South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board (business and risk)
Tuesday 27 October 2026 at 9.30am
Boardroom, Conference Centre, Kendray Hospital

AGENDA

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
9.30	**1. Welcome, introductions and apologies**	Chair	**Verbal item**	1	To receive
9.31	**2. Declarations of interest**	Chair	**Verbal item**	2	To receive
9.33	**3. Questions from the public** *(received in advance in writing by e:mail to membership@swyt.nhs.uk)*	Chair	**Verbal item**	5	To receive
9.38	**4. Minutes from previous Trust Board meeting held 29 September 2026**	Chair	**Paper**	2	To approve
9.40	**5. Matters arising from previous Trust Board meeting held 29 September 2026 and board action log**	Chair	**Paper**	5	To receive
9.45	**6. Service User / Staff Member / Carer Story**	Chief Operating Officer	**Verbal item**	10	To receive
9.55	**7. Chair's remarks**	Chair	**Verbal item**	3	To receive

With all of us in mind.

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
9.58	**8. Chief Executive's report**	Chief Executive	**Paper**	7	To receive
10.05	**9. Assurance from Trust Board Committees** • Transformation, Innovation and Sustainability Committee 6 October 2026 • Quality and Safety Committee 13 October 2025 • Commissioning Committee 13 October 2025 • Audit Committee 16 October 2026 • Finance, Investment and Performance Committee 19 October 2026	Committee chairs	**Paper**	20	To receive
10.25	**10. Risk and assurance**				
10.25	10.1 Board Assurance Framework	Deputy Chief Executive/Director of Strategy, Inclusion and Change	**Paper**	10	To receive
10.35	10.2 Corporate / organisational risk register	Deputy Chief Executive/Director of Strategy, Inclusion and Change	**Paper**	15	To receive
10.50	10.3 Independent review of the women's pathway	Chief Operating Officer	**Paper**	5	To receive
10.55	10.4 Child and Adolescent Mental Health Services (CAMHS) CQC Inspection	Chief Nurse and Director of Quality and Professions	**Paper**	5	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
11.00	10.5 Learning from healthcare deaths report	Chief Nurse and Director of Quality and Professions	**Paper**	5	To receive
11.05	10.6 Independent public inquiry to examine the events at the Countess of Chester Hospital (Thirlwall report)	Chief Nurse and Director of Quality and Professions	**Paper**	5	To receive
11.10	10.7 Safeguarding Annual Report	Chief Medical Officer	**Paper**	5	To receive
11.15	10.8 Drugs and Therapeutic Annual Report	Chief Medical Officer	**Paper**	5	To receive
11.20	10.9 Freedom to Speak Up bi-annual report	Freedom to Speak Up Guardian	**Paper**	5	To receive
11.25	10.10 Workforce equality standards	Chief People Officer	**Paper**	5	To receive
11.30	10.11 Planning update	Deputy Chief Executive/Director of Strategy, Inclusion and Change	**Paper**	5	To receive
11.35	*Break*			10	
11.45	**11. Performance**				
11.45	11.1 Integrated Performance Report (IPR) month 6 2026/27	Director of Finance, Estates and Resources	**Paper**	15	To receive
12.00	11.2 Care Group Performance Report	Chief Operating Officer	**Paper**	10	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
12.10	**12. Integrated Care Systems and Partnerships**				
12.10	12.1 South Yorkshire update including South Yorkshire Integrated Care System (SYICS)	Chief Executive	**Paper**	8	To receive
12.18	12.2 West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update	Chief Executive	**Paper**	7	To receive
12.25	12.3 Provider Collaboratives and Alliances	Director of Finance, Estates and Resources	**Paper**	5	To receive
12.30	**13. Governance**				
12.30	13.1 Internal Governance Structure	Deputy Chief Executive/Director of Strategy, Inclusion and Change	**Paper**	5	To approve
12.35	**14. Strategies and policies**				
12.35	14.1 Trust Board Fit and Proper Persons and Declarations of Interest Policy	Deputy Chief Executive/Director of Strategy, Inclusion and Change	**Paper**	5	To approve
12.40	**15. Trust Board Work Programme**	Chair	**Paper**	1	To note
12.41	**16. Date of next meeting** The next Trust Board meeting held in public will be held on 1	Chair	**Verbal item**	1	To note

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	December 2026				
12.42	**17. Any other business**	Chair	**Verbal item**	3	To note
12.45	*Close*				

With **all of us** in mind.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Minutes of the public Trust Board meeting held on 28 July 2026
Cheswold Park Hospital, Doncaster

Present:	Jayne Brown (JB)	Trust Chair (Chair)
	Natalie McMillan (NMc)	Deputy Chair, Senior Independent Director
	Celia Weldon (CW)	Non-Executive Director
	Gary Ellis (GE)	Non-Executive Director
	Margaret Kitching (MK)	Non-Executive Director
	Martin Neeson (MN)	Non-Executive Director
	Rokaiya Khan (RK)	Non-Executive Director
	Mitch Waterman (MW)	Appointed University of Leeds Associate Non-Executive Director
	Mark Brooks (MBr)	Chief Executive
	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:	Dawn Lawson (DL)	Deputy Chief Executive and Director of Strategy, Inclusion and Change
In attendance:	Christine Brereton (CB)	Chief People Officer
	Adele Fox (AF)	Chief Operating Officer
	Sue Barton (SB)	Deputy Director of Strategy and Change
	Izzy Worswick (IW)	Deputy Director of Partnerships, Planning and Governance
	Musab Abrar (MA) (item 6 only)	Resident Doctor Calderdale and Kirklees Mental Health Liaison Team
	Charles Pope (CP) (item 6 only)	Resident Doctor North Kirklees Older Peoples Services
	Andy Lister (AL)	Company Secretary
	Gemma Lockwood (GL)	Corporate Governance Manager
	Debbie Beynon-Fisher (DBF)	Corporate Governance Officer (author) (MS Teams)
Observer:	Emma Cox (EC)	Associate Director, Operational Management

TB/26/84 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 welcomed Celia Weldon (CW) to her first Trust 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/26/85 Declarations of interest (agenda item 2)
Declaration of Interest from CW was received and noted.

It was RESOLVED to NOTE the declarations of interest.

TB/26/86 Questions from the public (agenda item 3)
No questions were received from members of the public.

TB/26/87 Minutes from previous Trust Board meeting held 28 July 2026 (agenda item 4)
Izzy Worswick (IW) noted a minor amendment relating to the Transformation, Inclusion and Sustainability Committee (TISC) Terms of Reference (ToR) and clarified that the Terms of Reference were approved (not received) subject to the agreed changes.

Subject to this amendment, the Board approved the minutes of the meeting held on 28 July 2026 as an accurate record.

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

TB/26/88 Matters arising from previous Trust Board meeting held 28 July 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/26/89 Service User/Staff Member/Carer story (agenda item 6)
Subha Thiyagesh (STh) introduced two of the Trust's resident doctors, Musab Abrar (MA) and Charles Pope (CP), to share their experience of working and training within the Trust. STh outlined work undertaken in response to NHS England's 10-point action plan and ongoing collaboration across medical, operational and quality improvement teams.

MA stated that he is a psychiatry resident doctor in the Calderdale and Kirklees Mental Health Liaison Team, has experience across several trusts and acts as a peer representative, enabling other doctors to raise issues or concerns. He noted the Trust's open communication, responsive leadership and supportive culture, citing examples of doctors' concerns being heard and addressed. He acknowledged the NHS England Resident Doctor 10-Point Action Plan's role in improving facilities, placements, rotas, payroll and annual leave, and described the Trust as welcoming and supportive, enabling trainees to lead quality improvement and influence change.

MA confirmed he had not encountered any payroll or rota compliance issues since taking up the role and reflected positively on the progress made which enables resident doctors to focus on delivering patient care.

CP advised that he is a final-year psychiatry trainee and completed his medical training and first five years of practice in Cardiff before entering psychiatry during the pandemic. In recent years, he has worked across several Yorkshire locations and trusts. Drawing on his experience of varied services and teams, he described SWYPFT as a positive place to train and work and one he would consider for a future consultant role. He added that higher trainees attend a structured monthly meeting to review each Yorkshire and Humber Deanery Trust, raise concerns and compare experiences and typically few issues were raised regarding SWYPFT.

JB asked how the Trust could improve resident doctors experience of working within the Trust. MA stated that the Trust already provides a highly supportive environment and highlighted the importance of maintaining responsive communication and access to support when issues arise. He shared that he felt confident raising concerns and that these would be heard and addressed. CP advised that day to day issues are often addressed promptly by Trust staff, preventing them from becoming significant barriers to effective working.

Caroline Johnson (CJ) raised a question regarding relationships with the wider multidisciplinary team (MDT) and whether any improvements were required. CP stated that there is positive collaboration across services, with strong support from nursing colleagues, consultants and the wider MDT, and a strong emphasis on teamwork, benefiting both staff experience and patient care.

Nat McMillan (NMc) asked whether resident doctors felt safe at work and whether there were any concerns for the Board to address. MA confirmed that he felt safe and well supported, with clear routes to raise any wellbeing concerns. CP agreed and added that SWYPFT provided a supportive, psychologically safe environment. He advised that other organisations have identified further support e.g. support groups for doctors affected by patient suicide and suggested the Trust could learn from these type of developments.

RK highlighted the increasing complexity of patient presentations, including overlapping mental health, criminal justice and immigration-related needs, and the challenges they create for assessment and cross-system support. CP agreed, noting that multidisciplinary teams use comprehensive, dynamic risk assessments and robust risk management processes to provide safe, high-quality care.

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

TB/26/90 Resident doctors ten point plan (agenda item 7)

STh updated the Board on progress against the NHS England Resident Doctors 10-Point Action Plan and the Trust's assurance framework. This work brings together resident doctors, medical education, operational services, estates, IT and workforce teams to improve working conditions and address concerns. A task and finish group oversees delivery and reports through the Trust's governance structure.

ST advised there has been progress in e-rostering, work scheduling and exception reporting. Regular forums enable resident doctors, educational leads and the Guardian of Safe Working to review issues and actions. Exception reporting remains below acute Trust levels, consistent with mental health provider benchmarks, with no significant concerns identified.

In relation to statutory and mandatory training requirements, there are continuing challenges associated with differing training requirements and employment arrangements across organisations and work is ongoing to minimise barriers and improve the overall training experience. STh stated that resident doctors' experience and engagement remain central to the programme and feedback from trainees continues to inform actions and priorities.

A draft Board Assurance Framework has been developed in line with NHSE guidance and will provide formal governance, oversight and escalation arrangements. A refined version will be presented to the People and Remuneration Committee (PRC) later in the year.

STh advised that organisations are being encouraged to reduce reliance on locally employed doctors where possible. Therefore, the Trust is undertaking a review of locally employed and Trust-grade medical posts to ensure there is an appropriate balance between training opportunities, workforce sustainability and service delivery requirements.

Christine Brereton (CB) confirmed that the initial focus of the programme was on addressing recurring concerns relating to rota management, payroll accuracy and annual leave processes.

Mitch Waterman (MW) sought assurance that resident doctors were aware of and could access research, education and clinical academic opportunities aligned with their career aspirations. STh outlined the range of development opportunities available within the Trust, including the appointment of trainee research ambassadors, and advised that resident doctors are encouraged to engage in research, education and quality improvement initiatives as part of their professional development. CP noted that the Trust provides valuable opportunities for teaching, quality improvement and wider professional development and resident doctors are aware of available opportunities and know who to approach for support and guidance.

It was RESOLVED to NOTE the Resident Doctors ten point plan.

TB/26/91 Chair's remarks (agenda item 8)

JB advised that, following Mike Ford's departure, there was need to identify a Non-Executive Director to take on oversight of Freedom to Speak Up. It was proposed that RK take on this role and step down from the Transformation, Innovation and Sustainability Committee (TISC) to fulfil the associated responsibilities. JB will replace RK on the Transformation, Innovation and Sustainability Committee.

It was agreed to formally approve the appointment of RK as Non-Executive Director lead for Freedom to Speak Up and the associated changes to committee membership arrangements were noted.

JB advised that the private Board meeting would include:

- Any private matters for integrated care systems and partnerships
- Complex clinical matters report
- The Provider Capability Assessment
- Finance update including Value for Money programme
- An update on the Older People's Service transformation
- A pharmacy contract approval

It was RESOLVED to NOTE the Chair's remarks.

TB/26/92 Chief Executive's report (agenda item 9)

Chief Executive's report

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

- Summer pressures as a result of the heat resulted in consistently high demand for mental health services, which was particularly notable in inpatient services. There is national scrutiny on operational and financial performance and winter preparedness. The Trust has maintained performance while responding to seasonal demand.
- Following the independent review into events at the Countess of Chester Hospital, all NHS organisations have been asked to consider the findings at Board level. The Quality and Safety Committee (QSC) will review the report before it is presented to the Board to identify relevant learning and assurance.
- Progress on the independent review of the Trust's women's pathway has been affected by the temporary absence of the lead reviewer. An initial draft report has been received and initial findings will be presented to QSC in October before presenting the report to Trust Board in October.

Action – Adele Fox

- The Trust has maintained a Segment One rating under the NHS Oversight Framework (NOF) for Quarter one. The sustained organisational effort required to maintain the highest level of performance and oversight assurance was acknowledged.
- The annual NHS Staff Survey has launched, with a positive initial response rate.
- The seasonal flu vaccination programme for staff has commenced, supporting wider health and wellbeing and winter resilience objectives.

- Changes to the Integrated Care Board (ICB) landscape were noted with significant organisational restructuring taking place across South and West Yorkshire ICBs, and substantial workforce changes are being implemented.
- Place Provider Partnership arrangements continue to develop and work is underway to review effectiveness following approximately six months of operating in shadow.
- Despite ongoing pressures across inpatient and community services, overall performance remains good across the majority of key indicators. Progress continues across a number of workforce metrics, including appraisal completion rates, which are reported in more detail through the Integrated Performance Report.
- A three-day Care Quality Commission (CQC) inspection commenced on Monday 28 September 2026, in Children and Young People's Mental Health Services.

Gary Ellis (GE) sought assurance on funding arrangements for mental health emergency departments and the Trust's involvement in future funding discussions. Adele Fox (AF) confirmed that approximately £1.5 million in capital funding had been secured for the Barnsley scheme. Wakefield are developing a combined emergency department and crisis hub, while Calderdale are exploring a hub model. An options appraisal for Barnsley has been completed, with a joint working group established to determine the preferred model and location.

JB requested clarification on how the £1.5m capital bid for mental health emergency department developments would be delivered, and how revenue consequences would be managed. MBr advised that the capital bids were developed and submitted within a very short timeframe, meaning initial consultation was limited and high-level rather than fully detailed. Following Barnsley's successful bid, work is underway to define the full scope and design of the scheme and the Trust is working with the acute hospital revisiting what the scheme should include in practice, ensuring it reflects operational needs and best use of resources.

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

TB/26/93 Assurance and receipt of minutes from Trust Board Committees and Members' Council (agenda item 10)

Joint Partnership Board 20 July 2026

Mitch Waterman (MW) provided an update following the Joint Partnership Board meeting on 20 July 2026:

- Progress in strengthening the strategic partnership between the Trust and the University of Leeds continues.
- The Joint Partnership Board (JPB) have formally established two operational sub-groups focused on education and research. Terms of reference and membership arrangements have been agreed, and both groups have commenced work against their initial objectives. MW confirmed that STh is to chair one of the groups and oversight of both groups will continue through the JPB.
- Sub-groups will map the Trust's education and research activity to assess current provision, capability and development opportunities. Initial findings are expected to be reported to the JPB in January 2027 before presentation to Trust Board. The timescale reflects the exercise's scale and complexity and supports a robust evidence base for agreeing future priorities.
- Early discussions are underway regarding a southern campus initiative involving the Trust, University of Leeds, Mid Yorkshire Teaching Hospitals and the West Yorkshire Combined Authority to support research, education, innovation and economic growth. GE highlighted previous work undertaken by the Mid Yorkshire Teaching Trust in relation to research and development facilities and suggested that lessons from this earlier work could inform future planning.

MW acknowledged the importance of balancing ambition with tangible outcomes and confirmed that the emerging work programme would continue to focus on delivering measurable benefits for both the Trust and its partners.

The minutes of the Joint Partnership Board meeting held on 27 April 2026 were noted.

Members' Council 12 August 2026

JB provided an update following the Members' Council meeting on 12 August 2026 and requested that the report be taken as read.

JB reported that although the meeting was well-attended, there was insufficient time to complete the planned leading well discussion. Therefore, a dedicated follow-up session has been arranged focusing on leading well. JB suggested reviewing future agendas to allow sufficient time for meaningful discussion of key items.

Action – Andy Lister

The minutes of the Members' Council meeting held on 12 August 2026 were noted.

Commissioning Committee 14 August 2026

Martin Neeson (MN) provided an update following the Commissioning Committee meeting on 14 August 2026:

- Specialist forensic services across South and West Yorkshire continue to report rising demand, delayed discharges and sustained bed pressures, increasing waits, external placements and forecast deficits across both commissioning collaboratives.
- An operational planning review is underway to examine opportunities to increase medium secure bed capacity and improve patient flow through more effective discharge arrangements.
- In South Yorkshire, progress was noted in relation to the expansion of community forensic services, which is intended to support timely discharge from inpatient services, reduce bed pressures and improve the overall efficiency of patient pathways.
- Ongoing monitoring through robust quality and safety governance arrangements continues to provide assurance regarding the management of operational and clinical risks.
- Future commissioning arrangements beyond 2027 will be considered at a future Commissioning Committee meeting once further national guidance becomes available.

JB requested assurance regarding the timescales and practical delivery of proposed bed capacity expansions. STh advised that the executive trio are developing a phased increase in Cheswold Hospital capacity by maximising existing wards, recruiting medical staff and proposing additional ward capacity. Planning work is underway in conjunction with regional partners to determine the most effective configuration of future bed provision, taking account of demand, patient flow and workforce availability. A formal proposal will be put forward once the planning and workforce considerations have been fully assessed.

JB also asked whether there is sufficient commissioning expertise and capacity within the organisation to support an increasingly complex commissioning environment. AS advised that both South and West Yorkshire specialised provider collaboratives have commissioning functions and work is underway to strengthen collaboration across the two. Workforce reductions within ICBs may be contributing to delays in securing community care packages required to support patient discharge and further evidence is being gathered to better understand the extent of this impact. It was noted that commissioning capacity across the wider system continues to evolve as integrated care arrangements mature.

