive home grown research.
	• Build stronger connections with operational teams through our research divisions (Appendix 2) • Ensure multidisciplinary engagement across projects. • Monitor and evaluate impact of R&D initiatives. • Select bids based on alignment with annual plan, strategic priorities and R&D priorities. Utilise the TRIG to ensure wider conversation and build in timeline for decision trees.	• Ensure clinical representation within the TRIG • Enhance and develop the divisional structure of the department to ensure every clinical group and profession is included
	• Host the EMRI research network and establish the Centre for Mental Health Equity building on our community engagement and community research leaders and connectors programmes. • Identify, through our data and academic partnerships, applied research activities which practically change the way in which we are managing acuity, access and support to vulnerable and marginalised groups.	• Ensure academic resources i.e. scholarships, internships and PhDs are embedded within the Trust, working on key health inequality and digital projects which support our Trust objectives.

7. Monitoring and evaluation

Trust monitoring
The implementation, monitoring and evaluation of the Trust's R&D strategy will be managed by the Trust R&D team on behalf of the chief medical officer and Trust board.

The R&D senior leadership team, in conjunction with the chief medical officer, will provide appropriate updates and items of escalation to appropriate strategic and operational groups within the Trust. The R&D team via its operational and senior leadership team will provide appropriate quality account information and ensure any metrics and key performance indicators (KPIs) are reported against.

NIHR RRDN monitoring
The R&D operational and delivery team will provide appropriate quarterly metrics in relation to the KPIs set by the Department of Health and Social Care.

Delivery of ambitions and objectives
The ambitions will be delivered through the R&D operational plan which provides a broad framework for KPIs and milestones for each of the objectives (these will include or reference the linkage to Trust strategic objectives and those identified by the NIHR RRDNs).

The operational plan will be used to monitor progress with regards to delivering the KPIs. These will be reviewed at a monthly R&D operational meeting chaired by the head of research with escalations and oversight at the senior leadership team meeting.

An annual progress report will be submitted to the Trust board to evaluate progress on delivering the R&D operational plan, review actions against objectives and develop a new annual plan for the following year. When required, reports will be submitted to highlight progress or any risk factors to the internal groups (clinical governance group, operational management group, quality and safety committee) and external group (RRDN partnership group).

Dissemination
An annual or bi-annual R&D conference will be held to showcase innovations, share best practice, and enhance networking across all stakeholders.
The R&D department will continue to provide monthly updates in relation to study portfolio management and an annual performance report to the RRDN to track high level objectives and study targets. As part of its key milestones, the department will develop a communications and dissemination plan to ensure that maximum publicity and impact are highlighted for the projects undertaken.

Appendix 1: R&D team structure

To manage the high intensity of research and complexities of developing national portfolio of studies, the R&D team is structured to be ambitious through the utilisation of an overarching research and development operational and governance structure (Figure 4).

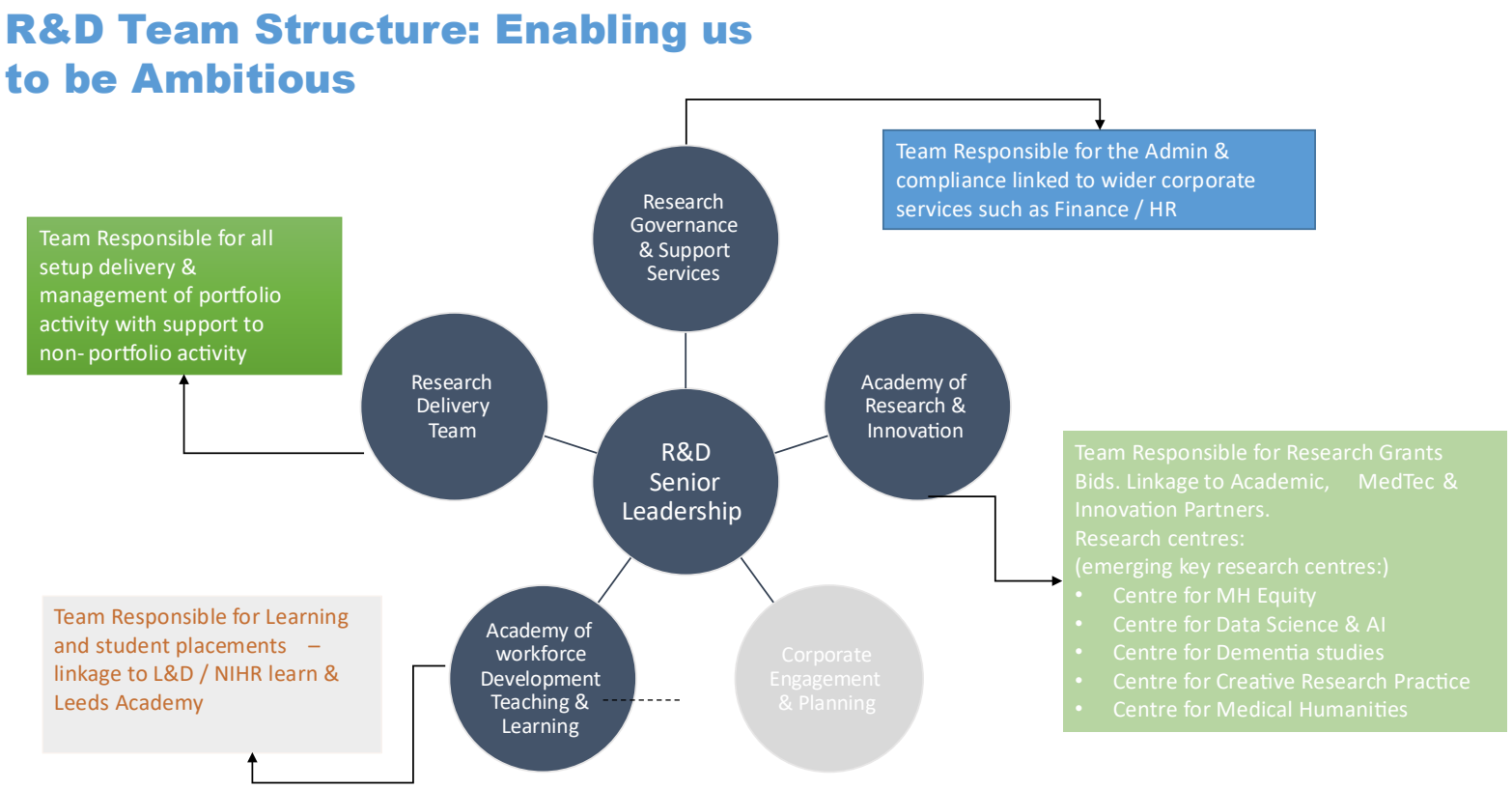


Figure 4: Overarching research and development, operational and governance structure

Appendix 2: Research and development – study delivery

To enable the research delivery team to develop deep knowledge and understanding of clinical specialisms, as well as supporting agility, the delivery team is structured into various domains within the organisation. Within each of these it is envisaged that research capability and capacity will be further supported through the development of a clinical lead with associated medical research ambassadors and representatives from AHPs, psychological professionals, nursing and social work.