The minutes of the Commissioning Committee meeting held on 14 August 2026 were reviewed in private due to being commercial in confidence.

Mental Health Act Committee 26 August 2026

Rokaiya Khan (RK) provided an update following the Mental Health Act Committee on 26 August 2026 and the findings arising from the Mental Health Act monitoring visits:

- Thirty two of the forty three CQC actions identified during 2025/26 relate to repeat findings, representing an increase compared with the previous year. Recurring themes are care planning, risk assessments, patient involvement and ensuring patients are appropriately informed of their rights under Section 132 of the Mental Health Act. The Committee recognised progress in closing actions and sought assurance that root causes were being addressed to deliver sustained improvements in practice.
- There is continued focus on health inequalities and four years of inequalities data is now available with work underway to triangulate the information with audit findings, service user feedback and community intelligence to better understand inequalities in access, experience and outcomes.
- Preparations are underway for the forthcoming Mental Health Act reform to ensure the Trust is prepared for the phased implementation of legislative changes. Appropriate governance arrangements are being established to oversee the programme of work.
- Assurance was received regarding the management of blanket restrictions, with fifty one restrictions recorded during Quarter one, of which only one remained open at the end of the reporting period.

NMc sought assurance that existing governance and improvement processes were sufficiently robust to deliver a measurable reduction in repeat findings. RK confirmed that strengthened oversight is being delivered through closer triangulation between the Mental Health Act Committee and the Quality and Safety Committee. Training programmes and governance processes are being reinforced, including targeted improvements in practice and compliance monitoring. Monthly assurance reporting through Quality and Safety Committee is being used to track whether actions are delivering sustained improvement. CJ confirmed that early indicators show an improvement in risk assessment completion and audit activity, which are expected to support sustained compliance improvement. STh added that each CQC-related action is individually reviewed through governance routes, including escalation processes and quality improvement tracking systems, and ongoing audit mechanisms are in place to ensure findings are recorded and followed through to closure and learning.

JB asked why recurring findings remained evident despite previous improvement activity. STh advised that some issues reflect the complexity of clinical practice, human factors and the challenges associated with delivering statutory requirements consistently within busy clinical environments. CJ added that significant work has been undertaken to understand the root causes of identified issues and analysis has demonstrated the cumulative impact of multiple policies, procedures and documentation requirements placed upon clinical staff over a number of years. As a result, a programme of work is now underway to simplify clinical processes, reduce administrative burden and ensure that staff are supported to comply with essential requirements. NMc requested a clear timeline for completing the work on reducing administrative burden and addressing recurring issues to prevent recurring issues in the future. CJ confirmed that the Quality and Safety Committee report will continue to be presented to Board as part of the ongoing improvement programme, ensuring continued visibility and assurance.

Action – Caroline Johnson

The minutes of the Mental Health Act Committee held on 2 June 2026 were noted.

Quality and Safety Committee 8 September 2026

Margaret Kitching (MK) provided an update following the Quality and Safety Committee on 8 September 2026:

- Patient flow pressures continue to be a significant area of focus and extensive work is underway by operational teams to improve patient flow and discharge arrangements. It was noted that many of the challenges are driven by factors beyond the direct control

of the Trust, including pressures within partner organisations and wider system capacity constraints.

- Data shows the Trust is an outlier in relation to some elements of restrictive practice therefore reducing restrictive practice continues to be a priority. Progress has been made through improvement activity and strengthened oversight arrangements and continued vigilance and monitoring are required due to the potential impact on patient experience and organisational risk.
- Assurance reports and annual reviews were presented to the Committee, including updates relating to safeguarding, medicines management, clinical effectiveness and medical appraisal. Appropriate governance arrangements remain in place and no significant concerns have been raised requiring escalation to Trust Board.
- The Trust's Happiness Programme was presented which was well received and described as innovative, patient-centred, demonstrating tangible benefits for service users and a strong example of improvement and innovation in practice which has potential to be expanded across the organisation. SB confirmed that the programme is supported through charitable funding and has generated positive outcomes for those participating. JB suggested that this be presented to the Board as a future Board story.

Action – Andy Lister

The minutes of the Quality and Safety Committee held on 7 July 2026 were noted.

People and Remuneration Committee 15 September 2026

NMc provided an update on key points from the last People and Remuneration meeting held on 15 September 2026:

- The Committee received assurance across a broad range of workforce matters which will continue to be monitored closely in light of the increasingly challenging operating environment.
- Potential implications of emerging national proposals relating to zero-hours contracts were discussed and it was noted that the position remains subject to ongoing national development. At present, no immediate action is required, however the issue will remain under review to ensure the Trust is able to understand and respond to any future legislative or policy changes affecting workforce arrangements. Further updates will be provided as further information becomes available.
- Workforce risks arising from the challenging financial environment were noted, including cost-reduction programmes and sickness absence. These and wider system pressures will remain under review through the Trust's assurance processes to identify and mitigate unintended consequences and ensure the risk profile reflects emerging local and national challenges.
- A recent internal audit report on EDI reporting (focus on Public Sector Equality Duty and Involvement) provided significant assurance. The importance of acknowledging strong audit outcomes alongside areas identified for improvement was acknowledged.
- Update received on the continued development of Trust policies through a trauma-informed approach. Work is underway to embed trauma-informed principles within policy development and organisational practice, ensuring policies reflect the Trust's values and commitment to creating supportive environments for both staff and service users.

The minutes of the People and Remuneration Committee held on 14 July 2026 were noted.

Finance, Investment and Performance Committee 23 September 2026

Gary Ellis (GE) provided an update following the Finance, Investment and Performance Committee meeting held on 23 September 2026:

- The Trust remains marginally ahead of its planned financial position at Month five, however the organisation continues to face significant financial challenges. The Trust has reported a cumulative deficit of £2.2m and delivery of the year-end financial plan

will be challenging. Key areas of pressure include provider collaborative arrangements, bank staffing expenditure and the delivery of recurrent value for money and efficiency programmes.

- The Value for Money programme is on plan, although later-year schemes present delivery risks. Maintaining financial balance will require tighter control, difficult decisions and continued scrutiny of expenditure and investment. Further options to support the financial plan are being developed for consideration through the Trust's governance processes.

JB acknowledged the seriousness of the financial position emphasising the need for greater grip and pace. AS advised that benchmarking showed favourable performance against comparable mental health providers, making further efficiencies harder to identify, but confirmed that opportunities to improve financial sustainability continue to be explored.

NMc noted that only six months of the financial year remains to implement corrective actions, emphasising the need for timely decisions to maximise their impact. Therefore, future decisions will require careful consideration of investment deferral, reduction or reprioritisation.

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

TB/26/94 Performance (agenda item 11)

TB/26/94a Integrated Performance Report (IPR) month 3 2026/27 (agenda item 11.1)

Quality

Caroline Johnson (CJ) provided a summary of the Quality and NHSE (national) indicators and noted the following:

- A number of quality indicators continue to demonstrate positive performance.
- Complaint handling performance remains strong, with 100% of complaints responded to within the required six-month timeframe. The quality of complaint responses remains high, with comprehensive investigations and detailed responses being provided to complainants.
- No incidents of prone restraint were recorded during August 2026, with continued positive performance to date into September. This reflects the sustained focus on reducing restrictive interventions across services.
- Breaches in information governance are below the planned trajectory. Incidents relate to administrative processes rather than inappropriate access to records, and care groups are undertaking targeted quality improvement activity to address recurring themes. Heightened controls have been implemented following high-profile incidents and none of the reported breaches involve inappropriate access to patient records.
- Following the separation of management and clinical supervision arrangements, some areas remain below target and continue to require additional support. Work is ongoing within those services to improve compliance and strengthen assurance.
- In relation to ligature risk management, a small number of repairs have exceeded completion timeframes however delays were minimal, typically by a single day, and were attributable to practical issues such as access to service areas given clinical activity and availability of equipment. CJ confirmed ligature management is a continuous programme of assessment and mitigation across the estate, and where delays are reported these are mitigated by risk assessment.
- Improvement activity related to care planning and risk assessments is beginning to deliver positive results, with early evidence of improvement in compliance and assurance measures.
- Concerns have been raised regarding staff safety and wellbeing, including incidents relating to sexual safety and violence towards staff. Work is underway through a joint programme involving nursing, operational and workforce leaders to develop the Trust's "All of Us Together" campaign, with a focus on creating safer working environments and strengthening organisational responses to incidents affecting staff.

MBr highlighted the continued impact of clinically ready for discharge patients on inpatient occupancy, patient flow and organisational performance. Delayed discharges remain one of the most significant operational challenges facing the Trust and the associated impact on quality, capacity and financial performance, and requires close oversight through the Quality and Safety Committee, operational management group and wider system partnership discussions.

Health Inequalities

Sue Barton (SB) provided an update on health inequalities and noted the following:

- The health inequalities framework is included in the IPR, providing trend analysis and actionable intelligence on variation in access, waiting times and service use to inform decisions and improvement.
- Work continues on ethnicity and deprivation as key drivers of health inequalities. Contextual population data supports interpretation across Trust localities, while improving data quality remains a priority to ensure robust analysis, with some areas requiring further attention.
- The report analyses inpatient length of stay and access to community services, using average and median measures to balance extreme cases and identify differences in outcomes or access between population groups, informing improvement priorities and annual planning.

JB welcomed the increasing maturity of the reporting and sought assurance that organisational effort is being directed towards areas where the Trust could have the greatest influence on reducing inequalities. SB explained that whilst some drivers of inequality, such as housing, employment and wider social determinants sit outside the direct control of the Trust, the organisation has a role in influencing these factors through partnership working. The Trust maintains strong relationships with public health teams, housing partners and local authorities across all four places and inequalities data is routinely discussed to support collective action.

STh confirmed ongoing work with primary care, public health and system partners to ensure future service developments address physical and mental health inequalities and provide equitable access. The Mental Health Act and Quality and Safety Committees are also examining how deprivation, ethnicity and intersecting factors affect access and outcomes for patients with longer stays, to better target improvements.

SB advised that inequality considerations are being embedded within wider clinical transformation work, including the Transforming Clinical Pathways programme to improve understanding of the interaction between mental health needs, cultural factors and wider social circumstances, while strengthening the cultural competence of the workforce. This includes ensuring staff are equipped to recognise the impact of ethnicity, deprivation and other determinants on patient experience and outcomes and distinguish between cultural, social and clinical factors when assessing and treating service users.

People

Christine Brereton (CB) provided an update on People and noted the following:

- Appraisal performance remains strong at 94.5% over the rolling 12 month period, exceeding the 90% target. The transition to the April–September appraisal cycle has been successful, with completion rates improving and positive staff feedback received.
- Statutory and mandatory training compliance remains strong. Targeted care group work has improved information governance training performance, supported by detailed reporting to identify service-level hotspots and corrective action.
- Sickness absence is 5.7%, above the trajectory for the 5% target set for March 2027. Although performance compares well regionally, further improvement is needed to achieve 4% by March 2029. The sickness absence reduction plan remains a priority and focuses on hotspot analysis, long-term cases and tailored care group and workforce support.

AF highlighted the significant contribution made by care groups in delivering improved appraisal performance and advised that care groups, supported by workforce business partners, achieved this alongside substantial operational pressures and competing priorities.

JB noted that staff feedback of the revised appraisal process had been positive and the collaborative efforts of care groups, workforce teams and managers in embedding the new approach was acknowledged. It was agreed that forthcoming staff survey will be a useful opportunity to assess the wider impact of the changes on staff experience and engagement.

Care Groups

Adele Fox (AF) provided an update on care groups and noted the following:

- The paediatric audiology service has achieved significant, sustained improvement through focused quality improvement and dedicated staff effort.
- In relation to length of stay and patient flow, older people's services continue to perform well. However sustained pressures remain within mental health and learning disability services due to the number of patients clinically ready for discharge but unable to move on due to lack of appropriate placements or community packages of care. These cases typically involve individuals with highly complex needs requiring specialist accommodation, enhanced support arrangements or bespoke care packages and work is ongoing with partners and commissioners to secure appropriate placements and reduce delays.
- Quality improvement activity within Children and Young People's Services has begun to generate positive outcomes in relation to access and waiting times.
- Neurodevelopmental pathways continue to experience significant demand and waiting list pressures. Work continues with commissioners and independent providers to improve capacity and support transitions between children's and adult services, whilst maintaining oversight of triage and assessment arrangements.
- Mental health inpatient bed occupancy remains high, with occupancy excluding leave recorded at 91.6% in August 2026. Robust oversight arrangements have been implemented to ensure that escalation beds (previously non-designated beds) are utilised safely and appropriately, with regular reviews by executive and operational leaders.
- Bank staffing expenditure remains a challenge, although usage has reduced compared to previous periods. A revised approach to oversight has been introduced, replacing broader review meetings with targeted care group deep dives designed to identify opportunities for further improvement and more effective workforce deployment.
- In relation to Single Point of Access (SPA) services in Calderdale and Kirklees, previous improvements achieved through business continuity arrangements have reduced during the reporting period, resulting in a small decline in performance against assessment targets. Business continuity measures have been reinstated and additional resources redirected to the affected services. Delays remain relatively limited and no significant safety concerns have been identified. A wider review of SPA arrangements is underway to support a sustainable long-term solution.

JB sought assurance on geographical and system variation in discharge delays. AF advised that learning disability services often require highly specialised placements, while mental health services are more affected by complex risks requiring specialist accommodation and support. Challenges exist across all areas, with the longest delays arising where suitable placements or care packages are difficult to source.

MK queried whether there are any additional system or step-down approaches for patients who are clinically ready for discharge but remain in inpatient settings because community arrangements were unavailable. AF advised that some organisations had adopted step-down models however unless sufficient downstream capacity exists, such approaches could relocate patient flow pressures rather than resolve them. Escalation processes with commissioners, local authorities and system partners remain in place to progress delayed discharges and address barriers wherever possible.

Finance

Adrian Snarr (AS) provided a finance update and noted the following:

- The Trust retained its Segment One rating under the revised National Oversight Framework (NOF) arrangements. It was noted that only a small number of non-acute Trusts achieved Segment one status and this was recognised as a significant demonstration of sustained organisational performance, quality and governance.
- The Trust remains marginally ahead of its financial plan at Month five. There is increasing concern regarding delivery of the year-end financial target and the Trust's financial plan has been profiled to reflect a deficit position during the first half of the year, with recovery and surplus generation planned during the second half in order to achieve break-even overall. Therefore, the focus remains on strengthening financial performance throughout the remainder of the year.
- Current staffing levels remain aligned with plan however, forecast workforce numbers suggest that additional recruitment during the second half of the year could increase financial pressures. Work is underway to exercise tighter workforce controls and maintain staffing levels within agreed establishment plans. It was noted that workforce expenditure remains one of the most significant contributors to the Trust's financial position and effective management of recruitment and staffing will be critical to reducing financial risk.

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

TB/26/94b Care Group Performance Report (agenda item 11.2)

AF provided a summary of the Care Group Performance Report for the Community Mental Health Care Group:

- Care groups continue to demonstrate strong performance in a number of key areas despite ongoing service pressures.
- Appraisal and statutory and mandatory training compliance across Community Mental Health services remains positive and reflects the wider organisational improvement.
- There has been an increase in sickness absence, mainly related to long-term absence. Appropriate support mechanisms are in place supporting staff to access timely interventions and support a return to work where appropriate.
- Performance against the four-hour crisis response target remains above the Trust's 90% target at 97.7%. However, there is continued pressure within routine assessment pathways.
- Care Programme Approach (CPA) compliance remains strong across all localities and continues to demonstrate positive results through internal audit and monitoring processes.
- There have been some sad deaths of individuals known to the Trust’s community mental health services. The Trust’s suicide prevention and mortality leads are reviewing emerging themes, including substance misuse-related deaths, to strengthen learning and preventative action. Findings will be reported through the Trust’s governance processes to inform quality improvement and suicide prevention work.

MK sought assurance regarding whether there were any links between recent mortality trends and access pressures within Single Point of Access (SPA) services. AF advised that detailed reviews had not identified delays in SPA assessments as a contributory factor. CJ added that improvement work is focused on strengthening understanding of wider themes, including access to means, risk management and preventative interventions.

CB asked how the care group deep-dive process aligns with the new monthly performance review arrangements and whether there is an opportunity to further strengthen the relationship between the two processes. AF explained that the monthly performance reviews provide ongoing accountability and scrutiny, whilst the Board deep dives offer an opportunity to consider issues in greater detail.

CW raised a question regarding the challenges associated with recruiting substantive medical staff and reducing expenditure on agency medical cover. STh explained, the Trust compares favourably with many peer organisations and has made progress in reducing reliance on agency staff through the use of bank arrangements and proactive recruitment.

It was RESOLVED to RECEIVE and NOTE the care group report for the Community Mental Health Care Group.

TB/26/95 Risk and Assurance (agenda item 12)

TB/26/95a Patient Safety Oversight Report (agenda item 12.1)

CJ presented the quarter one Patient Safety Oversight Report and noted the key points:

- A dedicated Learning and Improvement Group has been re-established to oversee the systematic review of learning from incidents, complaints, investigations and other safety information. The group will ensure that themes identified are translated into improvement actions and continue to monitor the Patient Safety Incident Response Framework (PSIRF) priorities and ensure they are delivered.
- There has been further reduction in the number of self-harm incidents following improvement work across inpatient services.
- Positive trends were reported in relation to falls prevention, reflecting the impact of ongoing safety initiatives and local improvement programmes.
- Medication incidents continue to occur and detailed analysis is taking place to understand the underlying causes. Pharmacy, nursing and operational teams are focused on identifying learning opportunities and strengthening medicines management processes across services.
- Two deaths were included in inpatient mortality reporting as both patients died within thirty days of discharge. Oversight has been strengthened through a re-established Mortality Assurance Group, providing greater scrutiny of themes, trends and learning.

STh advised that medication incidents were linked to supply-chain issues, service user non-attendance and local ordering processes, rather than wider system failures. Increased pharmacy technician support and strengthened local arrangements are in place to improve availability and reduce missed doses. No significant concerns related to electronic prescribing were identified and the Trust will be joining a national quality assessment in order to provide further external assurance on prescribing safety.

MK sought assurance on managing deteriorating physical health for service users. CJ advised that electronic assessment devices are being rolled out across inpatient services to automate NEWS2 (National Early Warning System) scores, reduce errors and strengthen escalation. The Physical Health Strategy is also being updated and recent audits found no significant concerns with observations but identified scope to improve recording. Electronic monitoring will help to simplify processes and strengthen compliance and assurance.

It was RESOLVED to NOTE the Patient Safety Oversight Report.

TB/26/95b Fuller Inquiry Board Assurance Framework (agenda item 12.2)

CJ presented the Trust's Fuller Inquiry Board Assurance Framework, developed in response to the inquiry's recommendations and subsequent national requirements.

The assurance framework provides a structured assessment of the inquiry recommendations, identifying those applicable to the Trust, and sets out the actions, controls and sources of assurance in place. CJ advised that many of the recommendations have already been considered through existing quality and governance arrangements and a number of actions have been incorporated into wider organisational improvement programmes. The Trust's speaking up arrangements have been updated, strengthening the mechanisms available to staff to raise concerns safely and ensure alignment with national expectations.

The framework consolidates existing assurance arrangements, provides clear oversight of patient safety, professional accountability, speaking up, workforce culture, leadership and organisational learning, aligned to the national recommendations.

It was RESOLVED to RECEIVE the report as assurance, APPROVE the proposed assurance statement and NOTE its submission to NHS England.

TB/26/95c Medical Appraisal / Revalidation Annual Report (agenda item 12.3)

STh presented the annual Medical Appraisal and Revalidation Report and provided a summary of the key points:

- The Trust currently holds prescribed connections for 189 doctors, including a small number working within a partner organisation for whom the Trust remains the designated body.
- The report demonstrates a high level of engagement with the appraisal process, with 97% of eligible doctors completing an appraisal during the reporting period.
- Outstanding appraisals are related to timing issues associated with appraisal completion dates rather than concerns regarding engagement or compliance.
- Quarterly monitoring continues through the IPR to provide ongoing oversight of appraisal activity and performance.
- Eight positive revalidation recommendations have been made. One has been appropriately deferred pending sufficient multi-source feedback, with no concerns about professional practice or performance.
- Regular engagement with the General Medical Council and Employer Liaison Adviser ensures the Trust's arrangements remain compliant with national requirements.
- There is a well-established cohort of trained appraisers, robust quality assurance processes and regular appraiser development sessions.
- Face-to-face appraiser training continues ensuring consistency of approach and supporting ongoing professional development.
- Positive feedback from doctors was noted, with 99% of respondents indicating that they would be happy to have the same appraiser for future appraisals, demonstrating a high level of confidence in the process.
- Further work will focus on strengthening continuing professional development arrangements for doctors undertaking educational roles and ensure that appraisal processes continue to support both professional development and organisational objectives.

CW sought assurance regarding the sustainability of the appraiser workforce and whether sufficient numbers of doctors were coming forward to undertake appraiser roles. ST confirmed that new consultants are encouraged to gain experience before expressing an interest in becoming an appraiser, following which they undergo a structured recruitment, training and development process.

MK welcomed the positive assurance provided by the report and sought clarification regarding the small proportion of appraisals that had not been completed within the required timescales. STh advised that where delays occur, they are reviewed individually to understand the circumstances and provide support where required. Appraisal quality is actively monitored and feedback from doctors is used to support appraiser development. In rare cases where concerns regarding appraisal quality are identified, additional support and oversight arrangements are implemented to maintain the integrity of the appraisal process.

NMc noted that the report had been considered by both the People and Remuneration Committee and the Quality and Safety Committee prior to Board approval and suggested that future governance arrangements be reviewed to minimise duplication whilst maintaining appropriate oversight.

Action – Andy Lister

It was RESOLVED to APPROVE the Medical Appriasal – Revalidation Annual Report.

TB/26/95d Sustainability Annual Report (agenda item 12.4)

SB provided an update on progress against the Trust's Social Responsibility and Sustainability Strategy and Green Plan:

- Responsibility for oversight of sustainability has been transferred to the Transformation, Innovation and Sustainability Committee (TISC).
- Sustainability work continues amid increasing climate impacts and uncertainty about future system leadership and ICB oversight. However, the Trust remains committed to its sustainability ambitions and embedding social responsibility in decision-making.
- Considerable progress has been made across a range of sustainability initiatives during the reporting period, demonstrating successful local innovation and improvement activity. Future work will move beyond measuring sustainability activity towards demonstrating tangible reductions in environmental impact and carbon emissions.
- A review of the existing performance framework has taken place and a revised set of performance measures are being developed to provide clearer accountability and stronger focus on outcomes.
- There is increasing focus on climate adaptation alongside carbon reduction and work is underway to strengthen the resilience of the Trust's estate and services to climate change and extreme weather.
- Future work will focus on targeted, measurable carbon reduction through initiatives including solar energy, sustainable infrastructure and estate modernisation.

CW sought assurance regarding the Trust's ability to access external sustainability funding and capital investment opportunities. AS confirmed that the Trust had been successful in securing external funding for several projects, including solar energy schemes. However, future funding opportunities are likely to require organisations to contribute a proportion of the capital investment themselves.

In relation to reducing medicines waste and improving medicines sustainability, CW asked whether appropriate systems were in place to manage the storage and usage of medicines. STh confirmed that medicines stock management is actively monitored and work is taking place to improve procurement, storage, prescribing and discharge arrangements in order to minimise waste and ensure effective use of resources whilst maintaining patient safety.

It was RESOLVED to NOTE the Sustainability Annual Report.

TB/26/95e Winter planning (agenda item 12.5)

AF presented the Board Assurance Framework (BAF) for Winter Planning and advised that the self-assessment forms part of the Trust's annual assurance requirements and is submitted to the ICB following Board approval. AF summarised the key points:

- The BAF has been reviewed through a Quality Impact Assessment process to ensure potential risks to service quality and patient care have been appropriately considered.
- The report identified a number of areas of strength, particularly the support provided to acute sector partners and the established arrangements for managing seasonal demand.
- Areas of risk and dependency are identified, including factors that are outside the Trust's direct control, e.g. patients who are clinically ready for discharge, and the potential impact that delays within wider system pathways have on bed capacity, patient flow and operational resilience during the winter period.
- Successful delivery of elements of the winter plan remains dependent on support from acute Trust partners, particularly in relation to medical workforce arrangements. Workforce rotas are planned in advance, however, there are risks associated with the availability of external medical support and the potential need to utilise bank staffing arrangements during periods of increased pressure.

CW requested clarification regarding the risks associated with acute medical support for community hospital and Hospital at Home services. AF confirmed these services operate as joint arrangements

with acute sector partners and rely on partner organisations being able to provide and mobilise appropriate clinical cover. Discussions are underway to explore a more formalised mutual aid or memorandum of understanding approach that would support the movement and deployment of staff during periods of significant operational pressure.

It was RESOLVED to APPROVE the Self Assessed Board Assurance Framework for Winter Planning for 2026/27.

TB/26/95f Out of Area Placements (agenda item 12.6)

AF provided an update on out of area bed placements and regional expectations for the Trust to reduce planned out-of-area placements to zero.

AF advised that while the Trust aims to eliminate all inappropriate placements, operational dependencies currently prevent a zero target. The Trust has previously reduced its planned out-of-area placement trajectory in its three-year plan submission from five to three (by March 2029) and a further reduction to zero would require wider system support. AF confirmed that current placements are clinically appropriate and do not reflect poor capacity management. Three options were presented, with the recommended position of retaining the aim to eliminate out of area placements whilst recognising the practical constraints currently affecting delivery. This approach would provide a realistic reflection of the current position and allow meaningful dialogue with regional colleagues regarding the support required from partner organisations to achieve future reductions.

MBr added adopting a plan of zero would not accurately reflect the operational realities facing the Trust and stressed the importance of maintaining a credible and evidence-based plan that recognises the genuine challenges associated with inpatient capacity, discharge delays and system pressures.

STh highlighted the need for wider system partners to support the Trust in addressing barriers to discharge and patient flow in order to achieve zero out of area placements. Challenges relating to delayed discharges, Ministry of Justice processes and access to appropriate placements are all contributing factors that are beyond the sole control of the Trust.

It was RESOLVED to NOTE the Out of Area bed assumption from three to zero, CONSIDER the clinical, operational and system constraints set out in this paper, SUPPORT/AGREE retaining three out-of-area beds as the Trust's current operational planning assumption with the longer-term aspiration of zero but the plans submitted remain at three.

TB/26/95g NHS Oversight Framework (agenda item 12.7)

Following discussion under item 11.1, AS advised that the paper provides an explanation of the NHS Oversight Framework (NOF) scoring process and confirmed that the framework consists of twenty five indicators in total. It was noted that not all scoring methodologies have been published nationally despite the release of the overall ratings.

It was RESOLVED to NOTE the update on the NHS Oversight Framework for 2026/27.

TB/26/96 Integrated Care Systems and Partnerships (agenda item 13)

TB/26/96a South Yorkshire update including South Yorkshire Integrated Care System (SYICS) (agenda item 13.1)

MBr provided an update on developments across the Integrated Care System (ICS), including changes within South Yorkshire and West Yorkshire Integrated Care Boards (ICBs), provider collaborative arrangements and Place Provider Partnerships:

- The new ICB operating model formally went live on 1 September 2026 and recruitment and redeployment activity is ongoing.

- The South Yorkshire ICB is currently reporting a £1.8m deficit position linked to assumptions regarding deficit support funding.
- Both South and West Yorkshire systems have come under scrutiny regarding talking therapies performance. The Trust continues to achieve the required recovery rates.
- Leadership changes were noted within Doncaster & Bassetlaw Hospital resulting in further changes at both Barnsley and Rotherham hospitals.
- The South Yorkshire Mental Health, Learning Disability and Autism Collaborative recently reviewed progress against its identified priority programmes, including eating disorders and out of area bed placements and also considered the approach to the Mental Health Investment Standard. Work continues to ensure that mental health, learning disability and autism providers remain influential within system planning and investment discussions.
- Barnsley's Place Provider Partnership (PPP) meeting discussed alignment with the future Health Commissioner role and the consultation related to single and multi-provider contracts.
- A recent leadership event discussed the three core workstreams which are centred on improving discharge, neighbourhood health care and Hospital at Home developments. The event brought together wider system leaders to strengthen collaboration and prepare for increased place-level responsibility, including functions previously held at ICB level.
- There is ongoing focus on winter planning and improving system flow through place-based arrangements.

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

TB/26/96b West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update (agenda item 13.2)

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:

- MBr advised that developments in West Yorkshire regarding operating model and recruitment and redeployment into the new structure largely mirror those in South Yorkshire.
- As organisations adapt to the new ICB operating model and workforce restructuring, there is increased emphasis on collaborative provider leadership and locality-based delivery arrangements.
- Within Wakefield there is a proposal to bring together the existing Mental Health Alliance and Learning Disability and Neurodiversity Alliance into a single alliance structure.
- Place Provider Partnership discussions have focused on future community investment priorities and service transformation opportunities, particularly developments within older people's services.

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/26/96c Specialised Provider Collaboratives and Alliances (agenda item 13.3)

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

- Specialised collaboratives continue to perform well from an operational perspective.
- Demand and capacity pressures continue across some specialist services therefore appropriate governance and performance arrangements remain in place.

- The position across most collaborative programmes remains in line with expectations and partnerships continue to support the delivery of specialist services across the wider region.
- In adult secure services, pressures remain closely linked to challenges in delayed discharges, limited availability of community placements and increasing demand across the regional system.
- Providers are working collaboratively to manage specialist service activity, resources and performance, improve access and pathways and address system-wide challenges collectively.

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

TB/26/97 Governance (agenda item 14)

TB/26/97a Trust Seal (agenda item 14.1)

Andy Lister (AL) confirmed the Trust Seal had not been used during the reporting period.

It was RESOLVED to RECEIVE the update on the Trust Seal.

TB/26/98 Strategies and Policies (agenda item 15)

TB/26/98a Estates Strategy Update (agenda item 15.1)

AS provided update on progress against the Trust's Estates Strategy and the paper was taken as read:

- Work on the Older People's Services development continues to progress and a report seeking approval of the guaranteed maximum price for the scheme will be presented to a future Board meeting.
- Exisiting Barnsley Local Improvement Finance Trust (LIFT) contracts are approaching expiry therefore future ownership and landlord arrangements for a number of primary and community care premises require review. The Trust occupies a significant proportion of space within these buildings and has been asked to consider assuming the role of landlord. AS advised that this presents both opportunities and risks for the Trust and any future proposal would require careful assessment of the financial, operational and strategic implications, including funding arrangements, ongoing maintenance liabilities and alignment with the wider estates strategy.

GE raised concern that meetings with local authority colleagues regarding the New Street development had been cancelled and sought assurance on the impact on delivery. AS was unaware of the cancellations and agreed to look into this further.

Action – Adrian Snarr

It was RESOLVED to RECEIVE and NOTE the update on progress against the Estates Strategy priorities for 2026/27.

TB/26/98b Research and Development Strategy (agenda item 15.2)

STh presented the Trust's five-year Research and Development (R&D) Strategy. The paper was taken as read and STh highlighted the key points to note:

- Strategy developed through the Executive Management Team (EMT) and QSC and sets out a framework to position the Trust as a regional and national leader in research and innovation, building on progress since 2022.
- The strategy has adopted an inclusive approach to research and innovation and is closely aligned with the Trust Strategy, Clinical Strategy and People Strategy.
- Underpinned by three core strategic aims, the strategy focuses on workforce development, partnership working, and innovation-led change.

- A key focus of the strategy is to ensure that research activity remains connected to operational priorities and contributes directly to improvements in patient outcomes, workforce development and service transformation.
- Significant progress achieved in recent years includes successful partnerships with universities and research organisations, increasing levels of research funding and development of a strong research infrastructure.
- Substantial research investment has been secured and the Trust has been recognised nationally as one of the leading mental health trusts for research activity.
- The strategy sets out governance arrangements and monitoring mechanisms to ensure delivery and accountability.

MW asked whether there is an opportunity to consider research activity as a partner or host and queried whether the Trust would like to lead research activity. STh agreed that establishing clearer priorities is important and advised that a number of current and planned research programmes already align with strategic priorities such as health inequalities, population health and the interaction between mental and physical health. CJ acknowledged the considerable research capability across the multidisciplinary workforce, including advanced practitioners and non-medical professionals who are increasingly leading and publishing research. Work is underway to strengthen implementation of research findings and ensure that evidence generated through research activity translates into improvements in clinical practice and patient outcomes.

SB added that many of the emerging research priorities align closely with the ambitions established through the Trust Strategy, particularly in relation to health inequalities, population health and integrated working, and suggested that there would be value in linking future research prioritisation more explicitly with the strategic ambitions previously agreed by the Board.

JB sought assurance that research investment was delivering measurable benefits. STh confirmed that this is an area of focus for the Research and Development team and impact evidence is collected for funders and external bodies.

It was RESOLVED to RECEIVE and APPROVE the Research and Development Strategy.

TB/26/98c Customer Services Policy (agenda item 15.3)

The Customer Services Policy was omitted from the papers due to a distribution error. CJ confirmed that the policy was time-sensitive due to its relevance to ongoing regulatory and quality assurance requirements. The policy requires Board approval.

It was agreed the policy should not be approved without members having an opportunity to review the content. Therefore, the policy will be circulated separately to Board members for review and comment. Subject to satisfactory review and consideration of any comments received from Board members, delegated authority will be given to the Chair and Chief Executive to approve the policy.

Action – Andy Lister

It was RESOLVED to RECEIVE and APPROVE the Customer Services Policy.

TB/26/99 Trust Board work programme for 2026/27 (agenda item 16)

The Trust Board work programme for 2026/27 was noted.

It was RESOLVED to RECEIVE the work programme.

TB/26/100 Date of next meeting (agenda item 17)

The next Trust Board meeting in public will be held on Tuesday 27 October 2026 at Kendray Hospital, Barnsley.

TB/26/101 Any other business (agenda item 18)
No further business.

Signature:

Date:

South West Yorkshire Partnership Teaching NHS Foundation Trust

TRUST BOARD 29 September 2026 – ACTION POINTS

= completed actions

Actions from 29 September 2026

Min reference	Action	Lead	Timescale	Progress
TB/26/92	Report on the Independent review of the Women's pathway to be presented to Trust Board in October	Adele Fox	October 2026	Women's Pathway paper on Trust Board agenda for 27 October 2026.
TB/26/93(1)	Review future Members' Council agendas to allow sufficient time for meaningful discussion of key items	Andy Lister	October 2026	Agenda for November Members' Council was reviewed through Members' Council Coordination Group on 7 October including Chair and Lead Governor and agreed appropriate timings for items.
TB/26/93(2)	Provide a clear timeline of the work underway by MHAC and QSC to simplify clinical processes, reduce administrative burden and address recurring findings	Caroline Johnson	October 2026	A report was presented to 13 October QSC outlining the reducing clinical admin burden programme plan. This provided clear timescales for each action within the plan. The next report to QSC in relation to progress will be provided in January 2027, by which time a substantial number of the key actions will be complete.
TB/26/93(3)	Happiness programme to be presented as a future Board story	Andy Lister	October 2026	This is the Board story for October 2026.
TB/26/95c	Review committee governance arrangements between QSC and PRC in relation to Medical Appraisal / Revalidation Annual Report to minimise duplication of reports presented to committees	Andy Lister	November 2026	

With all of us in mind.

TB/26/98a	To look into the cancellation of meetings in relation to Health on the High Street and clarify the impact on delivery of the New Street development.	Adrian Snarr	October 2026	The executive meeting for the initiative was chaired by the Leader and has been stood down. However, the HotHS Board that is attended by DL is still meeting and the project is progressing. At each meeting all partners provide updates, and the project is working through the RIBA stages. The next meeting is scheduled for Friday 13th November.
TB/26/98c	Customer Services Policy to be circulated for comments. Subject to satisfactory review, delegated authority to approve the policy to be given to the chair and CEO	Andy Lister	October 2026	Customer services policy was sent to all Non-Executive Directors and comments and responses were received prior to finalisation via the Chair and Chief Executive on Friday 2 October 2026.

Actions from 28 July 2026

Min reference	Action	Lead	Timescale	Progress
TB/26/74(1)	Review how equality, diversity and inclusion considerations have been integrated across the Board committee structure after six months.	Izzy Worswick	January 2027	Internal governance structure has been updated to document new governance arrangements and is on the October agenda.
TB/26/74(2)	Revised financial recovery plan to be developed with a revised trajectory aimed at returning the Trust to a break-even position	Adrian Snarr	October 2026	Financial forecast updated based on month 6 figures. No material reduction in risk. Technical solutions incorporated into latest risk and opportunity forecast tracker, to be discussed in Board following FIP (see triple A). A range of actions have been agreed at delivering value group (CEO led).
A report)	Explore further presentation refinements in future BAF iterations to provide clearer visual indication of how each strategic risk aligned with the Board's agreed risk appetite, to help identify areas outside tolerance.	Izzy Worswick	October 2026	A table in appendix 1 to the BAF shows risk scores against risk appetite to show areas outside appetite.
TB/26/75b(1)	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.	Adele Fox	October 2026	Risk reviewed with proposal to merge risks 1530,1839, 1319 and 2063 to be presented to Trust Board in October.