Helping us to be Ambitious

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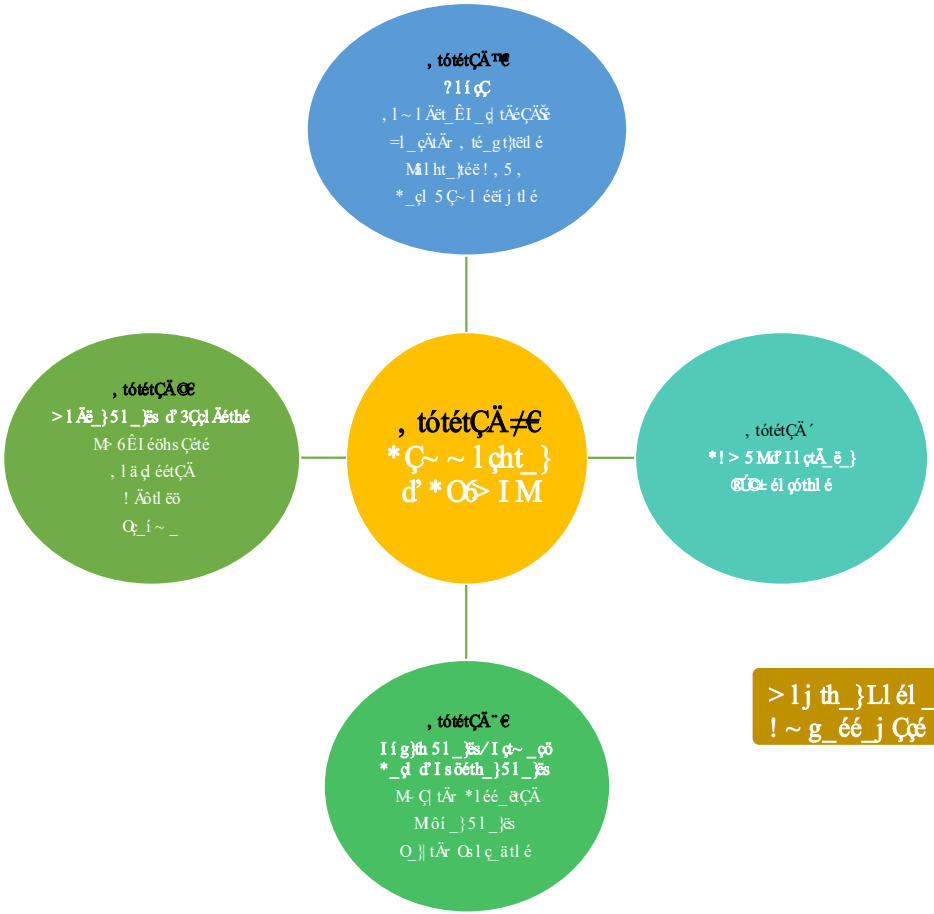
South West Yorkshire Partnership Teaching NHS Foundation Trust



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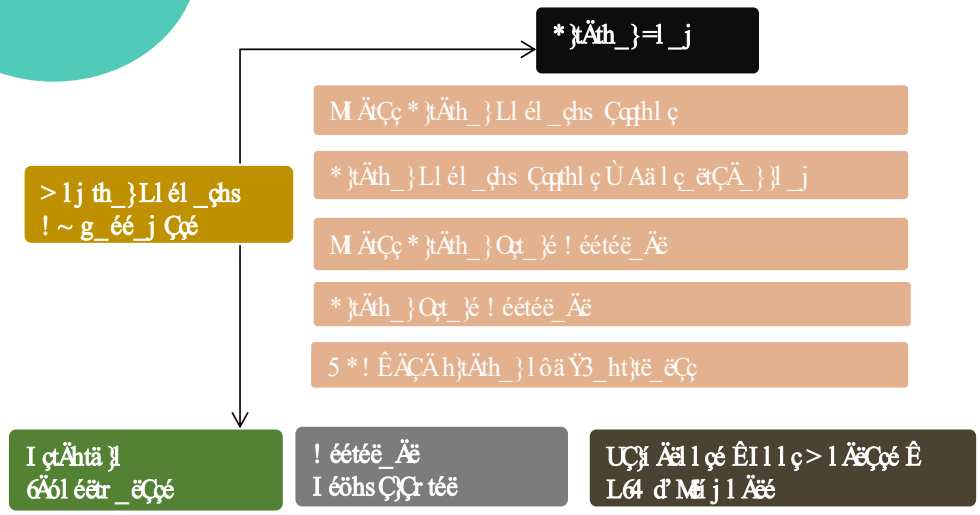
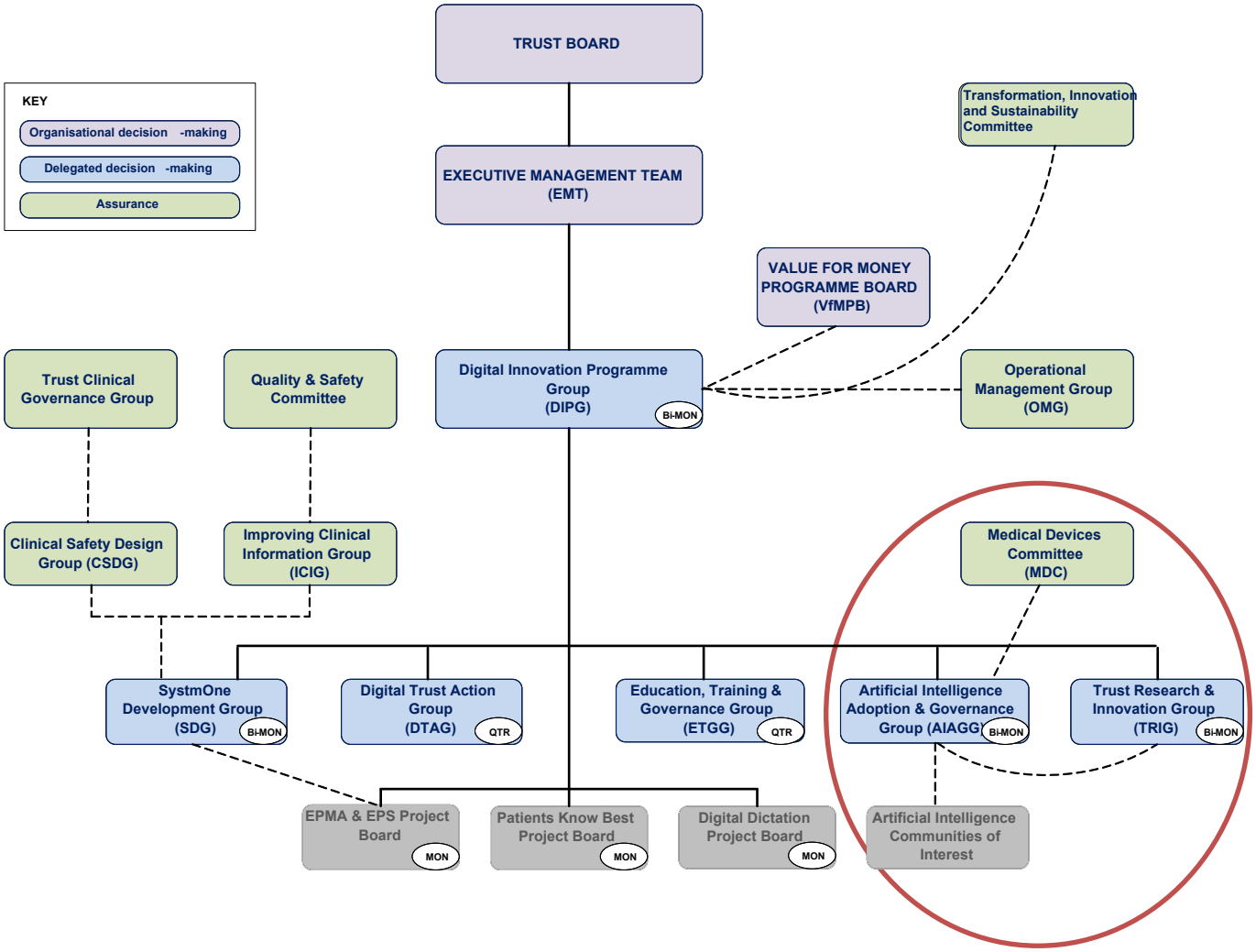
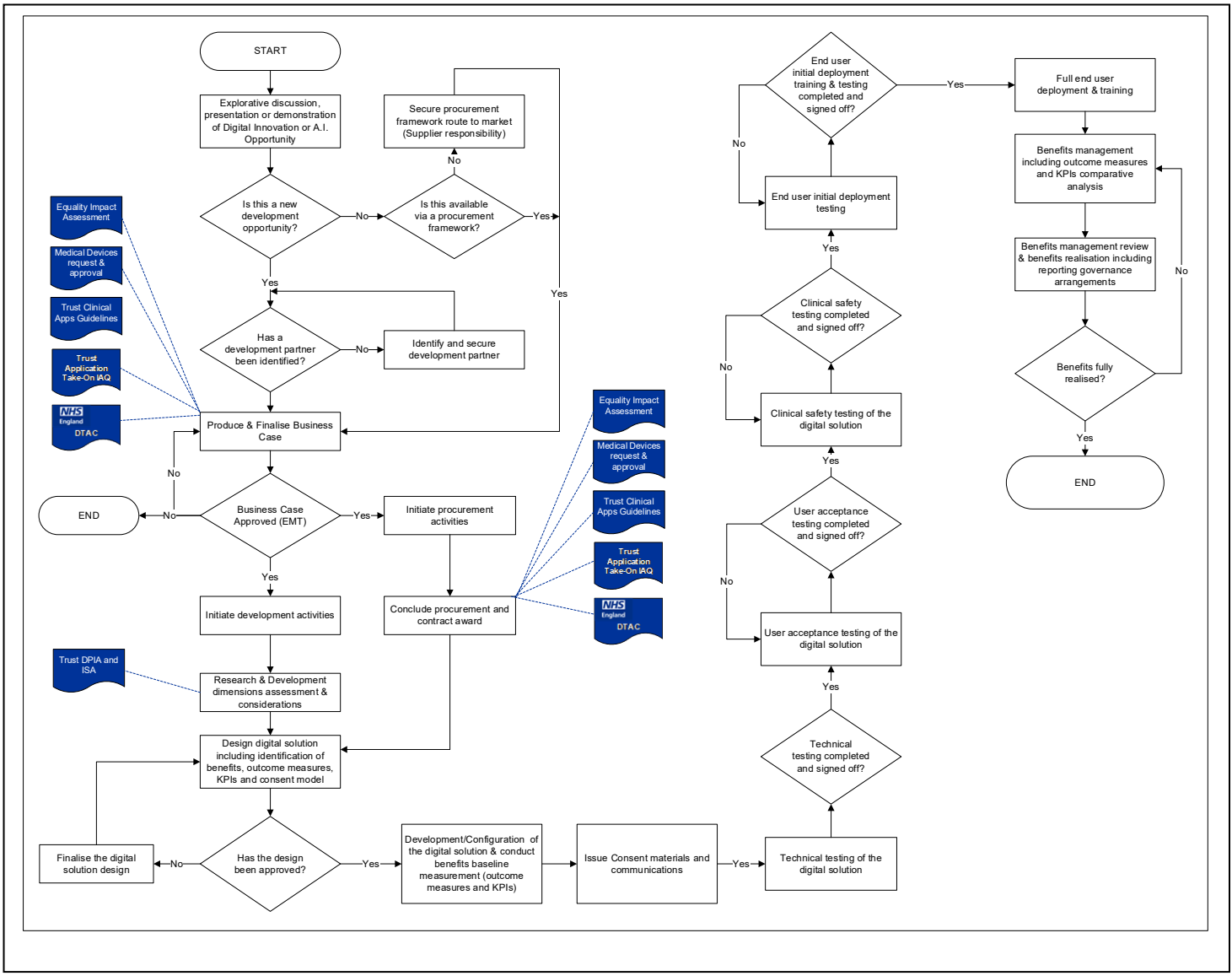


Appendix 3 R&D Linkage to Digital innovation & Governance



Appendix 3 R&D Linkage to Digital innovation & Governance (Decision mapping)



Appendix 4 R&D Partnerships & Infrastructure

Trust Collaborations

The R&D department is actively engaged with the different corporate and clinical services across the trust to enable a systematic approach to Research Development and delivery. The department actively offers opportunity for research collaboration, training advice and engagement activities across the following teams:

R&D regional and national infrastructure and partnerships

The R&D department also acts as the Trust's delegated interface between regional and national research infrastructure, including:

Health Research Authority (HRA)

Research within the NHS is a regulated activity, which means that research can only be undertaken within the NHS once it has been appropriately reviewed or ethically approved. All NHS research is registered through the Health Research Authority (HRA) whose role is to ensure that the research being undertaken is of high quality and ethically sound.

National Institute of Health and Social Care Research – Regional Research Delivery Network
The R&D department is a key partner organisation within the local RRDN. The RRDN is a collaboration of 26 NHS organisations, including acute and primary care partners, whose focus is to set up and deliver clinical research effectively within the area. The RRDN is supported by and through a national structure, National Institute of Health Research (NIHR), whose focus is to support the development and delivery of clinical research within the UK.

Innovation and Academic Health Science Networks (AHSN)
It is recognised in national policy that collaborations between service providers and academic organisations should be strengthened. This will help to improve the implementation of research and innovation into practice to improve services and service user outcomes. To support this, there are 15 Academic Health Science Networks (AHSNs) across England, including one in Yorkshire and the Humber. Their role is to connect the NHS with academic organisations, local authorities, the third sector and industry to facilitate change based on research and innovation, which improves outcomes for service users and generates local economic growth and prosperity.

Applied Research Collaborations (ARCS)
There are also 15 Applied Research Collaborations (ARCs) with similar roles. They have a focus on growing applied health and care research and increasing the rate at which research findings are implemented into practice. The Yorkshire and Humber ARC has four main themes, healthy childhood, mental health and multimorbidity, older people and urgent care. The Trust will continue to engage with these networks.

The R&D department has an active and developmental relationship with a number of academic and professional organisations whose aim is to develop and support the range of research activity across the UK.

Appendix 5: How to get involved in research and innovation

Research and innovation is for everyone – service users, staff, carers, relatives, friends – all members of our communities. You can get involved by:

- Participating in active research studies for which you are eligible.
- Contributing research and innovation project ideas.
- Contributing to the design, development, delivery and dissemination of research, particularly within our research units.
- Contributing to the evaluation of innovative technology or innovative service delivery.
- Becoming a research advocate or a digital navigator and encouraging the links between service users, clinical services, research and innovation teams and the public.
- Sharing your own research experiences with others.