TB/26/75b(2)	Consider incorporating learning from the culture review commissioned by PRC within the controls and assurance arrangements for risk 1887 (speaking up).	Izzy Worswick	October 2026	Learning from the culture review was considered as part of the review of risk 1887.
TB/26/75b(3)	Executive leads to consider splitting risk 1888 (sexual safety) into separate components and bring any recommendations back to Trust Board.	Caroline Johnson/Christine Brereton	October 2026	It has been agreed that the risk will remain as a combined risk currently as the two components intersect in many cases.
TB/26/75f	Further update on progress against the National Staff Standards self-assessment framework and implementation plan to be brought back to the Board in December 2026	Christine Brereton	December 2026	

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 8

Private/Public paper:	**Public**		
Title:	**Chief Executive's Report**		
Lead Director:	**Mark Brooks - Chief Executive**		
Mission/values:	As an all-encompassing report this reports aligns fully with the Trust mission and all of its values		
Purpose:	To provide the strategic context for the Trust Board conversation.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	All risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships.	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:	During the week commencing 28 September the Care Quality Commission (CQC) inspected our CAMHS services over the course of three days. The inspections covered our services in Barnsley, Wakefield, Calderdale, and Kirklees. Similarly, the CQC inspected our older adult mental health services during the week commencing 12 October. We were pleased to welcome the CQC to our services and I would like to thank all colleagues involved in the inspections. At the time of writing this report we have received summary written feedback from the CAMHS inspection which is incorporated within this month's papers to Trust Board. It is expected that the written feedback from the older adult services inspection will be received prior to the Trust Board meeting so a verbal update will be provided at the meeting with a paper provided to the November Trust Board. At a recent meeting hosted by NHS England for the North-East, Yorkshire and Humber region the findings of the Aubrey Report carried out at County Durham		

With **all of us** in mind.

and Darlington NHS Foundation Trust were presented. These findings will be shared in more detail with the Trust Board at its November meeting. Key headline learnings that could apply to any Trust Board include a focus on reassurance rather than assurance, not acting on information that suggested performance issues, a lack of triangulation, and similar lack of confidence in speaking up. These reports are always salient reminders of how things can go wrong and that as a Trust Board the importance of constructive challenge and curiosity needs to remain strong.

On a similar theme this Trust Board meeting includes a report regarding the review by Lady Justice Thirlwall into the concerns at the Countess of Chester Hospital. All Trust Boards have been asked to consider this review. Trust Board members are familiar with the process we adopt to review independent reports and this report that exposes serious governance concerns is no exception. We will continue to engage with these reports and wider NHS system to challenge our own approach and processes to ensure the care we provide is safe and delivered in way that fully aligns with our Trust values and best practice.

Our flu vaccination programme for this Winter has commenced. The benefits of receiving the vaccination are well documented and we are encouraging all our colleagues to take up the offer. We have built on what was learnt last year and at the time of writing this report 1,144 (25%) colleagues have already had the vaccination. This is a similar level of vaccinations completed compared to the same time last year.

The final report from the independent review of mental health conditions, ADHD and autism, chaired by Dr Peter Fonagy, was published in October. The report consists of 607 pages so we will summarise the report and take it via the Board Committee route before having a fuller view at our Trust Board in the near future. Some key headlines to make Trust Board members aware of are summarised as:

- There is a real rise in distress and a particular impact on young people
- People should be able to access prevention, wellbeing, early help and practical non-clinical support without needing a diagnosis first.
- Health, social care, education and employment services need to work together more effectively around people's needs.
- Rapid access to quality-assured assessment and specialist clinical care should be protected for those with the greatest need.
- Success should be measured by whether support improves people's quality of life, functioning and participation.
- The report acknowledges rising levels of mental distress, particularly among children and young people and young women, and highlights ongoing challenges around underdiagnosis and misdiagnosis. It emphasises gaps in the evidence base and argues that support should be better aligned to need rather than relying on diagnosis as the primary gateway to services

At the time of writing this report 1,832 (32.5%) of colleagues have completed the 2026 NHS staff survey. As previously reported, we place great importance on receiving feedback from colleagues so we can take action to improve in the future.

The Trust's financial position remains challenging with a deficit of £1.8m recorded at the end of month 6. This shows an improved cumulative position

following confirmation of some non-recurrent income in the last month. Work continues to further tighten grip and oversight as we maintain drive and focus on delivering our year-end break-even target whilst maintaining safety.

During October we have been celebrating black history month. I was delighted to handover an issue of the weekly View that we circulate to all colleagues to Manreesh Bains and Allyson Ominiyi, who articulated an excellent and thought-provoking message. Manreesh and Allyson are chair and vice-chair of our race equality and cultural heritage network and reminded us that we all have a key role including 'a willingness to listen when experiences are uncomfortable to hear, to recognise inequalities when they are brought to our attention, and to take responsibility for the changes that are needed'. As a Trust we take our equality, diversion and inclusion responsibilities seriously and as a Board we need to continually challenge ourselves regarding how we can improve the lives and experiences of everyone who uses our services and works for us.

The Equality and Human Rights Commission's (EHRC's) Code of practice for services, public functions and associations came into force on 5 August 2026. It provides statutory guidance on the implementation of the Equality Act 2010 and has implications for NHS organisations, both as providers of services and as employers. To support NHS organisations in the provision of single-sex services in line with the relevant legislation and statutory guidance, NHS England has published a) Privacy, dignity and safety in hospital accommodation and b) on NHS staff facilities – new guidance on the provision and use of NHS staff facilities. We are carefully reviewing this guidance to identify any changes that we need to make.

At a recent national event for leaders of trusts in the mental health, learning disability and autism sector attended by Dawn Lawson in her capacity as deputy chief executive, there was clear focus on payment mechanisms and the work taking place to deconstruct block contracts, the development of an updated mental health strategy, and neighbourhood care.

Both nationally and regionally there is considerable work taking place on winter preparedness with increases in respiratory illnesses already being experienced. The focus on operational and financial performance needs to remain in place as the challenges of Winter are met.

Both South and West Yorkshire integrated care boards (ICB) have commenced working to their new operating models and the final stages of recruitment and redeployment are in motion. As place provider partnerships have now been operating in shadow for just over six months each place is taking the opportunity to consider what has worked well to date, what needs to change and how positive impact can be made on the health of our communities.

Our operational performance largely remains good with the Trust continuing to meet many national, local and internal targets. The main issues of note are very similar to what has recently been reported to Trust Board in recent months with high demand and complexity across many services which results in constant pressure on our inpatient wards. Out of area bed usage remains relatively low and our people metrics are consistently strong, including appraisal compliance. Focus remains on the quality of risk assessments and care planning.

	The focus of this Trust Board meeting is on business and risk. The nature of the reports regularly received at our Board effectively illustrate the risks that are pertinent to the environment in which we operate. Clear examples of this in the October agenda are our learning from healthcare deaths report, the review of the women's pathway, the Thirlwall report and freedom to speak up report. We have a clear focus on risk to support mitigations within our agreed risk appetite. Other key risks under the spotlight currently include the Trust and wider NHS financial position, the impact of changes within integrated care boards, and the sustained demand challenges impacting on our services. We were delighted to welcome members of NHS England's Board to Fieldhead during October. Guests were interested to learn about the Trust and enjoyed service visits to some of our wards. The Trust continues to participate and engage in national awareness days, weeks and event. As examples during October, we have promoted World Mental Health Day, Stoptober, Infection Prevention Control week, Freedom to Speak Up month and stammering awareness day. There have been a number of changes and appointments made at a senior level in partner organisations. Keith Nurcombe has been appointed as chair at Mid Yorkshire Teaching Trust and Caroline Shaw as the interim chief executive at Locala. Therese Patten, chief executive of Bradford District Care NHS Foundation Trust has been seconded to North Lincs and Goole NHS Foundation Trust for twelve months. Phil Hubbard will be interim chief executive during this period. 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. • The Trust was nominated in the Inclusive Organisation of the Year category at the recent Asian Professionals National Alliance (APNA) Award 2026, in recognition of our Connecting People approach. We were honoured with an outstanding contribution to inclusion recognition, acknowledging the work taking place to create more inclusive services, workplaces and communities. • The Trust's volunteer service celebrated its 10th anniversary in September. We now have over 160 volunteers giving over 31,000 hours of time, experience and kindness to our services a year. • In September, the Trust's research and development team shared the story of their inspiring poetry project, The Hope Collective, at the UK's biggest poetry and performance festival hosted by the BBC. As part of the BBC Contains Strong Language Festival's 10th anniversary celebrations, the team presented two sessions on The Hope Collective at MediaCity in Salford. • We successfully rolled out our electronic prescription service (EPS) across ADHD, CAMHS, Barnsley, Calderdale, Kirklees and Wakefield community teams with over 2,000 prescriptions being generated electronically so far. • Our teams came together with local partner organisations in Barnsley to host an informative event marking national Falls Awareness Day 2026 (19 September). A range of supportive services joined forces at Barnsley Market Hall to raise awareness of falls and provide support to visitors.

	• Our Barnsley Stroke service has come top in the country for our results in the SSNAP National audit for stroke. This is a challenging audit so it's a huge achievement for the team.
Recommendation:	**Trust Board members are asked to:** • **NOTE** the Chief Executive's report.



The Brief

1 October 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



On Falls Awareness Day (25 September), our teams came together with local services to offer falls advice and support to people visiting Barnsley Market

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

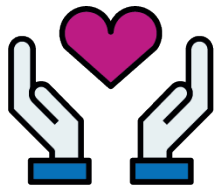
With **all of us** in mind.

JOB NO 5581 MAR26

Updates on our priorities

NHS
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.



Personalised Care Framework
A Trust-wide framework for personalised care planning is moving through final approval and implementation planning, including how outcomes, care plan quality and local service use will be supported.



Caseload management and productivity
The caseload management tool is established in a number of services, and feedback is now being gathered to understand how well it is supporting teams. This will inform further development, consistent use, data quality and links with supportive caseload management, workload planning and productivity.



Reducing clinical administrative burden
Work is progressing on risk assessment and care planning, with care group workshops and process mapping being planned to understand current practice and identify opportunities to reduce duplication.

Patient flow and care closer to home
Work is being brought together on admission pathways, purposeful admission, patient flow and care closer to home, so further priorities, leads and milestones can be agreed.



Children and young people's access and neurodevelopmental waits
Children and young people's services remain above the 75% 18-week target, alongside continued pathway pressure and long waits in neurodevelopmental services. Improvement activity on neurodevelopmental pathways is underway, including testing ambient voice technology to support parts of the assessment process, with further work being planned to pathway map and define the wider 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.

Patients and staff at **Cheswold Park Hospital** came together for a successful Physical Health Fair, promoting healthy lifestyles through interactive activities on topics including exercise, nutrition, sleep, infection prevention and falls awareness. Highlights included a static bike challenge, healthy eating advice from a Trust dietitian and a falls prevention escape room, helping service users learn practical ways to improve their health and safety. The event demonstrated strong partnership working and a shared commitment to supporting physical and mental wellbeing. Read more on the Trust website.

Stoptober is back this October, encouraging smokers across South and West Yorkshire to quit for 28 days, making them five times more likely to stop for good. Since launching, more than 2.5 million people have used Stoptober to begin their smokefree journey. Support is available from Yorkshire Smokefree and the Trust's Quit Team for staff, service users and local residents. Read more on the intranet.

Applications open for Medical Research Council BEACON Award. Healthcare professionals across the North of England are invited to apply for a new funding opportunity designed to support clinical academic career development at key transition points.

The West Yorkshire ICB has secured funding for an extensive **winter health and wellbeing campaign**, which will include all elements of healthcare including mental health. We are a part of the initial planning for this campaign. If you would like to find out more please contact our communications team.

There is still time 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.

Celebrating 10 years of our volunteer service
This September marked a significant milestone as the Trust's volunteer service celebrated its 10th anniversary. We have over 160 volunteers giving over 31,000 hours of time, experience and generous kindness to our services a year. Find out more on our website.



Earlier this year, we once again welcomed guests from ASL Gallura, a **public healthcare** organisation based in Italy to the Laura Mitchell Health and Wellbeing Centre, as part of the regular teaching sessions delivered by Calderdale Core Pathway for mental health professionals.

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:

- Continued 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
- Information Governance Breaches
- Medical Devices
- Fire

A new **operational risk management procedure** has been approved introducing minimum standards for review of risks on Datix and presentation of risk reports to Care Group governance meetings. The procedure can be found on the intranet.

There is also risk management training available via e-learning for band 6 staff and above, found at ESR - 378 Risk Management Training (ELearning).

Accessing patient data – don't let curiosity kill your career

All staff have a legal and professional duty to protect confidential information. Patient records must only be accessed when there is a legitimate work-related need as part of your role. Unauthorised access to patient information is unlawful and undermines the trust that patients place in our services. Recent national communications from NHS England reiterates that, in almost all cases, unauthorised, inappropriate or unjustifiable access to patient records is likely to constitute gross misconduct

NHS England has issued new guidance for NHS organisations on preventing, detecting and investigating inappropriate access.

Thank you for your continued commitment to protecting patient confidentiality and maintaining high standards of information governance.

Best quality

Our performance in August

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

- **52.9%** of people completing Talking Therapies treatment and moving into recovery
- **100%** of Talking Therapies referrals beginning treatment within 18 weeks. **98.9%** within 6 weeks.
- **92%** of MH service users followed up within 72 hours of discharge from inpatient care
- **75.2%** assessed within 14 days
- **92.8%** inpatient risk assessment completed within 24 hours before or after admission
- **92.7%** on community active caseload at month end with a risk assessment which has been reviewed within the last year
- **89.5%** of people died in a place of their choosing
- **85.2%** in CAMHS services waiting less than 18 weeks for treatment

Find out more about Word360 and our interpreter services on Friday 23 October. The sessions focus on how we can continue to improve accessible communication and make the most of the support available. To register, email Gary Garvey – places are limited.

Friends and Family: 86% of people in our mental health services rated us good or very good. 97% in our physical health community services.

Our **customer services** team dealt with 40 new formal complaints in August, a 3% increase from last month. 21 complaints were closed and 100% were closed within the six-month statutory timeframe. There has been a 32% decrease in the number of compliments received.

The Barnsley Integrated Community Stroke Team has been recognised for having the recommended services and personnel to deliver high-quality care after achieving excellent results in the latest Sentinel Stroke National Audit Programme (SSNAP)) organisational audit. The results highlight the strength of Barnsley's integrated approach to stroke rehabilitation and recovery, with services receiving the highest ratings among comparable services across South Yorkshire. Read more about this on the intranet.

Congratulations to the Art Recovery and Creativity group at Newton Lodge who received a commended award from judges at the Koestler Awards 2026. The ARC group is a cross-pathway group for service users from all wards, who spend time with others engaging in meaningful creative activity to support recovery. The artwork was designed and created by a collaboration of 7 service users over 7 weeks, inspired by this year's themed category…'Roots'.



Best quality

Our performance in July

South West Yorkshire Partnership Teaching NHS Foundation Trust

- **87** inappropriate out of area bed days
- **0** child / young person under 18 in an adult inpatient ward
- **5.2%** of service users clinically ready to discharge. There were 29 people still delayed at the end of the month.
- **95.5%** with care plan that includes service user input/views
- **95.3%** of our service users have their ethnicity equality data recorded, **57.9%** their disability status, **58.7%** their sexual orientation, and **99.6%** deprivation (postcode)
- We had **10** information governance breaches

Make sure you follow the Trust's approved **document management procedure** (available on the intranet) when scanning and filing patient documentation in SystmOne. Scanned documents should not be dragged and dropped directly into a patient record via the Communications and Letters section in SystmOne, as this may result in risk to patient safety and patient documentation being stored incorrectly within the clinical record.

Gemma Hinchliffe took over the Trust role for Person in a Position of Trust (PiPoT) and Local Authority Designated Officer (LADO) from 1 October 2026. Gemma's role has oversight of any PiPoT concerns which often arise in relation to professional conduct, boundary issues, allegations of abuse, criminal behaviour, or behaviour outside work that may affect a person's suitability to work with vulnerable adults. Her LADO involvement is required where concerns relate to children or a professional's behaviour poses a potential risk to children.

We have now successfully rolled out our electronic prescription service (EPS) across ADHD, CAMHS, Barnsley, Calderdale, Kirklees and Wakefield community teams with over 2,000 prescriptions being generated electronically so far. Thank you to all teams involved in the rollout.

"It's enabled me to offer a safer, quicker and beneficial service to my patients." – Staff member

"It has made it more efficient and user friendly for the ADHD brain. Reduced my anxiety around getting my medication considerably."
- Service user

Are you trained as an Incident Support Facilitator? As part of reviewing our staff psychological support offer, we would like to know who is trained to offer psychological debriefs following an incident. Please complete this survey.

Best quality

Getting your flu vaccination

NHS
South West Yorkshire Partnership Teaching NHS Foundation Trust

It's time to book your flu vaccination



How you can get yours

- **Look out for an email from VaccinationTrack** which will include all the information you need to register on our system and book a clinic slot
- Visit the intranet for **drop in clinic dates**
- **Contact a peer vaccinator** – these are your colleagues who have been specially trained to give the flu vaccination. Contact any one of them in an area convenient to you and they'll arrange a quick and easy way for you to have your vaccination.

A little thank you

To say thank you for your support in helping to keep yourselves, your loved ones, service users and colleagues safer, we'll be awarding a £25 Amazon voucher in two draws at the end of October and the end of November. Record your vaccination status on VaccinationTrack to be in with a chance.

Got any questions?

If you've got any questions or need any support to book your vaccination, contact our dedicated email address.
fluvaccinations@swyt.nhs.uk

Flu myths and facts

MYTH: "I'm healthy, so I don't need the vaccine"
Fact: Being healthy doesn't stop you from catching or spreading flu. You may not have symptoms but can still pass it on to vulnerable people.

MYTH: "I've had flu vaccines in the past, so I don't need one this year"
Fact: The flu viruses can change from one winter to the next. The flu vaccine is needed every year for protection.

MYTH: "The vaccine might make me ill"
Fact: The flu vaccine cannot give you flu. Side effects like mild fever or sore arm are common and short-lived. It could reduce the chance of you becoming seriously ill and help you recover faster if you get ill.

MYTH: "The vaccine doesn't work"
Fact: Last year, the flu vaccination programme prevented an estimated 104,000 hospital admissions and 7,100 deaths. It could reduce the chance of you becoming seriously ill and help you recover faster if you get ill.

Nothing about me without me

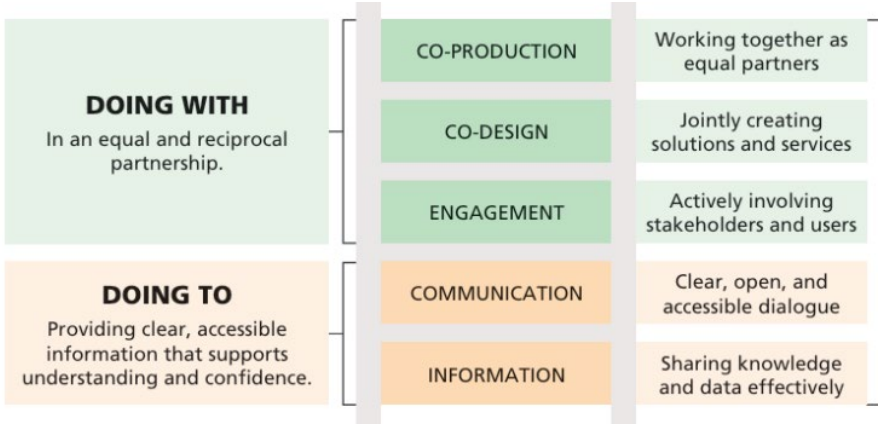
Our involvement approach

South West Yorkshire Partnership Teaching NHS Foundation Trust

Our Trust Involvement approach is a simple way to show the different opportunities we have to involve services users, carers and members of the community.

When planning service improvements, pathway developments, quality improvement projects or changes to services, use the **Ladder of Involvement** to identify the most meaningful approach. Wherever possible, move beyond simply informing people and seek opportunities for engagement, co-design and co-production.

Ladder of Involvement



Tell Us What's Being Heard

We know valuable feedback is being gathered every day across teams and services, but we cannot evidence its impact unless it is shared. We are asking colleagues to submit:

- Service user feedback and patient stories
- Carer feedback
- Community insight and feedback from forums, groups and events.

This information will inform our **Nothing About Me Without Me Report** and help us demonstrate the difference involvement is making.

Experience of Care

We are completing the NHSE Experience of Care Framework self-assessment to understand how well we listen to feedback, learn from experiences and improve care. The review will highlight strengths, identify areas for development, and showcase existing good practice across services. Colleagues are being asked to provide evidence of feedback, engagement and improvement work, helping to strengthen a culture of continuous learning and improve experiences for patients and carers.

If you have an involvement idea or any feedback contact one of the team on involvingpeople@swyt.nhs.uk

Best place to work and learn

Our performance in August

South West Yorkshire Partnership Teaching NHS Foundation Trust

- **5.7%** sickness rate for the month.
- The rolling 12 months sickness rate is **5.3%**

As of 30 September, **89.2%** of colleagues had recorded a completed appraisal. If you haven't done so already book yours in as soon as possible.

Our **leading well** conversations continue. Please share your thinking and conversations via leadingwell@swyt.nhs.uk. A range of information and resources to support your leading well conversations is available on the intranet.

Colleagues from across our services are invited to attend the **Trauma Informed Celebration and Learning Event** on 11 November at the Priory Centre in Barnsley. The day will bring together colleagues for learning, discussion and collaboration, focusing on trauma informed approaches, quality improvement and better outcomes for our staff, service users and communities. More info is on the intranet.

October marks **Freedom to Speak Up** Month and this year's theme is *"Back to Basics: 10 Years On."* It's an opportunity to raise awareness of the importance of creating an environment where everyone feels safe to speak up, listened to, and where meaningful action follows. Join our online FTSU drop-in sessions throughout the month. Find out more.

We've launched our Health and Wellbeing Resource pack to share information and resources from the **Occupational Health and Wellbeing** team. The pack includes various posters, leaflets, and guides that can be used for your team's wellbeing conversations.



Are you interested in improving your **wellbeing at work**, and helping to promote a healthier, more supportive workplace? Live Well Wakefield can help. They offer one-to-one support and workshops to encourage a healthy working life. Find out more on their website.

Did you know our Recovery and Wellbeing Colleges are for staff too? Check out our courses on offer in Barnsley, Calderdale and Kirklees, and Wakefield. There's everything from macrame to mindfulness!

Celebrate **Black History Month** 2026 this October. Keep an eye out for stories shared by our colleagues about their history, culture and the importance of the month. Join us every Friday throughout October in our dining rooms for our Black history Month menu.

We value '**all of you**'. Make sure you update your personal information on ESR, including your equality monitoring information.

Best place to work and learn

NHS Staff Survey: You said. We listened. We're acting. Tell us what's next.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Last year…

- 53% of colleagues participated
- Our Trust priorities were **we are compassionate and inclusive** and **we are safe and healthy**
- Your local priority was an additional People Promise theme
- Putting the data in your hands as soon as it is released

New to 2026

- **Live response dashboard** - See participation across the Trust and target support where needed
- **Year-round improvement cycle** - Listen. Act. Improve. Listen again
- **Aligned to NHS Staff Standards** - Providing a clearer picture of staff experience
- Refreshed intranet pages

Take part in the NHS Staff Survey 2026

Make your voice count! Share your experiences, feedback and what matters to you.

Your Voice. Your Team. Your Future.

The survey closes on Friday 27 November, but we encourage you to participate by Wednesday 25 November to ensure your voice is counted.

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust





With all of us in mind.

Continuously improving

We are changing our ways of working. As new processes become embedded, we're learning, adapting and refining our approach to deliver meaningful and sustainable change for colleagues and services.

Quick facts:

- Your responses are confidential
- Takes around 10 minutes
- Honest feedback matters
- Complete the survey to be entered into the prize draw
- Visit the Staff Survey intranet page for FAQs and resources

You said, we're doing

- Refreshed and implementing the new appraisal process.
- Providing feedback on Our Behaviours.
- Ensuring colleagues have supportive conversations about wellbeing, development and attendance.
- Find out more

The more colleagues who complete the Staff Survey, the richer the insight becomes. That means better data, better decisions and more meaningful improvements for our people.

Best value

Our finances in August

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

Performance Indicator		Year to Date	2026/27 Forecast
	NHS Oversight Framework	1	1
1	Surplus / (Deficit)	(£2.2m)	£0m
2	Agency Spend	£0.7m	£1.8m
3	Bank Spend	£9.4m	£20.7m
4	Financial sustainability and efficiencies	£5.9m	£17.7m
5	Cash	£57.6m	£58.7m
6	Capital Spend	£3.4m	£14.9m
7	Better Payment Practice Code	98%	

The year-to-date financial position in August 2026 shows a deficit of 2.2m. We need to improve our monthly run rate to enable a break-even position to be delivered this year

Agency spend, which continues to be limited to a small number of medical posts, has reduced from £162k to £130k in month.

Bank spend has continued to fluctuate. August is the second monthly reduction, this month due to reduced medical locum costs. The year to date £9.4m represents 7.2% of the total Trust pay bill.

The current cash position continues to be positive at £57.6m.

The Trust continues to progress with 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.

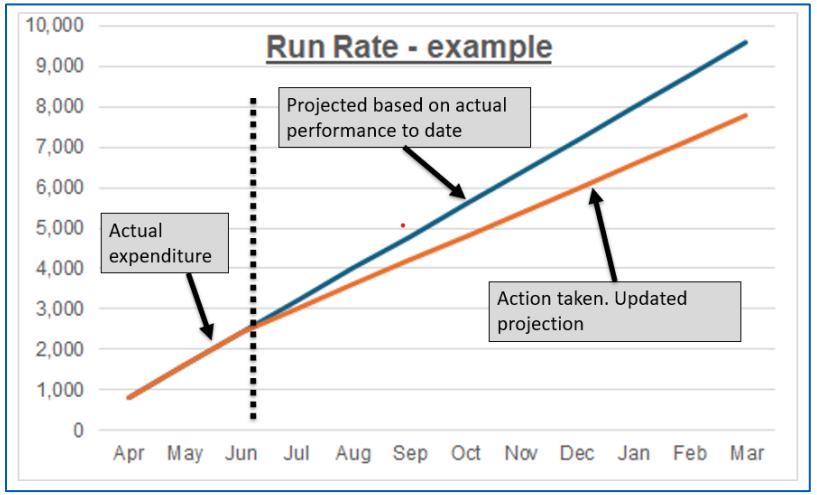
Best value

Managing finances all year round - our run rate

South West Yorkshire Partnership Teaching NHS Foundation Trust

Our run rate is the financial path we're currently on. If nothing changed this is the projected outcome in the future. It helps us understand whether we're likely to achieve our financial plan, overspend or perform better than expected.

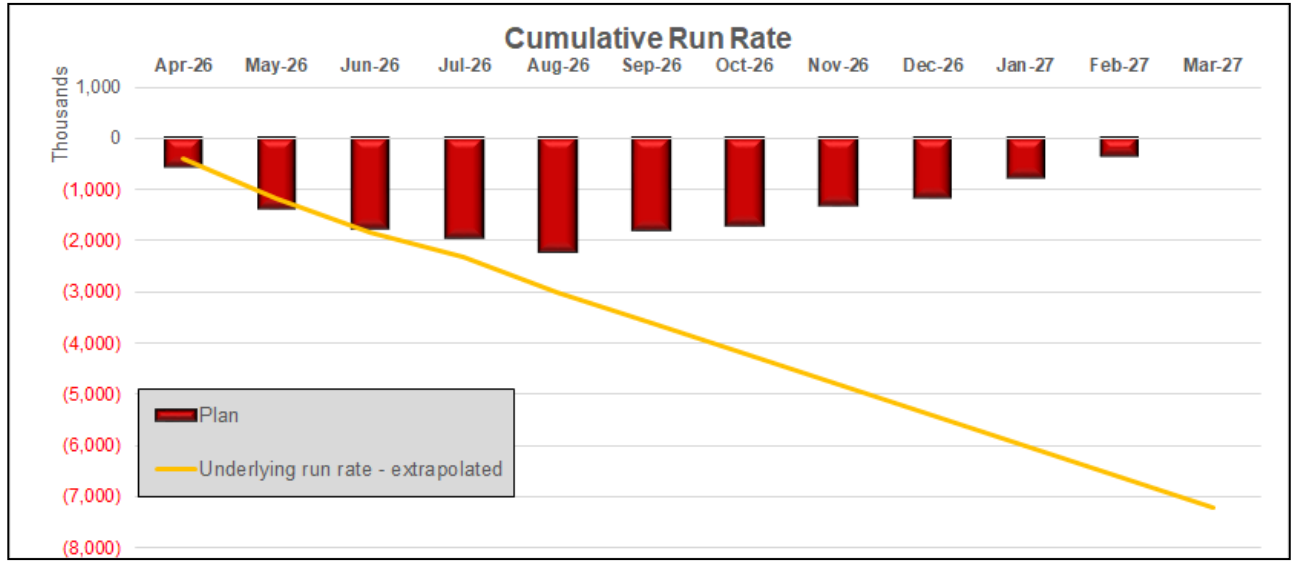
For example, imagine your food shop costs £200 per week. This would mean that your run rate would be £10,400 per year (£200 x 52 weeks). This doesn't mean it's fixed but is an estimate based what you are currently spending. If you took an action to reduce your spend to £150 per week this would reduce your annual run rate to £7,800 per year (£150 x 52 weeks).



Our current run rate, shown on the right, demonstrates that if we continue on our current path we will not meet our financial targets.

This means that we need to really focus on our value for money initiatives for the rest of the financial year. This includes our pay and non-pay expenditure, and will mean we may need to make some difficult decisions in the coming months.

Please do all you can to help us maintain our focus on value for money, reduce our expenditure, and improve productivity.





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.

Don't access patient records unless you have a genuine work-related reason to do so.

Share any service user or carer feedback, comments and stories with our involvement team colleagues.

Share and learn by attending our trauma Informed Celebration and Learning Event.

Protect yourself and those around you by having your flu vaccine.

Help us to improve, Share your views and thoughts by taking part in the NHS Staff Survey.

Take a look at the resources and support available from our occupational health and wellbeing team.

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 27 October 2026
Agenda item 10 – Assurance from Trust Board Committees

Transformation, Innovation and Sustainability

Date	6 October 2026
Presented by	Martin Neeson, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert** • **Capacity & capability**: To note the competing demands for resources that maybe required in the formation of the proposed Place Provider Partnerships. Specifically in the context of the Trust's intent to retain its NOF1 position, the CQC well-led assessment and the route to achieving Advanced Foundation Trust Status. **Advise** • **AI Ambition and Governance**: Current arrangements were received for the adoption of new AI applications and their associated risks & opportunities. It was noted that this is a fast-moving field. The provision of guidance in respect to the governance and applications of respective AI tools is appropriately. It was noted that NHS North England / Deloitte has issued an AI governance framework and that some NHS Trusts had formalised the role of AI Champions within respective Directorates. • **Strategic ambition 3:** The committee received the outputs from the August Trust Board strategy day. How to ensure the success of the strategic ambition and how to translate this to measurable outcomes with delivery clarity was undertaken. This identified the need to focus on those vital few actions that secured success with the appropriate level of structure and resource assigned. • **Male pathway medium secure**: The higher demand for male pathway medium secure Trust commissioned services was noted. It was advised that as a Provider, the Trust was exploring some options that involved collaboration with several external stakeholders. This would be progressed during the period ahead and revisited at the January TISC. **Assure** • **Place Provider Partnerships:** The committee reviewed the progress being made towards the establishment of the West Yorkshire Place Provider Partnerships (PPP) provided to the September Trust Board. The Trust's response to the proposal (in respect to a suggested enlarged scope and as a suggested route to an IHO) was endorsed by TISC. Shadow phase has been extended until April 2028. • **Older people's mental health inpatient transformation:** With the new facility's construction phase due to commence during the current quarter, the case for the investment in respect to the positive transformation of service provision through dedicated specialist wards designed for either dementia or functional mental health needs was received. When complete during 2028 this will enable clearer specialist pathways with tailored therapeutic support and more personalised care being available. • **Estates Strategy:** An update on the progress to delivery of the estate strategy was received. It was noted that it is 'on track' albeit with some challenges, such as capital constraints, capacity and sufficient technical skills (e.g. in respect to converting net zero investment ambitions into viable projects).

With all of us in mind.

Approved Minutes of previous meeting for receiving	Minutes of 21 July 2026

Quality and Safety Committee

Date	13 October 2026
Presented by	Margaret Kitching, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	**Alert:** • **Apparent suicides and associated safety risks**: The Committee received a detailed review of inpatient-related and community apparent suicides. In line with guidance, the inpatient review included deaths occurring within 30 days of discharge and considered deaths on wards, during agreed leave, while absent without leave and following discharge. Recurring themes included leave and discharge decision-making, transitions of care, family involvement, communication of risk information and the period immediately following discharge. Further work is underway to better understand these themes and translate the learning into targeted improvement activity. • Attention was drawn to the concentration of inpatient-related deaths associated with The Dales. The Committee Chair asked whether this intelligence should inform the Trust's quality surveillance approach and whether enhanced surveillance should be considered. Notwithstanding the improvement work underway and areas of partial assurance, the Committee concluded that the continuing level of inpatient-related suicide risk remained sufficiently significant to alert the Board. **Advise:** • **Community nasogastric feeding for children and young people** The Committee received a presentation on the development of community nasogastric feeding for young people with restrictive eating disorders. The Wakefield pilot involved five patient episodes and reported 350 paediatric bed days avoided and estimated savings of £185,000 compared with projected inpatient care. The Committee welcomed the emerging evidence, particularly the potential to support young people closer to home and reduce reliance on inpatient care. Further work will consider scalability, commissioning arrangements, longer-term outcomes and the experience of children, young people and families. • **Reducing restrictive practice**: The Committee was advised of developing Trust-wide work to reduce restrictive practice and seclusion. Care Groups are developing local improvement plans, the Restraint Reduction Network is providing a leadership programme, and work is underway to reposition the restrictive practice team towards greater practice-based support on wards and with complex patients. Learning from areas that have successfully managed complex presentations without access to seclusion facilities is also being shared. A fuller approach to reducing restrictive practice will return to the Committee. • **Women's pathway review**: The Committee received the findings of the external review of the women's mental health pathway. Areas for development included a more clearly defined Trust clinical pathway, greater consistency in trauma-informed and therapeutic approaches, stronger connectivity between community and inpatient services, improved involvement of women and families, workforce development, and environmental issues within inpatient settings. The Committee requested that future consideration focus particularly on the resulting actions, timescales and monitoring arrangements, with the full report able to be noted separately.