All current opportunities can be found on the R&D section of the Trust website – www.southwestyorkshire.nhs.uk.

If you have any questions, please contact research@swyt.nhs.uk

Appendix 6:

Equality Impact Assessment

POLICY AND STRATEGY
Equality Impact Assessment template

This EIA template is to be completed by staff when writing a new policy/strategy or when reviewing a policy/strategy. The EIA needs to demonstrate who would be impacted (local census data and workforce data) and what gaps there are.

Any gaps identified need to be included in section 6 where actions are listed to address and progress to ensure inclusivity and diversity in the policy/strategy.

	QUESTIONS	ANSWERS AND ACTIONS
1	**Name of policy/strategy?** *Prompt: is it new or revised?*	**The R&D revised Strategy 2026 -2031** **Revised**
2	**Description of the document:** *Prompt: what is the aim of the document?*	**Overview of Strategy:** **Executive Summary for the EIA:** This five-year strategy continues the journey the Trust has been undertaking to build a dynamic and integrated research culture within South West Yorkshire Partnership Teaching NHS Foundation Trust i.e. establishing the profile and credibility of the Trust as a key research partner regionally and nationally with academic institutions, industry and other NHS providers. A key aim of the strategy is grounded in identifying and challenging health and social inequalities and disparities. The strategy builds on the last 3 -5 years work where in the Trust has become a recognized 'champion' in community engagement, involvement, and co-production. This strategy therefore continues with the focus on **identifying, engaging, building networks and 'true' reciprocal co-production partnerships** with individuals, groups and or organisations (internally and externally to the trust) who may be able to further enhance or develop our understanding of health and social care needs within our place areas. The strategy consolidates the work undertaken to date with communities and individuals and looks to build upon home grown service user led research activity that is meaningful to our people and places. **Our Approach** Using our Trust values and behaviours, our approach to help deliver our aim is to ensure everyone (service users, carers, staff and the public we serve) have an opportunity to get involved, lead and support research activity. Under the banner **#AllofusinResearch** there is a commitment to help build sustainable research capacity and capability across the **life course of services** i.e.

creating opportunity that builds research capacity and capability across **All** of our place areas and clinical teams enabling research to develop from perinatal mental health to end of life care and from inpatient to all our community services.

Providing opportunity through the NHS for people to get involved in research is enshrined within the NHS Constitution (2021) and is the strategic driving force of change in the 10-year NHS 'Fit for the Future' plan (2025) and Life Sciences Sector plan (2025) announced by the Department of Health & social care.

Using our Life course Approach: Target Engagement:

Underserved Communities, Feasibility & Governance
The R&D dept. since 2019 has been a key national and regional partner (via the NIHR and RDN – Ethnic Minority Research Inclusion [EMRI] project) in monitoring participation and engagement of underserved communities within the research agenda.

Underserved communities are defined not just by the protected characteristics but also a recognition that social, economic, educational and environmental factors including language may pose barriers in people engaging and participating in research. These factors are further exacerbated by the increasingly interconnected and online virtual / social media world which can amplify specific narratives. The strategy therefore places an emphasis on developing appropriate **feasibility and governance processes** which take into account these wide ranging factors on specific study development and recruitment.

Evidence Driven Expansion of Portfolio
Individual studies by nature of the subject area may exclude or include specific populations or grouping of individuals, therefore, the focus for the R&D dept. and this strategy is to ensure that the **breadth of studies** which include the consideration of protected characteristics and the opportunity to participate or co-produce and direct activity is provided to all and is monitored and developed upon. As part of the monitoring and data gathering process and to inform training and development the R&D dept. will utilise the information and data gathered from the national Participant in Research experience Survey (PRES) which is the friends and family test equivalent in the research world.

Targeted study development will be informed by national policy and data such as the CORE20plus5[1], national and regional census data[2], localised demographic information from the respective JSNA's[3] within the four local authority areas and dashboard data from SWYT. This will allow the R&D dept. to monitor, identify and tailor the respective studies which may be impactful in reducing health inequalities within our area. This strategy therefore allows the R&D team to use the evidence base to identify where disparities exist and then search or develop studies and activities which support the wider trust and clinical colleagues to reduce or build mechanisms to challenge the respective disparities.

		This strategy therefore will have a positive impact on the trusts ability to address health inequalities and disparities. **Data Tracking & Reporting:** The strategy also places an emphasis on a refined track and monitoring process for all the protected characteristics and barriers / facilitators to research. The system to capture this information and possibly look at incorporating this into trust wide reporting systems will be a focus for the R&D team. The monitoring and reporting of this strand of the strategy will be managed through the senior leadership team in the R&D dept. and will be highlighted in the respective R&D improvement plan and Annual report submitted to the respective trust governance processes. The remaining sections of the EIA have been filled in to highlight an awareness of these respective protected characteristics. • Core20Plus5: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/ • Census 2011 • **www.wakefieldjsna.co.uk** Kirklees Joint Strategic Assessment (KJSA) | Kirklees Council Joint Strategic Needs Assessment (JSNA) | Calderdale Council Joint Strategic Needs Assessment (JSNA) (barnsley.gov.uk)
3	**Lead contact person for the Equality Impact Assessment**	**Name: Dr Wajid Khan** **Job title: Head of Research**
4	**Who else is involved in undertaking this Equality Impact Assessment** *Prompt: list all people involved by name and job title*	**Snior R&D Team:** **Prof Subha Thiyagesh** **Prof Lusie Marino** **Dr Moe Kapoor** **Prof Mike Doyle** **R&D operational Team:** **Mark Harper, Helen Carter**
5	**Sources of information used to identify gaps and barriers** *Prompt: local, regional, national research/reports/journals & profession updates. Complaints and compliments data.*	**Regional & National Data sets have been used to inform and track EIA progress: R&D statistics form the NHIR Open Data platform are used to ensure and highlight demographics for study recruitment** The remaining sections of the EIA have been filled in to highlight an awareness of these respective protected characteristics. • Core20Plus5: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/ • https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/ • Census 2011 Kirklees Joint Strategic Assessment (KJSA) | Kirklees Council Joint Strategic Needs Assessment (JSNA) | Calderdale Council • Joint Strategic Needs Assessment (JSNA) (barnsley.gov.uk) • https://fingertips.phe.org.uk/ • NIHR Ethnic Minority Research & Inclusion Project (EMRI) https://sites.google.com/nihr.ac.uk/crnyh/home • NIHR Health Inequalities policy Research Program https://www.nihr.ac.uk/documents/best-research-for-best-health-the-next-chapter/27778 • NIHR Participant in Research Questionnaire (PRES): https://www.nihr.ac.uk/patients-carers-and-the-public/i-

		want-to-learn-about-research/participant-in-research-experience-survey.htm • The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. fyfv-mh-one-year-on.pdf (england.nhs.uk) Over all the data and information from the above respective sites indicates that as a trust we cover areas which have multiple levels of social and health inequalities often exacerbated by substance, alcohol and or physical health comorbidities and work with a specialist population that through their mental health needs are increasingly disadvantaged in accessing and engaging with services. Challenges in accessing research are further exacerbated by language, culture stigma, social media reporting (in the case of vaccine research study uptake) and physical and practical barriers such as transport or capacity to travel to and from clinics. Data from the respective sites has also highlighted the need to enhance the feasibility checks before a study or activity is undertaken to ensure barriers and facilitators in engagement and participation are identified at the beginning of study set up and development. The strategy objectives which focus upon the enhancement and development of appropriate recording metrics to capture and track impact of engagement work are essential in providing the evidence base for new ways of working.

For section 5a-5j, use the following data links to populate the EIA with narrative about your service and workforce.

Workforce data link: An Introduction to Equality Impact Assessment (EIA) (sharepoint.com)

Service data links:

Equalities Monitoring Report - Power BI Report Server

Equalities Monitoring Report Open Referrals - Power BI Report Server

EIA narrative: ***What does the information you have sourced tell you about the impact it will have on the following equality groups in terms of service provision, access and delivery?***

5a **Disability Groups:**

Prompt: consider people who have Learning Disabilities or Difficulties, Physical, Visual, Hearing disabilities and people with long term conditions such as diabetes, cancer, stroke, heart disease. Also consider how you meet their needs in line with the Accessible information standard.

Area	Non- disabled	Disabled
England	45,715,455 82.7%	9,774,620 17.3%
Barnsley	19,0655 78%	53,920 22%
Calderdale	168,780 81.7%	37,855 18.3%
Kirklees	357,620 82.6%	75,590 17.4%
Wakefield	282,165 79.9%	71,195 20.1%

Source: Census 2021 data

Workforce data: Please refer to the Trust Strategy (Our Strategy) EIA

		Service data: Please refer to the Trust Strategy (Our Strategy) EIA **EIA narrative:** Alternative hardware or software can be made available if specific adjustments are required, although this would appear highly unlikely in terms of Network Security.
	QUESTIONS	**ANSWERS AND ACTIONS**
5 b	**Gender:** *Prompt: Female & Male issues should be considered*	<table><tr><th>Area</th><th>Male</th><th>Female</th></tr><tr><td>England</td><td>27,656,336 49%</td><td>28,833,712 51%</td></tr><tr><td>Barnsley</td><td>120,279 49.2%</td><td>124,293 50.8%</td></tr><tr><td>Calderdale</td><td>100,790 48.7%</td><td>105,901 51.3%</td></tr><tr><td>Kirklees</td><td>212,346 49%</td><td>220,870 51%</td></tr><tr><td>Wakefield</td><td>173,831 49.2%</td><td>179,539 50.8%</td></tr></table> **Source: Census 2021 data** **Workforce data:** Please refer to the Trust Strategy (Our Strategy) EIA **Service data:** Please refer to the Trust Strategy (Our Strategy) EIA **EIA narrative:** Gender equality is reported as part of our workforce approach and digitally enabled services continue to ensure environments and workplaces remain gender sensitive and appropriate
5 c	**Age:** *Prompt: Older people & Young People issues should be considered*	<table><tr><th>Area</th><th>Under 18</th><th>18-39</th><th>40-59</th><th>60-79</th><th>Over 80</th></tr><tr><td>England</td><td>11,774,609 20.8%</td><td>16,161,002 28.6%</td><td>14,897,132 26.4%</td><td>10,858,911 19.2%</td><td>2,798,379 5%</td></tr><tr><td>Barnsley</td><td>50,068 20.5%</td><td>65,448 26.8%</td><td>65,850 26.9%</td><td>51,606 21.1%</td><td>11,595 4.7%</td></tr><tr><td>Calderdale</td><td>45,122 21.8%</td><td>51,990 25.2%</td><td>57,280 27.7%</td><td>42,548 20.6%</td><td>9,694 4.7%</td></tr><tr><td>Kirklees</td><td>98,029 22.6%</td><td>11,9116 27.5%</td><td>114,735 26.5%</td><td>81,845 18.9%</td><td>19,484 4.5%</td></tr><tr><td>Wakefield</td><td>73,625 20.8%</td><td>96,756 27.4%</td><td>94,822 26.8%</td><td>71,717 20.3%</td><td>16,440 4.7%</td></tr></table> **Source: Census 2021 data** **Workforce data:** Please refer to the Trust Strategy (Our Strategy) EIA **Service data:** Please refer to the Trust Strategy (Our Strategy) EIA **EIA narrative:** No impact anticipated. Support mechanisms available for people of any age who might be considered less tech-savvy via Service Desk.
5 d	**Sexual Orientation:** *Prompt: Heterosexual, Bisexual, Gay, Lesbian groups should be considered*	<table><tr><th></th><th>Straight or heterosexual</th><th>Gay or lesbian</th><th>Bisexual</th><th>Other sexual orientation</th><th>N answ</th></tr><tr><td>d</td><td>43,403,110 89.37%</td><td>747,805 1.54%</td><td>623,504 1.29%</td><td>165,305 0.34%</td><td>3,626 7.4</td></tr><tr><td>ey</td><td>182,948 91.57%</td><td>2,990 1.5%</td><td>1,817 0.91%</td><td>396 0.2%</td><td>11, 5.8</td></tr><tr><td>dale</td><td>149,815 89.91%</td><td>2,811 1.69%</td><td>1,968 1.18%</td><td>550 0.33%</td><td>11, 6.8</td></tr><tr><td>s</td><td>311,501 89.96%</td><td>4,340 1.25%</td><td>3,697 1.07%</td><td>998 0.29%</td><td>25, 7.4</td></tr><tr><td>eld</td><td>261,615 90.98%</td><td>4,321 1.50%</td><td>2,968 1.03%</td><td>689 0.24%</td><td>17, 6.2</td></tr></table> **Source: Census 2021 data** **Workforce data:** Please refer to the Trust Strategy (Our Strategy) EIA

Service data: Please refer to the Trust Strategy (Our Strategy) EIA

EIA narrative: No impact.

5e Religion or Belief:

Prompt: Main faith groups and people with no belief or philosophical belief issues should be considered

Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other	No religion
26,167,899 46.3%	262,433 0.5%	1,050,533 0.5%	269,283 0.5%	3,801,186 6.7%	420,383 0%	322,410 0.6%	20,715,664 36.7%
125,502 51.3%	435 0.2%	416 0.2%	62 0%	1,404 0.6%	256 0.1%	862 0.4%	102,906 42.1%
85,677 41.5%	630 0.3%	1,173 0.6%	153 0.1%	19,650 9.5%	387 0.2%	1,045 0.5%	86,787 42%
170,577 39.4%	996 0.2%	1,723 0.4%	187 0%	80,046 18.5%	3,476 0.8%	1663 0.4%	150,599 34.8%
173,070 49%	797 0.2%	1,270 0.4%	127 0%	11,279 3.2%	501 0.1%	1,405 0.4%	145,950 41.3%

Source: Census 2021 data

Workforce data: Please refer to the Trust Strategy (Our Strategy) EIA

Service data: Please refer to the Trust Strategy (Our Strategy) EIA

EIA narrative: No impact.