	• **Equality, diversity, inclusion and health inequalities**: The Committee received the revised equality, diversity, inclusion and health inequalities assurance report and welcomed the establishment of a clearer reporting route following previous governance changes. It agreed that future reporting should develop a sharper focus on the "so what", demonstrating outcomes and impact alongside activity and process. The Committee also supported strengthening the equality, diversity, inclusion and health inequalities golden thread through other Quality and Safety Committee reports rather than treating it as a standalone agenda item. **Assure:** • **Safer staffing:** The Committee received the revised safer staffing report and gained assurance from the oversight of fill rates, recruitment, temporary staffing, mandatory training and ongoing work to strengthen deployment through SafeCare. It noted the importance of further triangulating care hours per patient day, staffing incidents, supervision and patient safety outcomes to identify whether recurring staffing pressures are concentrated within particular wards. Overall, the Committee considered the report provided a good level of assurance. • **Children and Young People's Waiting List Internal Audit:** The Committee received the internal audit of Children and Young People's waiting-list arrangements, which reported a moderate assurance opinion. Actions are in place, including development of an overarching waiting-list management policy, with progress to continue to be reported to the Committee while actions remain open. The Committee took assurance from both the audit opinion and the planned oversight of outstanding actions. • **Improving equity in access to healthcare:** The Committee received the developing approach to improving equity in access to healthcare. Work is using existing intelligence, including protected-characteristic and deprivation data, alongside service-user and community insight and quality improvement methodology, to understand variation in access and outcomes. The Committee welcomed the direction of travel and agreed that health inequalities and equality, diversity and inclusion require a planned programme of focused oversight across the year, rather than being considered as a standalone issue.
Approved Minutes of previous meeting for receiving	Minutes of 8 September 2026

Commissioning Committee

Date	13 October 2026
Presented by	Martin Neeson, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	**Alert:** • **Capacity pressures**: Both West Yorkshire (WY) and South Yorkshire & Bassetlaw (SYB) collaboratives reported unprecedented demand alongside reduced discharge rates. South Yorkshire (SYB) and West Yorkshire both continue to report their highest occupancy rates since the collaboratives were established in 2021. SYB reported occupancy of 164 patients (against a planning forecast of 154 patients). WY reported occupancy levels of approximately 96%. This is leading to longer waits and increasing Out of Area (OOA) placements (SYB with 20 OOA and WY with 57 OOA). • **Financial pressure**: SYB report a deteriorating financial forecast of (£1.534m). This has been driven by an increase in the number of adult secure referrals and an increase in patient numbers of 7. WY report a worsening financial forecast of (£1.261m). This is being driven by

	higher than forecasted occupancy, higher utilisation of OOA and increased costs vs forecast in exceptional packages of care. **Advise:** • **Operational planning**: The bed modelling exercise produced by the WY Provider Collaborative that explored efficient use of secure beds has led to a review being initiated on the configuration of Newton Lodge (LD beds and male MI beds). An anticipated recommendation by January 2027 has been noted. • **Discharge improvement work:** Both collaboratives have prioritised discharge improvement activity. This includes weekly discharge reviews, cumulative length of stay reviews, delayed discharge analysis, work with Adult Social Care, improved discharge forecasting and strengthened repatriation arrangements. • **Community Forensic Service development:** Progress continues within SYB on the development and expansion of Community Forensic Services, with collaborative delivery arrangements agreed to improve patient flow, reduce admissions and support earlier discharge. • **Collaborative Contracts April 2027:** NHS England is progressing work on future Provider Collaborative arrangements and has requested declarations of intent from existing lead providers. This was discussed at an extraordinary Board meeting on 16 October 2026. • **Regional collaboration**: Positive progress provided from the Yorkshire and Humber collaborative engagement workshops (WY, SYB and Humber & North Yorkshire). This encompasses four workstreams including out-of-area placements, Single Point of Access arrangements, patient demographics and learning disability pathways. A potential additional workstream relating to pricing and financial benchmarking is under consideration. **Assure:** • **Quality oversight:** Both collaboratives remain under routine quality surveillance, with no significant patient safety concerns requiring escalation. Robust quality governance and assurance arrangements remain in place. • **Patient experience improvements:** SYB reported significant progress through its patient experience and Patient Related Outcome Measures (PROMs) programme, improving patient involvement in assessment, decision-making, multidisciplinary meetings, discharge planning and communication throughout care pathways. • **Learning Disability and Autism pathways:** WY reported improved discharge outcomes for patients with Learning Disabilities and Autism, with five discharges achieved so far this financial year and continued focus on reducing unnecessary length of stay. • **Regional collaboration:** Collaborative relationships between South Yorkshire, West Yorkshire and regional partners continue to strengthen, with shared work focused on improving quality, patient flow, pathway effectiveness and service sustainability.
Approved Minutes of previous meeting for receiving	Minutes of 14 August 2026 presented in private.

Audit Committee

Date	16 October 2026
Presented by	Celia Weldon, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert** • **Internal Audit:** As required by the Internal Audit Charter, the Committee approved the proposed External Quality Assessment

	Approach for 360 Assurance which will commence in April 2027. The Committee is required to inform the Trust Board **Assure** • **Risk and governance:** Strong assurance was received on the triangulation of the ORR, BAF and IPR, and where gaps were identified, appropriate oversight arrangements and mitigations were demonstrated as being in place. • **Internal Audit:** Good progress continued against the Internal Audit programme, with **100% of actions due implemented**. Significant Assurance was reported for the EDI and Budget Setting, Monitoring and Reporting reports; Waiting List Management received Moderate Assurance. Terms of Reference have been produced for the audits of the Board Assurance Framework and Freedom of Information/Subject Access Requests • **External Audit:** provided a verbal update on progress to commence planning for the 2026/2027 audit. • **Procurement:** Assurance was received on procurement compliance with no significant matters requiring escalation • **Counter Fraud:** Assurance was received on counter fraud arrangements, with no significant matters requiring escalation. • **Cyber Security:** assurance was received on operational cyber controls, testing and accreditation. Further work will clarify Board-level responsibilities under national cyber guidance. • **FTSU:** Assurance was received on FTSU processes and triangulation arrangements, with further work planned to strengthen interpretation and presentation of the data. **Advise** • **Organisational capacity:** Risk 1217 remained under review given capacity and resilience considerations, including those associated with place-based provider collaborative arrangements. • **Super User Access:** Benchmarking has informed proposals for strengthened controls, which are in the process of being implemented. Once complete, this will be reconsidered by External Audit with a view to concluding on the issue. • **Internal Audit Report - Waiting List Management:** The Committee noted the Moderate Assurance opinion and agreed that consideration should be given to whether a 'Trust-wide waiting list' approach is required, alongside further work on understanding risk and safe waiting. The report has also been considered by the Quality and Safety Committee (QSC) • **Counter Fraud Risk Register:** There were four new risks on the register. In relation to (old) risk 1805 around ensuring the identity of agency workers can be evidenced, the Committee did not support the proposal to reduce the score from 6 to 3; the current score will remain pending further review. • **Clinical Audit:** Further assurance is required on the clinical audit process, including programme development, learning and links with incident processes. A further update will be provided in January and the respective responsibilities of the AC and the QSC will be discussed with the Chairs of AC and QSC and the Chief Nurse • **FTSU:** Reporting will be refined to distinguish clearly between cases where an individual who has spoken up and self-reports/perceives a detriment, and those where detriment has subsequently been established.

Approved Minutes of previous meeting for receiving	Minutes of 14 July 2026.

Finance, Investment and Performance Committee

Date	19 October 2026
Presented by	Gary Ellis, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert** • At the end of month 6 the Trust had an in-month surplus of £384k which is £32k worse than plan. We now have a cumulative deficit of £1.8m. The year-to-date position remains just ahead of plan. • Pressure remains as bank usage continues to fluctuate following two months of reductions it has increased in month by £229k. The current forecast is that the Bank expenditure target will be exceeded. In addition, the Provider Collaborative position remains challenging with pressures in both West and South Yorkshire. • Although to date the value for money programme is ahead of plan for this to be maintained in the second half of the year schemes need to have a positive impact on the Trust run rate. The savings from the Value For Money Programme that are categorised with a high level of risk is now £4.8m and these are related to workforce key lines of enquiry. • At this stage the largest risk relates to productivity and difficult decision schemes. • To support achievement of the breakeven target a number of actions are in development/negotiation these include: o Specialised Commissioning support from NHSE for CPH o Recovery of historic VAT linked to tribunal outcome o Likelihood that the new nursing profiles will not take effect until 2027/28. **Advise** • The financial context from NHS England is that all systems are adverse to plan at month 5 with deficits increasing (actual deficit £223.5m). Focus of overview remains on pay/workforce metrics (£ and WTE) and efficiencies. The underlying financial position table provided shows we have had a deterioration in our underlying financial position. • FIP received an update of the development of the operational plan for 2027/28. A key focus of the plan will be to ensure credible and deliverable plans that set ambitious yet achievable goals. The plan will need to clearly articulate the resources required, realistically reflect workforce and financial constraints, and include mitigation strategies for key risks. Robust triangulation between finance, performance, workforce and quality will be critical. • The Capital update confirmed that agreement has now been reached regarding progress of the OPS capital project. A target start date for material spend on this project is November. However, it is anticipated the revised cost plan may exceed the value approved within the original business case and Board approval is likely to be required prior to contract execution. • The Trust is also advancing a more comprehensive refurbishment of Brook ward at Cheswold Park Hospital supported by £6m of safety funding to be delivered over the next two financial years.

	<u>Assure</u> • The quarter 2 forecast position for the NOF segmentation score is 1 which is a sustained position. • A review of committee related risks was undertaken. It was agreed that risk 1957 (Risk that the Trust's financial viability will be further impacted by ongoing unfunded pressures) consequence score should increase from 3 (moderate) to 4 (major), increasing the overall risk score from 9 to 12 and this was supported by EMT on 8 October 2026. • FIP received assurance from the Care Group Performance Report where performance is generally strong with most access, quality, safety and workforce indicators meeting target. The principal exception is 14-day routine assessment in Calderdale and Kirklees, FIP members strongly supported timely implementation of the improvement plans identified. • The current cash position is positive, but work is ongoing to ensure effective management of our working capital, with a focus on addressing the current accrued income balance. • Performance in respect of the better payment practice code demonstrates compliance with the target.
Approved Minutes of previous meeting for receiving	Minutes of 20 July, 17 August and 23 September.

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

South West Yorkshire Partnership Teaching NHS Foundation Trust

Minutes of the
Transformation Innovation and Sustainability Committee on
Tuesday 21 July 2026
at 1.30pm – 4:00pm
Via Microsoft Teams

Present	
Martin Neeson	Non-executive Director and Chair of Transformation Innovation and Sustainability Committee (Chair)
Rokaiya Khan (RK)	Non-executive Director
Gary Ellis (GE)	Non-executive Director
In Attendance	
Sue Barton (SB)	Deputy Director of Strategy, Inclusion and Change
Subah Thiyagesh (ST)	Chief Medical Officer
Dawn Lawson (DL)	Executive Director of Strategy, Inclusion & Change / Deputy Chief Executive
Izzy Worswick (IW)	Associate Director
Tony Wright (TW)	Sustainability Change Manager
Keyana Ojaghi (KO)	(Minutes) PA to Executive Director of Strategy, Inclusion & Change / Deputy Chief Executive

TIS/01/001 Welcome, introductions and apologies (agenda item 1)

The Chair welcomed all to the first meeting of the Transformation Innovation and Sustainability Committee, introductions were given and apologies were noted as above.

TIS/01/002 Declarations of interest (agenda item 2)

There were no declarations of interest declared by the group.

TIS/01/003 Terms of Reference and workplan (agenda item 3)

The Committee received the draft Terms of Reference and Annual Work Programme for the newly established Transformation, innovation and Sustainability Committee (TISC). MN explained that the Committee had been established by the Board to support the Trust's future readiness and invited members to consider its remit, distinct purpose and the value it could add alongside existing governance arrangements. DL stressed that the Committee should provide dedicated space for strategic thinking, transformation and longer-term ambitions, rather than becoming focused on operational reporting and assurance. GE, ST and RK supported the need for a clear and distinctive role,

With all of us in mind.

acknowledging some overlap with existing committees but recognising the benefit of bringing transformation, innovation and sustainability together within a single forum.

Members agreed that the Committee should maintain a strong focus on future opportunities, including digital transformation, artificial intelligence, innovation, sustainability, climate adaptation and the future healthcare environment, whilst balancing innovation with effective governance and risk management. DL highlighted the importance of considering the Committee's risk appetite to enable innovation without unnecessary constraints, and MN emphasised the need to create a safe environment in which new ideas could be explored and tested.

A recurring theme throughout the discussion was the importance of measuring the Committee's impact and effectiveness. RK and ST noted that while the Terms of Reference described the Committee's responsibilities and reporting arrangements, they did not define how success would be measured. MN proposed replacing the Any Other Business item with a standing agenda item on impact and outcomes to support ongoing evaluation of the Committee's effectiveness. The Committee agreed to amend agenda item 8 to Measuring Impact and Outcomes.

Members also considered governance arrangements and reporting lines. IW highlighted the importance of maintaining clarity regarding the Committee's delegated authority and its relationship with existing committees, particularly Audit Committee. GE emphasised the need to avoid duplicating scrutiny undertaken elsewhere while ensuring continued visibility and accountability for delivery of the Sustainability Strategy and Green Plan. TW supported this position and reiterated amendments previously submitted, advocating a greater focus on outcomes and achievements rather than traditional assurance reporting. The Committee unanimously supported TW's proposed amendment and agreed that additional reference to the Sustainability Strategy and Green Plan should be incorporated into the Terms of Reference.

IW advised that, subject to the agreed amendments, the Terms of Reference would be updated and submitted to the Trust Board for approval. She noted that the Committee had met prior to formal Board approval to enable work to commence without delay and reminded members that no decisions requiring delegated authority were being sought. DL commented that there had been significant value in meeting at this stage, allowing members to challenge the draft Terms of Reference, consider potential overlap with other committees and help define the Committee's unique remit. MN agreed that this rationale should be reflected within the report to the Board.

In reviewing the Annual Work Programme, MN suggested that the recent Digital Strategy review considered by Audit Committee should be reflected within the programme. DL queried whether the proposed frequency of Digital Strategy reporting would provide sufficient oversight, whilst ST noted that existing digital governance arrangements already offered assurance between formal committee reports. IW and MN agreed that direct reporting from operational groups, such as Estates and Digital Programme governance groups, was unnecessary and that assurance should instead be provided through strategic-level updates on the Estates Strategy and Digital Strategy to maintain the Committee's focus on future direction rather than operational detail. MN also highlighted the need for artificial intelligence and digital innovation to feature more prominently in the Committee's future work programme.

SB observed that much of the draft work programme remained assurance-focused despite the Committee's stated ambitions and proposed that each meeting include dedicated time for innovation, strategic thinking and future opportunities. Members supported this approach and agreed that the Annual Work Programme should place greater emphasis on innovation, transformation, future readiness and measuring impact and outcomes. MN proposed that this be reflected within Section 5 of the Annual Work Programme.

Action: Izzy Worswick

TIS/01/004 Place Provider Partnerships (agenda item 4)

The Committee received an update on the development of Place Provider Partnerships (PPPs), governance arrangements for the shadow year, neighbourhood development and the implications of evolving ICB functions. DL noted that governance arrangements and Memoranda of Understanding had been established to support the launch of PPPs but emphasised that these were only the foundation for future arrangements. She encouraged members to focus on the Trust's ambitions within each place and how these could be realised through the emerging partnership model.

Members welcomed the opportunities presented by PPPs but recognised significant uncertainty regarding their future scope and implementation. GE stated that it was important to understand what the Trust ultimately wished to achieve through PPPs and sought greater clarity regarding the commissioning responsibilities that may transfer from the ICB to provider organisations. He suggested that understanding the largest areas of expenditure and service provision would help inform future strategic decisions and questioned whether partnership arrangements could enable genuine service redesign rather than simply inheriting existing models. MN agreed, highlighting the significant potential opportunities for transformation but stressing the need to understand whether the Trust had sufficient capability and capacity to absorb any additional responsibilities. DL concurred, noting that providers may be expected to assume greater responsibility, risk and accountability than is currently recognised nationally, although it remained unclear whether organisations would choose to take on these roles.

IW outlined progress to date, describing the national shift towards ICBs acting as strategic commissioners and the potential for PPPs to assume delegated responsibilities across areas such as contracting, finance, community services and neighbourhood services. She confirmed that arrangements were currently operating in shadow form, with legal accountability remaining with the ICB, and summarised the governance structures being developed across Barnsley, Calderdale, Kirklees and Wakefield, including due diligence processes, risk frameworks, business cases and host provider arrangements. IW also reported that work was underway to define the Trust's ambitions for neighbourhood development through place-based SWOT analysis and workshops designed to establish a clear vision for the organisation's future role within neighbourhood models of care.

The discussion focused extensively on organisational ambition, influence and capacity. DL highlighted that each locality would require a different strategic approach and considered the Trust's commissioning experience to be a significant strength, placing it in a strong position to influence future arrangements and potentially assume leadership roles. However, she stressed the importance of maintaining sufficient capability and capacity to shape evolving discussions and retain influence while

keeping strategic options open. RK similarly identified capacity as a key consideration, questioning how the Trust would maintain influence across multiple partnership forums and avoid missing opportunities. She proposed that future reports provide greater clarity regarding the Trust's position and strengths within each opportunity area through place-based SWOT analysis. IW welcomed this suggestion, confirming that the outputs of the ongoing work would be presented to a future meeting, and reassured members that extensive executive engagement and collaboration was already taking place across all places, despite much of this activity not being visible to the Board.

ST reflected on previous EMT discussions and suggested that organisational ambition, rather than capacity alone, should be the primary focus. She encouraged the Committee to consider the outcomes it wished to achieve for local populations and how PPPs could deliver a fundamentally different approach from previous commissioning arrangements. She also raised concerns regarding maintaining the visibility of public health and ensuring prevention and population health remained central to future planning. MN supported these comments and questioned whether the current geographical configuration of partnerships represented the most effective long-term model, encouraging members to remain open to alternative arrangements should evidence demonstrate better outcomes for local communities.

Members also discussed the principle of subsidiarity and the extent to which responsibilities should be organised around geographical boundaries. DL cautioned against simply replicating historic structures, observing that some functions may be better delivered across wider geographies while others would require local leadership and ownership. She expressed enthusiasm about the Trust potentially becoming a pathfinder organisation and encouraged members to think differently about service design, placing patients and communities at the centre of decision-making rather than organisational structures. The Committee agreed that future neighbourhood models should be designed around population need, prevention and accessibility, recognising that this aligned closely with the Trust's strategic ambitions and the aspirations of the NHS 10-Year Plan.

TIS/01/005 Trust strategy measurement (agenda item 5)

The Committee received the first annual assessment of delivery against the Trust Strategy and the proposed framework for measuring strategic progress. SB advised that the report had previously been considered by Finance, Investment and Performance Committee (FIP) and represented the Trust's first attempt to systematically assess delivery of its strategy. She emphasised that the framework should be viewed as a developmental starting point rather than a final product and noted that additional partner feedback received since the report's drafting had been incorporated, providing positive assurance regarding the Trust's relationships with system partners. SB reported that no comparable NHS approach had been identified and that the methodology had therefore been developed internally, although further refinement would be required, particularly in relation to Strategic Aim 3 and defining the Trust's future ambitions.

DL highlighted the significant work undertaken to develop the framework and noted that the assessment demonstrated strong progress against Strategic Aims 1 and 2, whilst identifying the need for greater focus on Strategic Aim 3 and the development of

longer-term ambitions. She also advised that the framework had been aligned to the Well-Led Framework to support a broader assessment of organisational effectiveness and leadership.