5f Marriage and Civil Partnerships

Prompt: Single, Married, Co-habiting, Widowed, C Partnership status should be considered

Area	Married or in a registered civil partnership	Single – never married and never registered in a civil partnership	Divorced	Widowed	Separated
England	20,561,642 44.7%	17,450,122 37.9%	4,171,639 9.1%	2,790,036 6.1%	1,033,518 2.2%
Barnsley	87,177 43.6%	73,099 36.6%	21,183 10.6%	13,531 6.8%	4,799 2.4%
Calderdale	73,651 44.2%	60,324 36.2%	17,611 10.6%	10,794 6.5%	4,254 2.6%
Kirklees	159,426 46%	125,290 36.2%	32,022 9.2%	21,509 6.2%	8,027 2.3%
Wakefield	127,965 44.5%	103,484 36%	30,105 10.5%	19,017 6.6%	6,966 2.4%

Source: Census 2021 data

Workforce data: Please refer to the Trust Strategy (Our Strategy) EIA

Service data: Please refer to the Trust Strategy (Our Strategy) EIA

EIA narrative: No impact.

5g Pregnancy and Maternity

Prompt: Currently pregnant or have been pregnant in the last 12 months should be considered

Area	Number of live births 2021	Percentage of Total fertility rate (TFR)
England	595,948	1.55%
Barnsley	2,521	1.63%
Calderdale	2,143	1.71%
Kirklees	4,826	1.72%
Wakefield	3,857	1.68%

Source: Births in England and Wales: summary tables - Office for National Statistics

NB: The TFR is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lifespan. The national TFRs have been calculated using mid-year population estimates by single year of age. The sub-national TFRs have been calculated using mid-year population estimates by 5 year age group

Workforce data: Please refer to the Trust Strategy (Our Strategy) EIA

Service data: Please refer to the Trust Strategy (Our Strategy) EIA

EIA narrative: No impact.

5h Gender Re-assignment

Prompt: Transgender issues should be considered

Area	Gender identity the same as sex registered at birth	Gender identity different from sex registered at birth	Not answered

England	43,002,331 93.47%	251,844 0.55%	2,752,783 5.98%
Barnsley	189,640 94.92%	803 0.74%	9,389 4.70%
Calderdale	156,893 94.16%	829 0.89%	8,966 5.38%
Kirklees	323,432 93.40%	1,725 0.9%	21,214 6.13%
Wakefield	271,795 94.52%	1,280 0.81%	14,539 5.06%

Source: Census 2021 data

*NB: P*ercentages are calculated from the total usual resident population aged 16 years and over

Workforce data: Please refer to the Trust Strategy (Our Strategy) EIA

Service data: Please refer to the Trust Strategy (Our Strategy) EIA

EIA narrative: No impact.

5 l **Carers**

Prompt: Caring responsibilities paid or unpaid should be considered

Area	Yes – provide unpaid care	No – do not provide unpaid care
England	4,678,265 8.3%	48,734,833 86.3%
Barnsley	24,732 10.1%	206,377 84.4%
Calderdale	17,977 8.7%	206,631 85.8%
Kirklees	37,034 8.5%	371,038 85.6%
Wakefield	31,731 6.1%	301,565 85.3%

Source: Census 2021 data

NB: Missing values account for 'N/A' or 'not answered'

Workforce data: Please refer to the Trust Strategy (Our Strategy) EIA

Service data: Please refer to the Trust Strategy (Our Strategy) EIA

EIA narrative: No impact.

5 j **Race**

How has your service aligned race with the PCREF?
https://swyt.sharepoint.com/sites/Equalityandinvolvement/SitePages/Patient-and-carer-race-equality-framework-(PCREF).aspx

Prompt: Indigenous population and BME Groups such as black African and Caribbean, mixed heritage, South Asian, Chinese, Irish, new migrant, asylum & refugee, gypsy & travelling communities)

Area	White	Asian	Black	Mixed
England	45,783,401 81%	5,426,392 9.6%	2,381,724 4.2%	1,669,3 3%
Barnsley	236,964 (96.6%)	2,297 (0.9%)	1,715 (0.7%)	2,293 (0.9%
Calderdale	177,836 (86.1%)	21,726 (10.5%)	1,439 (0.7%)	4,027 (1.9%
Kirklees	318,969 (73.6%)	84,202 (19.4%)	9,948 (2.3%)	13,58 (3.1%
Wakefield	328,742 (93%)	12,633 (3.6%)	4,516 (1.3%)	4,938 (1.4%

Source: Census 2021 data

Workforce data: Please refer to the Trust Strategy (Our Strategy) EIA

Service data: Please refer to the Trust Strategy (Our Strategy) EIA

EIA narrative: No impact.

Involvement & Insight: Please list in the box below any involvement activity, reports or insight you have gathered by working with your staff team or service users/carers by involving them to gain their views on your service.

- *Have you reviewed existing insight i.e. patient experience, complaints, previous surveys to support EIA completion?*
- *Have you gathered the views of people to support EIA completion?*
- *Have you run a focus group, conducted a survey, had an open day where you gained feedback?*
- *Have you gathered views from your staff team on this new policy/strategy, or if reviewing what works well and what could be improved?*

Policy applies equally to all staff and any breaches would be monitored and investigated/reported to the Director of HR.

Consultations for the strategy & respective EIA have been held with clinical and non-clinical colleagues, research involvement group and the NIHR EMRI project group

Strategy shared via email to staff networks and clinical colleagues and governance structures within the trust

Strategy shared across network of peers for review and comments alongside NIHR and Academic regional partners

Strategy shared into carers lead for wider sharing and comments.

6. Action Plan

EIAs are now reviewed using a grading approach which is in line with our Equality Delivery System (EDS). This rates the quality of the EIA. This means that the team can review the EIA and make recommendations only. The rating and suggested standards are set out below:

- **Under-developed** – red – **No data**. **No strands** of equality
- **Developing** – amber – **Some census data plus workforce**. **Two strands** of equality addressed
- **Achieving** – green – **Some census data plus workforce. Five strands** of equality addressed
- **Excelling** – purple – **All the data and all the strands** addressed

Potential themes for actions: Geographical location, built environment, timing, costs of the service, make up of your workforce, stereotypes and assumptions, equality monitoring, community relations/cohesion, same sex wards and care, specific issues/barriers.

Previous actions update: please explain what progress you have made against the previous actions identified

The R&D department has delivered / exceeded the items identified in the last action plan:

Action 1: Update feasibility and governance recording systems:

This has been completed

- Where study information is available, we currently **track and report on all key characteristics** to the NIHR as well as Trust reporting structures.
- Within the Yorkshire and Humber region we are ranked number 2 for our diverse population recruitment i.e. out of 800+ recruits in 2025 over 490 recruits are from diverse populations and backgrounds (induing a wide dispersal on age, gender, ethnicity, economic background, physical and learning disability, social mobility and prison populations).
- This figure is dependent upon specific studies we open therefore as part of our **selection and triaging of studies** we have included **a specific area** which highlights underserved communities or groups with specific attention to the key characteristics. Within our governance recording system we also highlight any **key engagement strategies** to enable us to recruit successfully to these studies.

Action 2 & 3:
Action 2: NIHR Study Portfolio development: Actively engage with patterns and organisations that can help build and develop research capacity and engagement increasing portfolio activity in the respective areas:

Action 3: Engagement & Dissemination of results and activities

Both are Ongoing: These actions are ongoing and demonstrate our long term commitment to develop and design studies which engage diverse populations and organisations in our place areas.

Following our life course approach and utilising the data included in this EIA we continue to identify studies and support the development of research enquiry that helps us address health inequalities and unpick the question of 'why' such disparities exist but also focus upon the 'corrective' action to address these inequalities.
(a new action for this EIA is to follow the journey of dissemination further and to support wider implementation of any recommendations)

We continue to develop partnerships across the VCS community and faith sectors, as well as business and other statutory partners to help develop a consistent and structured approach to community engagement and support with the aim to diversify and develop our portfolio of studies.

In addition to the above:

- The R&D team have been successful in securing a £11m NIHR investment grant with the University of Huddersfield to develop a new research centre: Centre of Equity in Mental health which will help directly address health inequality and health disparity within our place areas alongside providing the evidence base for new and innovative practice.

- The R&D team are listed as a central NHS partner within the Wakefield NIHR Health Determinants Research collaboration (HDRC) grant (£5m over 5 years), this funding stream has helped to build engagement, training and support in to the Wakefield communities and helped to identify key wider determinants to mental health including housing, poverty and social mobility.

- Our recording mechanisms have been updated to reflect our support in helping identify or design studies which look at hidden communities or hidden experiences of communities through setting up workshops and activities specifically with our academic partners including University of Huddersfield, University of Leeds and University of Durham. i.e. we have over the last 3 years supported over **15 large community engagement events** which have supported our increase in research participation but also increase the number of communities organisations involved in the NHS England Research Engagement network (REN).

- Through the **NHS England REN** funding activity, we have trained and built research capacity in over 35 organisations in our place areas, created specific studies which look at age, gender, ethnicity, cultural history and socio-economic factors within our populations (key studies are):

    - Genes & Health – large public health study looking at genetic variations in diabetes and cardio-vascular disease across south Asians and the wider general populations – over 3 years we have recruited over 900+ participants to this study

    - Lollipop study – looking at COPD, Cadio vascular disease and diabetes within eastern Europeans, black & Asian populations. Over 2 year period we recruited over 250 participants this study

    - Several dementia studies looking at age, ethnic variation and gender variation in health promotion, diagnosis, prognosis and long-term care management – recruited over 250+ collectively to these studies

    - We have several studies working in learning disabilities, long term mental health and physical health conditions, forensic services and studies looking at professional burn out within health, police, armed forces and other wider statutory partners staffing groups.

    - We have a number of research bids working with university partners looking at creative health and spirituality to support wellbeing access and training needs.

    - We have supported over 40 community engagement and dissemination events having information stalls in shopping centres and public spaces like libraries along side targeted recruitment in GP practices and other health centres.

- Within our place areas we have created research hubs in Kirklees & Calderdale, Wakefield and Barnsley. The research partnerships are with the other health and statutory bodies as well as VCS to help build a consistent and structured approach to research development and delivery. The Hubs focus also on specific community engagement projects as underpinning our recruitment and co-production strategies in our communities – the HDRC work and the REN activity is a good example of this joint working

- Within the last 4 years and in addition to REN activity the Trust has directly gained additional NIHR funding or study related funding (£190k over 3 years) which has helped develop extensive research engagement activity to support direct activity within community organisations. This has led to the successful development of community engagement roles within the team as well as community facilitators within the team. These members have helped:

- Build an extensive database and volunteer network within our place areas which has been linked to the Trust community connector programs, Trust volunteer service and Trust Employability Team

- We have supported over 25 peer support workers within the trust to move from volunteering to co-producing research activity.

- We have supported dedicated engagement plans for the Born in Wakefield national Cohort study with over 10 000 mums for all backgrounds being involved in the study

- We continue to support the employability team to engage with schools, colleges and university partners in developing key Trust engagement and publicity material around research and the Teaching Trust activity

- We have opened a number of sexual health studies and specifically looked at working with the LGBT+ communities to develop focused engagement and activities.

- We host over 150 medical students and wider Leeds university students in specific Research training and provide guidance and support for project and dissertation development

- As part of our ongoing development we have created specialist research divisions which help manage the life course approach (Please see strategy appendix 1 and 2). A key feature of this approach is to establish links with the charity and voluntary sectors linked to that area for example we have established strong links with dementia charities and organisations working and providing services in this area. By doing this we are able to co-produce new funding bids and help to disseminate research findings.

- The Trust is recognised as a key engagement and community development, co-production partner in this respect we host a number of regional NIHR positions including the Ethnic Minorities in to research (EMRI) project lead for the west Yorkshire area.

- Working with our national and regional partners the dept. has been involved in a number of campaigns to limit the impact of false information around vaccines and the research process. This process has allowed the dept. to build an understanding of how social media and technology can pose challenges but also be a useful tool in helping explore new boundaries and engagement activities with underserved groups.

In addition to the above

- **Internally** the Trust R&D team link with the different staff groups and tthrough its research involvement group, staff networks, drop in sessions for staff and carers and the utilisation of trust coms; the dept. is actively encouraging and facilitating the development of novel research ideas and projects (i.e. staff coaction study – looking at cultural sensitivity and diversity within two services in the trust and then building cultural training activity around this need)

R&D Strategy 26- 31

This revised R&D strategy commits the trust to continue the gains and success it has achieved through its partnerships.
With an additional focus upon:

Who will benefit from this action? (tick all that apply)		Action 1: This is what we are going to do	Lead/s	By when	Update -outcome	RAG
Age	x	**Ongoing: Maintain the approach in tracking and reporting data in relation to** barriers and facilitators & ensure a stronger focus on highlighting and disseminating information and results publish and review this data with partners – link to Trust priorities and link to the PCREF activity which in turn helps to identify key study areas and gaps within research or evidence base i.e. Informing the Annual action plan	R&D Team Delivery leads & Engagement officer	2031	Reviews and updates will be undertaken as part of the Annual delivery plan and to ensure that there is a direct link to the Trust objectives	
Disability	x					
Gender reassignment	x					
Marriage and civil partnership	x					
Race	x					
Religion or belief	x					
Sex	x					
Sexual Orientation	x					
Pregnancy maternity	x					
Carers	x					

Who will benefit from this action? (tick all that apply)		Action 2: This is what we are going to do	Lead/s	By when	Update -outcome	RAG
Age	x	**Partnership & Portfolio development:** Using the data and information from our systems we will highlight and specifically target study development across the life course that promotes and engages each of the key protected areas Continue to screen and identify specific studies which highlight the hidden experience of individuals who may express one or more of the protected characteristics. Develop through our extensive networks the opportunities for community, grass root individuals to **lead, develop, design and co-produce research activity through our community connectors and wider programs.** Working with our Trust teams and wider partnerships – to maintain a listing of VCS and faith and business and community interests organisations that can work with us to support research activity in one or more protected characteristic area Utilise the New research centre at university of Huddersfield and the wider funding bids to support enquiry and dissemination and development of new innovative ways of working, co-production and leadership Actively engage with partners and organisations that can help build and develop research capacity and engagement increasing portfolio activity in the respective areas: Continue the professional development of specialist officers who will be responsible for championing and identifying research within that clinical or speciality area.	Delivery leads & Engagement officer	2031	Reviews and updates will be undertaken as part of the Annual delivery plan and to ensure that there is a direct link to the Trust objectives	
Disability	x					
Gender reassignment	x					
Marriage and civil partnership	x					
Race	x					
Religion or belief	x					
Sex	x					
Sexual Orientation	x					
Pregnancy maternity	x					
Carers	x					