Members welcomed the report and recognised the considerable work involved in its development. MN sought clarification regarding the comparator data used within staff survey benchmarking, emphasising the importance of understanding the underlying data used to inform strategic judgements. SB explained that comparator organisations were drawn from those using the same survey provider and intended to demonstrate performance against peer organisations over time, acknowledging the need to provide greater clarity and context in future reports.

Discussion also focused on organisational capacity and the increasing demands associated with partnership working. MN highlighted the significant increase in Executive attendance at partnership forums and questioned what activities may have been displaced as a consequence, stressing the importance of understanding the cumulative demands being placed on senior leaders. DL agreed, noting that the pressures extended beyond Executive colleagues to operational leaders, who were increasingly required to contribute to pathway, neighbourhood and system transformation discussions alongside their existing responsibilities. Members agreed that ongoing consideration should be given to whether organisational capacity was being directed towards the right priorities whilst maintaining delivery of core services.

GE summarised FIP's discussion, advising that members had welcomed the framework as an innovative approach to measuring strategic delivery and recognised the challenges associated with linking strategic ambitions to measurable outcomes. He noted that FIP viewed the framework as an important starting point and had emphasised the need to avoid organisational "echo chambers" by ensuring assessments were informed by a broad range of perspectives. GE further suggested that the framework should become a live and evolving tool rather than an annual exercise and welcomed its ability to provide a broader understanding of strategic performance than traditional statutory reporting.

The Committee then considered the future development of Strategic Aim 3 and the role of TISC in shaping a more ambitious strategic agenda. SB reported that feedback from FIP, including reflections from Jayne Brown (JB), questioned whether the Trust's ambitions were sufficiently bold. Whilst recognising the organisation's strong performance, she observed that the current narrative focused largely on being good at existing activities rather than articulating transformational ambitions or defining what the Trust aspired to become in the future. SB proposed that TISC should play a leading role in developing this agenda through further discussion on Strategic Aim 3.

RK supported this view, noting that previous discussions had highlighted an opportunity for the Trust to move beyond demonstrating strong performance and instead identify a smaller number of areas where it could excel and become nationally recognised. She suggested defining specific areas of excellence and demonstrating success through measurable outcomes, influence, reputation, research activity, innovation and external recognition. MN agreed and linked the discussion to the Committee's earlier consideration of Place Provider Partnerships and neighbourhood development, suggesting that future ambitions could be centred on population health, prevention, patient-centred care and system leadership, with the potential for the Trust to become a pathfinder organisation in these areas.

Members agreed that future ambitions should remain firmly rooted in the Trust's values and focused on delivering meaningful improvements for patients, communities and vulnerable groups. SB emphasised the importance of strategic capital, partnerships, participation and leadership, highlighting the need to focus on outcomes that make a tangible difference to people's lives. She reflected that NHS discussions can often place disproportionate emphasis on acute care performance measures rather than broader impacts on patients, families and communities. MN supported this perspective, noting the growing national focus on population health, prevention and community-based support, including increasing recognition of the relationship between homelessness, mental health and access to services.

The discussion concluded with consideration of the role of mental health within future strategic ambitions. SB highlighted the life-course approach being explored in Kirklees and stressed that mental health should be embedded throughout all stages of life rather than treated as a separate consideration. She noted the significant contribution of mental health to urgent and emergency care demand and advocated more integrated system-wide thinking. DL agreed, acknowledging the challenge of maintaining the visibility of mental health whilst fully integrating it within wider system priorities. She outlined how mental health had been embedded across thematic areas in Barnsley and emphasised the need to balance visibility with integration. The Committee agreed on the importance of ensuring that mental health, prevention and population health remain central to future planning, service development and the ongoing refinement of Strategic Aim 3.

The Committee RECEIVED the update

TIS/01/006 Annual priority update (agenda item 6)

The Committee received an update on the Trust's Annual Improvement Priorities, including the governance, intelligence and improvement methodology being used to monitor progress and identify areas requiring focused intervention. DL advised that a more structured approach had been developed to strengthen oversight by creating stronger links between governance, performance intelligence, quality improvement methodologies and delivery. She reported that early findings from the CQC Well-Led review provided assurance that the Trust's priorities aligned with key organisational risks and improvement opportunities, citing ADHD waiting times as an area identified through both internal and external assessment.

SB explained that the priorities had been developed through the Trust's bottom-up planning process and reflected progress in establishing a structured quality improvement methodology. She outlined the approach, which focused on identifying issues, developing a detailed understanding of root causes and then progressing to solution design and testing. The Committee heard that extensive analysis of performance data, intelligence, service user feedback and carer feedback had been undertaken to understand issues relating to access, waiting times and workforce costs. SB emphasised that the methodology was deliberately designed to avoid assumptions and premature interventions, ensuring that improvement activity was evidence-based and focused on underlying causes rather than symptoms.

Using access and waiting times as examples, SB reported that a wide range of services had initially been reviewed before analysis narrowed the focus to a smaller

number of priorities where intervention was most likely to achieve meaningful impact, including adult ADHD and children and young people's waiting times. She also outlined work relating to medical staffing expenditure, explaining that a structured "critical understanding" approach had been used to identify the factors driving costs before considering potential solutions.

Members welcomed the methodology and the evidence-based approach used to identify priorities. GE noted the significant interdependency between the improvement priorities, observing that workforce, quality, patient experience and financial sustainability were closely connected and should not be considered as separate workstreams. He highlighted the relationship between workforce strategy and reducing temporary staffing expenditure, suggesting that investment in substantive staffing could improve financial performance, continuity of care and patient outcomes. SB agreed, noting that evidence consistently demonstrated better outcomes and experiences where continuity of care was maintained and that service user feedback reinforced the value of being supported by familiar staff. Whilst the priorities had been presented separately for reporting purposes, she confirmed that they were being managed as an integrated programme through EMT arrangements. GE welcomed this assurance and reiterated the importance of recognising how improvement in one area could positively influence outcomes in another.

MN welcomed the analysis undertaken to identify priorities, particularly in relation to access and waiting times. He considered the rationale for prioritising adult ADHD and children and young people's waiting times to be robust, evidence-based and clearly articulated, providing assurance that resources were being directed to areas where the greatest benefit could be achieved.

RK welcomed the clarity of the process used to identify priorities but sought clarification regarding the next stage of delivery, observing that whilst the report demonstrated a detailed understanding of the issues, it did not yet identify the actions or interventions that would be implemented. SB explained that the methodology intentionally separated the understanding phase from solution development, as organisations can often move too quickly to solutions before fully understanding the problem. She advised that the current focus remained on establishing a robust evidence base before progressing to intervention design and testing and confirmed that future reports would provide greater detail on proposed interventions and their impact.

RK supported this approach, noting that understanding root causes was essential to developing sustainable and effective solutions and would ultimately lead to better outcomes and decision-making. MN agreed but suggested that where obvious opportunities for improvement were identified, these should be progressed alongside the longer-term analytical approach to ensure practical improvements were not unnecessarily delayed. The Committee supported the methodology and recognised the value of maintaining a balance between thorough analysis and timely action.

The Committee RECEIVED the update

TIS/01/007 Green Plan update (agenda item 7)

The Committee received an update on progress against the Trust's Social Responsibility and Sustainability (SRS) Strategy and Green Plan, including delivery of

sustainability objectives, progress towards NHS Net Zero commitments, partnership working, risk management and priorities for the next six months. TW reported positive progress in embedding sustainability across Trust activities, including environmental sustainability, social value, population health, partnership working and wider organisational responsibilities. Progress had also been made in delivering Green Plan commitments, strengthening governance arrangements and developing partnerships to support sustainability outcomes and NHS Net Zero ambitions. However, TW noted that financial and operational pressures continued to present challenges and that future priorities would focus on embedding sustainability further within business processes, maintaining delivery of Green Plan actions and ensuring continued oversight of sustainability objectives.

Discussion focused on the future direction and reporting of the sustainability agenda. DL emphasised that the Green Plan represented only one element of the wider SRS Strategy and that future reporting should better reflect the broader agenda of environmental sustainability, social value, population health and organisational responsibility. ST supported this distinction, agreeing that future reports should avoid using the Green Plan and SRS Strategy interchangeably and instead reflect the wider strategic context. MN also supported this approach, stating a preference for future reporting to be framed around the broader SRS Strategy rather than solely around Green Plan delivery.

Members discussed the importance of demonstrating the practical value and impact of sustainability initiatives. GE observed that public and political discussions regarding sustainability and Net Zero had become increasingly complex and noted that support for environmental initiatives could diminish where they were perceived to create additional costs or operational burdens. He stressed the importance of clearly evidencing both environmental and financial benefits, citing examples such as reducing food waste, improving energy efficiency and strengthening resource management. DL agreed and highlighted the importance of ensuring the purpose, rationale and benefits of sustainability initiatives were clearly communicated. SB echoed these views, noting that many sustainability activities already aligned closely with wider organisational priorities, including value for money, efficiency, service improvement, reducing inequalities and improving population health. She emphasised that sustainability should be viewed as a core component of organisational improvement rather than a separate agenda and highlighted climate change as an important population health issue.

IW suggested that future reports should place greater emphasis on impact and outcomes, enabling the Committee to better understand what difference sustainability initiatives were making and how they contributed to organisational objectives and external reporting requirements. She stressed the importance of demonstrating measurable progress against strategic ambitions.

MN reflected on the wider opportunities presented by the SRS agenda, highlighting the importance of social value, climate adaptation, population health and community benefit alongside decarbonisation. Drawing on experience from other sectors, he suggested that future reporting should seek to quantify the broader social and economic value generated by the Trust through employment, procurement, community investment and service delivery. He considered that a greater understanding of these wider contributions could strengthen strategic decision-making and investment planning. MN also suggested that future reports should include benchmarking against

leading NHS organisations to provide assurance regarding comparative performance and identify opportunities for improvement. He further highlighted the strong links between sustainability, the Estates Strategy, climate adaptation and decarbonisation and noted the importance of ensuring sufficient resource and capacity were in place to support delivery.

Building on the discussion around partnership working, DL proposed further consideration of the Trust's approach to social value. Whilst acknowledging the strong evidence base supporting social value principles, she noted that their application within the NHS had historically been inconsistent. DL suggested exploring opportunities for the Trust and its provider partners to maximise social value and better understand the benefits that could be realised across the wider system. MN agreed, reiterating that social value represented a significant area for future development and highlighting the role of the Estates Strategy in supporting delivery of the Trust's Climate Adaptation Plan.

Action: Tony Wright

TW advised that discussions had already commenced with Estates and Facilities colleagues to strengthen alignment between sustainability objectives and wider organisational priorities. He also reported that, despite changes within the wider political environment, local partners remained committed to sustainability-related priorities. GE added that the work supported, rather than duplicated, activity within FIP, noting that initiatives such as investment in solar panels contributed both to sustainability ambitions and longer-term strategic objectives.

TW sought members' views on the preferred format of future reports, including whether reporting should remain broad and strategic or focus more heavily on outcomes, impact and benchmarking. Members agreed that further reflection was required before making any significant changes and supported maintaining the current reporting approach in the short term whilst future reporting arrangements were developed.

The Committee RECEIVED the update

TIS/01/008 Any Other Business (agenda item 8)

At the conclusion of the meeting, the Committee revisited its earlier discussion regarding how it would measure its effectiveness and assess whether it was making a meaningful contribution to the Trust's strategic ambitions. Members reflected on the value of the inaugural meeting, the Committee's purpose and the distinctive role it could play within the Trust's governance framework.

RK considered the meeting a positive and thoughtful start to the Committee's work. Whilst acknowledging that many questions remained unanswered, she felt this was appropriate given the Committee's early stage of development. She stressed the importance of avoiding duplication with other committees, ensuring time was used effectively and continually assessing whether the Committee was influencing strategic direction and adding value. RK suggested that, as the Committee matured, it should establish a framework to measure and demonstrate its impact, potentially through an annual assessment of its contribution.

Members agreed that the meeting had demonstrated the potential for TISC to provide a distinctive forum for strategic thinking, transformation and innovation. GE observed that discussions had approached issues through a different lens from traditional governance committees and had highlighted opportunities that might not naturally sit within existing structures. DL agreed, noting that the meeting had successfully brought together connected themes, including strategy, partnerships, sustainability, innovation and transformation, creating opportunities to make links across agendas and shape future organisational ambitions in a way not previously possible.

ST reflected that, as the Committee developed, there would be important learning regarding the types of papers and discussions that added the greatest value. She suggested that future meetings should regularly review whether agenda items remained sufficiently strategic and distinct from discussions taking place elsewhere. Whilst recognising the challenge of moving away from traditional committee reporting, she encouraged the Committee to focus increasingly on transformational issues, innovation and complex strategic challenges where members could contribute diverse perspectives and experiences.

MN agreed and highlighted the challenge of balancing immediate operational pressures with discussions about transformation and long-term change. He noted that many of the issues considered by the Committee would not deliver immediate results and that members would need to remain comfortable with uncertainty while exploring future opportunities and ambitions. He further emphasised that strategic thinking should be recognised as a valuable and legitimate function of the Committee, even where immediate solutions were not available.

TW welcomed the discussion, commenting that the meeting had moved beyond simply reviewing reports and instead focused on what the Committee wanted to achieve and how it wished to operate in the future. SB similarly reflected that one of the most valuable aspects of the meeting had been the opportunity for focused strategic thinking, observing that operational demands often limit organisations' ability to consider longer-term ambitions. Whilst not all the answers had been identified, she felt the Committee had begun to ask the right questions and that helping the organisation to frame those questions represented an important contribution in itself.

IW echoed these views and noted that the discussions had provided valuable insight into members' expectations regarding key strategic issues, including Place Provider Partnerships and the Trust's future ambitions. She felt the meeting had clarified the level of ambition members wished to see and identified the type of information that would best support future discussion, strategic development and decision-making.

The Committee concluded that the inaugural meeting had established a strong foundation for future work, demonstrating the value of a dedicated forum focused on innovation, transformation, long-term strategic thinking and organisational ambition.

The Committee RECEIVED the update

TIS/01/009 Matters to report to Trust Board (agenda item 9)

The Committee considered the key messages arising from its inaugural meeting that should be escalated to the Trust Board and reflected on how the Committee's work should be reported and communicated moving forward.

MN highlighted the significant progress made in developing a collective understanding of Place Provider Partnerships (PPPs). He noted that, whilst previous Board discussions had reflected uncertainty regarding their future role, the Committee had provided an opportunity to explore the complexity of the arrangements in greater depth. Members had considered the wider implications for population health, prevention, partnership working and future models of care, enabling more robust scrutiny of the opportunities and risks associated with future provider partnership arrangements. MN also noted that the discussion had improved understanding of neighbourhood development, PPPs and wider system change, providing valuable insight into the challenges being managed by Executive colleagues.

DL agreed and identified the creation of dedicated space for discussion of complex strategic issues as one of the Committee's most significant early achievements. She observed that many of the topics considered cut across traditional committee boundaries, bringing together strategy, sustainability, transformation, partnerships and organisational leadership. Members agreed that the Committee offered a distinctive forum for connecting these interdependent agendas, supporting longer-term strategic thinking and demonstrating the Trust's commitment to future planning, organisational development and strong governance within the Well-Led Framework.

Members discussed whether traditional committee reporting arrangements would adequately capture the Committee's contribution. SB questioned whether the standard Alert, Assurance and Advice (AAA) format reflected the nature of TISC's work, given that much of its value lay in strategic discussion, challenge, future ambition and exploratory thinking rather than formal assurance or decision-making. GE supported this view, suggesting that future reports may be more effective if focused on strategic themes, emerging opportunities and areas requiring further consideration. He also proposed that the Committee should actively inform future Board strategy sessions, ensuring its discussions help shape wider strategic planning and organisational development.

MN acknowledged the challenge of translating strategic discussions into conventional committee reporting formats and emphasised the importance of preserving the Committee as a forum where ambiguity, uncertainty and emerging ideas could be explored without the expectation of immediate decisions. IW advised that, as the Committee remained in its infancy, reporting arrangements would initially remain straightforward and formal outputs would continue to be reported through the Board's private agenda until the Terms of Reference and governance arrangements had been formally approved.

However, she agreed that future reporting arrangements should be reviewed to ensure they appropriately reflected the Committee's strategic role and contribution. DL suggested seeking the Board's views on how it wished to receive assurance, insight and strategic intelligence from a committee with such a distinctive remit, rather than imposing a traditional reporting model.

Reflecting on the inaugural meeting more broadly, MN noted that the Committee was already demonstrating positive impact and that the agreed work programme provided a strong foundation, whilst remaining a work in progress. He encouraged members to continue refining the programme and to consider whether an innovation space could

be used for some topics, enabling the Committee to focus on major strategic issues requiring discussion and direction.

RK commended MN's approach to chairing the meeting, highlighting the collaborative environment that had enabled members to shape the Committee collectively rather than work within a predefined model. She described the inaugural meeting as an excellent foundation for future discussions.

In closing, MN thanked members for their contributions, encouraged them to build on the foundations established during the meeting and formally closed the session.

The Committee RECEIVED the update

TIS/01/010 Date and time of next meeting (agenda item 10)

The next meeting of the Committee is scheduled to be held on Tuesday 6th October 2026 at 2.00pm via Microsoft Teams.

South West Yorkshire Partnership Teaching
NHS Foundation Trust

Minutes of Quality & Safety Committee
8 September 2026
9am 11.30am
Face to Face

Present:	Margaret Kitching (MK) Celia Weldon (CW) Nat McMillan (NM) Caroline Johnson (CJ) Prof Subha Thiyagesh (SThi)	Non-Executive Director (Chair of the Committee) Non-Executive Director Non-Executive Director Chief Nurse / Director of Quality and Professions (Lead Director) Chief Medical Officer
Apologies:	Adele Fox (AF)	Chief Operating Officer
In attendance:	Jonny Hall (JH) Yvonne French (YF) Amy Hartley (AH) Chris Lennox (CL)	Business Operations Manager Associate Director of Legal Services Deputy Director of Nursing, Quality & Professions Service Director
Observing	Debi Gibson (DG) Cornelle Parker (CP)	Director of Nursing and Quality NHS West Yorkshire Integrated Care Board NHS Alliance

QSC/26/102 Welcome, introduction and apologies (agenda item 1)
Margaret Kitching (MK) welcomed attendees, noted the apologies as listed above, and acknowledged those present as observers. The meeting was confirmed as quorate and proceeded.

QSC/26/103 Declarations of interest (agenda item 2)
The Committee noted that no further declarations of interest were raised, beyond those previously brought to members' attention.

The Quality & Safety Committee NOTED the declaration.