Who will benefit from this action? (tick all that apply)		Action 3: This is what we are going to do	Lead/s	By when	Update -outcome	RAG
Age	x	**Engagement & Dissemination & implementation of results and activities:** Provide case studies and lived experience case studies of individuals who have worked with the R&D team and have gone through our developmental programs i.e. Connecting people or NIHR training as way of further engaging marginalised groups Ensure that learning and good practice and data is shared between professionals and groups that have co-produced and engaged with the research so that this reinforces the need to support activity and builds trust within communities. Ensure that all activity is reported through coms, or other social media and publication outlets including peer reviewed journals and conferences	R&D Engagement officers	2031	Reviews and updates will be undertaken as part of the Annual delivery plan and to ensure that there is a direct link to the Trust objectives	
Disability	X					
Gender reassignment	X					
Marriage and civil partnership	X					
Race	X					
Religion or belief	X					
Sex	x					
Sexual Orientation	x					
Pregnancy maternity	x					
Carers	x					

7 Please state what methods of monitoring you are using to progress actions

Trust monitoring
The implementation, monitoring and evaluation of the EIA will be managed by the Trust R&D senior leadership team on behalf of the chief medical officer and Trust board.

The R&D operational plan which will track all the key KPI's and monitor progress will be reviewed at a monthly R&D operational meeting chaired by the head of research with escalations and oversight at the senior leadership team meeting.

The wider R&D senior leadership team, in conjunction with the chief medical officer, will provide appropriate updates and items of escalation to appropriate strategic and operational groups within the Trust.

NIHR RRDN monitoring
The R&D operational and delivery team will also provide appropriate quarterly metrics in relation to the KPIs set by the Department of Health and Social Care in relation to EDI.

8 Will you publish the Equality Impact Assessment? Please state where the EIA will be shared or published.

The EIA can be published once signed off by the Service Manager and the Equality & Engagement Manager.

9 EIA assessment by equality and involvement team

Name: Aboobaker Bhana
Equality and Involvement Manager
Date: July 2026
Rating: Achieving+

Recommendations: A comprehensive EIA that captures progress/actions from the previous strategy.
Continue to align with the NHS 10year plan /CQC PCREF, Trust strategic implementation plan, PCREF, Core20+5, EDS22and the Trust Anti Racism Framework.
Continue to link our Trained Community Connectors/Peer support workers and Volunteers into specific R/D bids.
Continue engagement with marginalised communities to drive the actions identified in the action plan.
Undertake a review of a Training needs analysis for specialist training requirements for the R/D team.

When you have fully completed all sections of the EIA
and it has been signed off in service,
you must email a copy to: InvolvingPeople@swyt.nhs.uk for grading

Please note that the EIA is a public document and may be published.

Failing to complete an EIA every year could expose the Trust to future legal challenge, as it is a legal requirement to write, review and implement in every service as part of meeting the Equality Act.

South West Yorkshire Partnership Teaching NHS Foundation Trust

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
Standing Items												
Welcome, Introduction and Apologies	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
Declarations of Interest	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
Minutes from the previous meeting	✘		✘	✘		✘	✘	✘		✘		✘
Action log and matters arising from previous meeting	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
Service User/Staff Member/Carer Story	✘		✘	✘		✘	✘	✘		✘		✘
Chair's remarks	✘		✘	✘		✘	✘	✘		✘		✘
Chief Executive's Report	✘		✘	✘		✘	✘	✘		✘		✘
Questions from the public (item 3)	✘		✘	✘		✘	✘	✘		✘		✘

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Any other business (public and private)	✘		✘	✘		✘	✘	✘		✘		✘
Assurance from Trust Board committees and Members' Council and Joint Partnership Board (Teaching Trust)	✘		✘	✘		✘	✘	✘		✘		✘
Risk and Assurance												
Board Assurance Framework	✘			✘			✘			✘		
Corporate / organisational risk register	✘			✘			✘			✘		
Strategic overview of business and associated risk											✘	✘
Review of Risk Appetite statement												✘
Complex Clinical Matters update (private session)	✘		✘	✘		✘	✘	✘		✘		✘
Patient Safety Oversight Report (formerly Incident management quarterly report (public))			✘ (annual)			✘		✘				✘
Guardian of safe working hours annual report							✘	✘				
Workforce Equality Standards						✘						
Medical appraisal / revalidation annual report						✘						
Ligature Annual Report								✘				
Freedom to Speak Up Annual report (October Annual report and April 6 monthly update)	✘						✘					
Medical Education Annual Board report								✘				
Data Security and Protection toolkit (delegated authority required for submission for 30 June)		✘	✘									
Cyber Board training (TBC)												
Annual report and accounts (private)		✘	✘									
Quality Account			✘									

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Annual Governance Statement	✘											
Equality and diversity annual report				✘								
Incident management annual report			✘									
Health and safety annual report				✘								
Patient Experience annual report			✘									
Sustainability annual report						✘						
Premises Assurance Model annual report				✘								
PLACE assessment annual report				✘								
EPRR Compliance report							✘					
IPC BAF				✘								✘
NHS Staff Survey												✘
Resident Doctors 10 point plan						✘						
Resident Doctor BAF								✘				
Staff standards				✘					✘			
Leadership and Management Framework				✘						✘		
Safer Staffing report			✘	✘						✘		
Integrated Care Systems and Partnerships												
South Yorkshire update including the South Yorkshire Integrated Care System (SY ICS)	✘		✘	✘		✘	✘	✘		✘		✘
West Yorkshire update including the West Yorkshire & Health & Care Partnership (WYHCP)	✘		✘	✘		✘	✘	✘		✘		✘
Provider Collaboratives and Alliances	✘		✘	✘		✘	✘	✘		✘		✘

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Performance reports												
Integrated Performance Report (IPR)	✘		✘	✘		✘	✘	✘		✘		✘
Care Group Performance report	✘		✘	✘		✘	✘	✘		✘		✘
CQC action plan updates			✘			✘		✘				✘
Strategic Direction												
Board Development		✘			✘				✘		✘	
Investment Appraisal Framework (private)	✘							✘				
Strategic Objectives/Priority Programmes												✘
Trust Board Annual Work Programme												✘
Trust Plan (private)						✘ (draft / private)	✘ (draft / private)	✘ (1st draft)		✘ (final draft)		
Finance and value for money updates (private)	✘		✘	✘		✘	✘	✘		✘		✘
Governance												
Constitution (including Standing Orders) and Scheme of Delegation (every 2 years – next Jan 2027)										✘		
Compliance with NHS provider licence conditions and code of governance			✘									
Going Concern Statement	✘											
Assessment against NHS Constitution				✘								
Audit Committee annual report including committee annual reports and terms of reference	✘											
Use of Trust Seal			✘			✘		✘				✘

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Internal governance structure review												✘
Strategies and Policies												
Digital strategy (including IMT) **update**			✘							✘		
Estates strategy **update**				✘		✘				✘		
Customer Services Policy						✘						
Trust Board declaration of interest register and fit and proper persons, interests and independence policy						✘						
Quality Strategy (date to be TBC after March 2026)												
Research and Development Strategy (TBC)												
People Strategy update												✘
Trust Strategy Measurement				✘								

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)*