QSC/26/104 Minutes from previous Quality and Safety Committee meeting held 7 July 2026 (agenda item 3)
The minutes of 7 July 2026 were approved as an accurate record.

It was RESOLVED to APPROVE the minutes of the Quality & Safety Committee meeting held on 7 July 2026 as a true and accurate record.

QSC/26/105 Matters arising from previous Quality & Safety Committee meetings and action log (agenda item 4)

Caroline Johnson (CJ) presented the matters arising and action log to the Committee.

4.1 R&D Strategy QSC/26/83
Matters Arising: R&D Strategy
The Committee received an update on the Research & Development Strategy following amendments requested at the previous meeting. Dr Subha Thiyagesh (STHi) confirmed that all requested changes had been incorporated and that the revised document, including a foreword from Mark Brooks and Jane Brown, had been circulated to members with tracked changes for review.

The Committee welcomed the revised Strategy and noted the significant work undertaken to strengthen the document. It was acknowledged that the Strategy clearly articulated the Trust's research ambitions and priorities. Some formatting issues were identified within the diagrams and associated lettering, and SThi confirmed that these be reviewed and corrected before final publication.

4.2 Freedom to Speak Up
The Committee received an update on the Freedom to Speak Up survey. CJ advised that only 27 cases had contributed to the survey findings and, following review with the Freedom to Speak Up Non-Executive Director, further work was being undertaken to strengthen the survey methodology and improve robustness.

MK noted that the small sample size limited the assurance that could be drawn from the results and stressed the importance of obtaining a broader and more representative response. Celia Weldon (CW) sought clarification regarding Non-Executive oversight arrangements following the reallocation of roles, while Natalie McMillan (NM) observed that similar concerns had already been raised through Audit Committee and highlighted the risk of duplication between committees.

The Committee agreed that ongoing oversight should sit with the Audit Committee, with any quality or safety related themes reported to the Quality & Safety Committee as required. This was agreed to be closed on the action log.

Action Log

Ref	Discussion	Outcome
QSC/26/83 R&D Strategy	R&D Strategy amendments completed and circulated.	Closed.
QSC/26/87 Safer Staffing 6 Month report	The item will be covered on the agenda today.	Closed.
QSC/26/91 NICE Annual Report	Updates to be incorporated within the next cycle of the report in October 2027.	Closed.
QSC/26/77 Matters Arising	Freedom to Speak Update. Update given above.	Closed.
QSC/26/77	Review of the interface with the clinical and quality strategies.	Closed.

Matters Arising	This is on the agenda today for discussion and the group agreed to close this action.	
QSC/26/77 Matters Arising	Establishment Reviews. The action was being progressed and that the related update/report was included on the current agenda for consideration later in the meeting and this action can now be closed.	Closed.
QSC/26/77 Matters Arising	Deprivation of Liberty/associated report originally due September.	It was agreed to defer to October.
QSC/26/51 Risk Register Review	Review of risk register, including inequalities and whether risks remain reflective of Committee remit.	Paper to be brought to October Committee.
QSC/26/55 Quality Assurance System Update	Quality Assurance System updates have been included with the report which is on the agenda today. Closed	Included on agenda. Closed
QSC/26/57 Community Mental Health Survey	Significant improvement work underway and improvement plan developed. Full report to come to the October Committee.	Full report to October Committee.
QSC/26/63 Completion of Actions from Internal Audits	Action completed.	Closed.
QSC/26/36 Clinical Strategy Update	It was noted that this item was on the agenda today and the action can be closed. NM also advised that she had attended the Clinical Strategy Steering Group	Covered on agenda. Closed.
QSC/26/42 Reports of Formal Sub Committees	Summary of sub-committee AAA reports completed; linked review of risk register required. Which will be on the October agenda.	Closed.

QSC/26/106 Review of Committee related risks, update following Board discussion (agenda item 5)

CJ presented the Committee risk register, highlighting that Risks 2084 and 2087 remained aligned to patient safety, organisational learning, clinical risk assessment and restrictive practice priorities. Risk 1839 had been reviewed to better reflect system pressures and patient impact, whilst Risk 1838 was under review to consider separate risks for staff, service users and visitors. A reduction in Risk 2012 (Paediatric Audiology) from 9 to 6 was proposed following seven months of stable and satisfactory performance.

NM reflected that Board discussions increasingly felt "riskier", particularly in relation to finance, demand and operational pressures, and questioned whether this was sufficiently reflected in

the risk register. She also welcomed the proposed reduction of the Paediatric Audiology risk, recognising the sustained improvement achieved.

Responding, SThi agreed that services felt increasingly challenged and explained that together with CJ they were strengthening scrutiny through Quality Impact Assessments and governance processes to ensure financial decisions did not adversely affect quality or patient safety. CJ added that oversight beneath the Committee had been strengthened through the Clinical Governance Group.

MK sought assurance regarding patient flow and clinically ready for discharge risks and invited operational views on whether current risk ratings reflected the lived experience of services.

Chris Lennox (CL) Director of Services, advised that the risks were real and significant, affecting service user experience, safety and operational performance. Whilst describing extensive mitigation work with local authority and system partners, she emphasised that improvements remained fragile and that delayed discharges, out-of-area placements and wider system pressures continued to present considerable risk. Amy Hartley (AH) agreed, noting that although staff worked hard to mitigate risks on an individual basis, the underlying system pressures remained largely unchanged.

When discussing whether the risks remained fully reflective of Committee responsibilities, CJ proposed a wider review of risk alignment and inequalities considerations. A paper reviewing the Committee's risks, inequalities and alignment to Committee responsibilities will be presented to the October Committee meeting. This is already noted on the action log.

The Committee supported the reduction of Risk 2012 and received assurance that quality and patient safety implications arising from operational and financial pressures continued to be actively monitored through strengthened governance and quality assurance processes.

It was Resolved to RECEIVE the Update.

QSC/26/107 Staff/Team Story (agenda item 6)

The Committee received a presentation from Jonny Hall, Business Operations Officer and Project Lead, on The Happiness Programme. The programme combines interactive sensory-light technology with structured staff training and support to provide safe, meaningful activities for people with cognitive and physical care needs. Funding was secured from EyUp! Charity in September 2024, with the equipment introduced to the Trust in January 2025.

Early case studies and events demonstrated positive engagement, including improved mood, reduced agitation, increased social interaction and perceived benefits to mobility. Service users described the activities as enjoyable, calming and helpful in distracting from pain. Staff feedback was also strongly positive: 100% considered the programme a useful intervention, 95% believed it could support recovery and would use it again, and 85% had observed improvements in mobility where applicable.

The Committee noted plans to continue seasonal events and case-study development, supported by the project user group. Further evaluation will include comparative data on falls, violence and aggression, and physiotherapy outcomes. A business case will be developed to support continuation of the programme, alongside exploration of future funding options.

The Committee strongly supported the programme, recognised its positive impact and agreed it should be highlighted to Trust Board as an example of innovation and patient-centred care.

QSC/26/108 Executive Trio Update inc. update of topical & legal risks, escalations, quality impact assessment (QIA) (agenda item 7)
CJ and SThi provided an update on key quality and safety priorities. They noted that operational pressures had eased slightly since August, although significant flow pressures remained. No further industrial action had been announced and positive engagement continued with the medical workforce.

An update was provided on the Women's Pathway Review, with a draft report now received and under review. An update will be brought to a future Committee meeting once the findings have been considered.

CJ reported progress on reducing restrictive practice following the external review. Work was underway to strengthen training, reduce the number of techniques staff are required to learn and embed a more reflective, human-rights-based approach. New roles and a revised model for the Restrictive Practice Team would increase ward-based support and cultural change. A programme of Practice Leadership development is in the process of being commissioned from the Restraint Reduction Network (RRN) to further support the work.

NM welcomed the work but challenged why, after several years of focus, learning about training and culture change appeared only now to be emerging. She emphasised the importance of understanding why previous interventions had not sufficiently reduced restrictive practice.

In response, CJ advised that the key shift was a move away from training-only solutions towards visible leadership, ward-based coaching and culture change. SThi acknowledged the challenge and reflected on previous work to improve data quality and recording. She advised that the external review had provided fresh insight and that the revised staffing model would support greater frontline ownership.

The Committee received an update on community deaths, where emerging themes around early intervention and substance misuse-related deaths had been identified. Further analysis and targeted quality improvement work will continue, with updates brought back through future reports.

There was positive feedback regarding improvement work at Elmdale and Nostell, where AHP-led initiatives were associated with reductions in violence, aggression and self-harm. This work was being aligned with existing improvement programmes, service user feedback and the Women's Model of Care review.

NM reminded the Committee that the forensic culture review had originally been commissioned through the People Renumeration Committee (PRC) and highlighted the importance of maintaining alignment between Committee oversight arrangements.

MK welcomed the external review and cultural focus on restrictive practice but reiterated that seclusion remained an area of concern and should remain within the Committee's Alert reporting.

It was Resolved to RECEIVE the Update.

QSC/26/109 Quality & Regulatory Oversight Paper (agenda item 8)
CJ reported that all CQC action plan actions had been completed, with work now focused on sustaining improvements. Between May and July, the Trust received 28 routine CQC enquiries, with no recurring themes identified. Recent Mental Health Act visits identified familiar themes around risk assessment, care planning, restrictive practice, dignity and patient

involvement, with improvement plans in place. Members also noted the Trust's involvement as a pilot site for a new CQC Conditional Discharge Review methodology.

CW sought assurance that the clinical audit programme remained on track and queried whether there were any capacity concerns. CJ advised that national audits were progressing well, however oversight of some local audits required strengthening as delays were not always identified early enough. A Clinical Audit Annual Report will be brought to a future Committee meeting and audit oversight will continue to be strengthened through the Clinical Governance Group.

Action: Sarah Harrison

ST provided assurance that mandatory national audits, including prescribing and medicines-related audits, remained on track and highlighted the systems in place to monitor completion and share learning.

MK emphasised the importance of ensuring clinical audit is informed by quality concerns and recurring incidents discussed by the Committee, noting that repeat incidents should trigger audit activity to test whether learning has been embedded. Development of a more structured clinical audit programme aligned to incidents, recurring themes, quality risks and organisational priorities will continue.

The Committee received assurance regarding regulatory oversight arrangements, noted the closure of all CQC action plan actions, and welcomed the ongoing work to strengthen clinical audit governance and organisational learning.

It was RESOLVED to RECEIVE the Update

QSC/26/110 Quality Assurance System Update (agenda item 9)

The Committee noted that this update would be included within the Quality Assurance System Annual Report.

It was RESOLVED to RECEIVE and NOTE the update.

QSC/26/111 Quality Assurance System Annual Report (agenda item 10)

CJ presented the first full-year review of the Quality Assurance System, advising that it was now providing reasonable assurance that quality governance arrangements were embedded across the Trust.

During the year, 190 of 198 services received routine monitoring, one service remained on enhanced monitoring and seven Cheswold Park wards remained under intensive monitoring pending CQC inspection. Willow, Barnsley Intensive Home-Based Treatment Team and Newhaven had returned to routine monitoring following improvement. Thirty-five ward walkarounds, reviews of 12 community teams and 24 resulting quality improvement plans had been completed.

Common strengths included compassionate, person-centred care, positive MDT working and strong team culture. Residual challenges included sustaining programme capacity, strengthening lived-experience involvement, developing community peer review arrangements and improving thematic organisational analysis.

NM welcomed the report, commenting that the system felt significantly more mature and embedded than in its first year and provided tangible assurance that the framework was

working effectively. NM stated that the Trust should recognise and promote the programme more widely as an example of good practice.

MK agreed that the report demonstrated substantial progress and greater maturity. She highlighted the value of thematic analysis arising from quality assurance reviews and noted that understanding recurring themes would help the Committee track improvement and cultural change over time.

MK also emphasised the value of Non-Executive participation in quality visits and walkarounds, noting that direct engagement with frontline services helped triangulate assurance obtained through Committee reports.

CW, as a new Committee member, commented that the report was accessible, comprehensive and provided reassurance regarding how quality was being monitored and improved across the organisation.

CJ advised that work was continuing to strengthen the risk profiling methodology and improve the aggregation of organisational learning. Further development of the risk profiling approach and thematic organisational analysis will continue as part of the next phase of the programme.

The Committee received assurance that the Quality Assurance System was embedded and delivering effective oversight of quality and improvement across services, whilst supporting further development of thematic learning and organisational assurance.

It was RESOLVED to RECEIVE and APPROVE the Quality Assurance System Annual Report.

QSC/26/112 CQC Action Plan Update (agenda item 11)

CJ advised the Committee that all actions relating to the CQC action plan had now been completed and requested that this item be removed from the QSC work programme going forward.

Action: Sarah Harrison

It was RESOLVED to RECEIVE and NOTE the request.

QSC/26/113 Quality Strategy Update (agenda item 12)

CJ presented the proposed approach to the national Quality Strategy, advising that rather than developing a separate Quality Strategy, quality would be embedded as a golden thread within the Trust Strategy. A Quality Framework would be developed to describe how quality is defined, governed, improved and assured, supported by an annual Quality Plan setting out priorities, actions and measures. This would align with the Trust's existing Quality Management System and avoid duplication.

MK supported the principle of embedding quality within the Trust Strategy but emphasised that quality priorities must remain clearly visible, measurable and routinely monitored. She noted that the key issue was not having a strategy document, but ensuring delivery against agreed priorities.

CJ clarified that a supporting document would still be developed, but this would take the form of a Quality Framework and Quality Plan rather than a standalone strategy. A draft Quality Framework and Quality Plan will be developed and brought back to a future Committee meeting for review.

Action: Caroline Johnson

NM supported the approach, describing it as pragmatic, but cautioned that the Trust must be able to demonstrate clearly to regulators and stakeholders that quality remains a strategic priority. She observed that embedding quality within the broader Trust Strategy may strengthen visibility and accessibility.

CW agreed that integrating quality within the wider strategic framework would support alignment across organisational priorities and help avoid unnecessary duplication.

ST advised that similar discussions had taken place at EMT and confirmed that concerns regarding the visibility of quality had been considered. She noted that the Trust had adopted a similar framework-based approach in other areas, such as medicines optimisation, and that a concise framework would provide greater clarity and practical value than a standalone strategy.

MK concluded that whatever form the document took, the Trust must be able to clearly demonstrate its quality ambitions and evidence delivery through governance and assurance processes..

The Committee endorsed the proposed approach to develop a Quality Framework and Quality Plan aligned to the Trust Strategy and agreed that this provided the most effective way of embedding quality across the organisation.

It was RESOLVED to RECEIVE and NOTE the Quality Strategy Update.

QSC/26/114 Care Plans and risk Assessment Improvement Update (agenda item 13)

AH reported significant progress against the 360 Assurance Action Plan, with all but two actions completed. The remaining actions related to implementation of the revised audit process, currently being tested through dip sampling, and the procurement of an external trainer to support implementation through secured CPD funding. AH confirmed that 360 Assurance was satisfied with progress against the action plan.

AH advised that the work had now moved beyond completion of the action plan and into a wider programme of reducing clinical administrative burden. This included reviewing care plans, assessments and documentation with staff, carers and service users to simplify processes, reduce duplication and align with national personalised care frameworks and digital transformation priorities. The revised audit process and training programme will be completed and monitored through the Clinical Governance Group.

CJ commended AH and clinical teams for the pace of delivery and highlighted the links between this work and the improvement programmes at Nostell and Elmdale, where reducing administrative burden was helping release clinical time for care.

ST welcomed the progress made and reflected on the tendency over time to add documentation requirements following incidents without removing existing processes. She supported the focus on simplification and advised that the programme was being aligned with wider digital innovation work.

MK welcomed the assurance provided and commented on the potential benefits of digital solutions, including ambient voice technology, in reducing administrative burden. She noted that external regulatory findings often related to documentation rather than the absence of clinical assessment and emphasised the importance of understanding the scale of issues through audit. MK reiterated that documentation would remain an important area of Committee focus.

Progress against care planning and risk assessment improvements will continue to be monitored through the Integrated Performance Report and ongoing assurance reports.

The Committee received assurance that the recommendations from the 360 Assurance review had largely been addressed and supported the wider programme to improve clinical documentation, reduce administrative burden and strengthen the use of digital solutions.

It was RESOLVED to RECEIVE and NOTE the Care Plans and Risk Assessment Improvement Update.

QSC/26/115 Resus Annual Report (agenda item 14)

CJ presented the first Resuscitation Annual Report, advising that overall compliance with mandatory resuscitation training was 86.2%. Work was underway to validate workforce data and address pockets of lower compliance. Members were advised that NEWS2 compliance remained strong, Red Bag Scheme compliance was 100%, and the team continued to review deteriorating patient incidents, choking incidents and physical healthcare events to support organisational learning. Additional external training provision had been commissioned to support Immediate Life Support (ILS) training requirements.

MK welcomed the report and noted the strong performance against key indicators, particularly NEWS2 compliance and the achievement of 100% compliance with the Red Bag Scheme. She sought clarification on whether the compliance target reflected national expectations.

SThi clarified that doctors had previously been undertaking the level of training required at the time (BLS), but that expectations had since changed. She advised that doctors were now moving to ILS training through planned renewal cycles and confirmed that staffing rosters take account of resuscitation competencies to ensure suitably trained staff are available.

SThi further advised that whilst organisations would always aspire to achieve 100% compliance, a range of approximately 80-85% was generally regarded as nationally acceptable for mandatory training, with assurance provided through workforce planning and roster management arrangements.

The Committee received assurance regarding resuscitation governance, training compliance, deteriorating patient management and emergency preparedness arrangements, and welcomed the positive performance reported across key indicators.

It was RESOLVED to RECEIVE and NOTE the Resus Annual Report.

QSC/26/116 D&T Annual Report (agenda item 15)

SThi presented the annual report, providing assurance on medicines governance, prescribing practice and progress against the Pharmacy and Medicines Optimisation Framework. The Committee were made aware of the successful completion of the Electronic Prescribing and

Medicines Administration (EPMA) rollout across all inpatient services, including Cheswold Park Hospital and Home-Based Treatment Teams. SThi also reported progress with the Electronic Prescription Service, enabling service users to collect prescriptions from their chosen community pharmacy.

SThi advised that work continued with ICB partners on the STOMP programme, medicines optimisation, electronic monitoring templates and value-for-money initiatives. She emphasised that all medication-related changes continued to be subject to clinical governance review through the Drugs and Therapeutics Committee to ensure quality and patient safety remained central to decision-making. She also highlighted the Trust's strong performance in Yellow Card reporting, reflecting proactive identification and reporting of adverse drug reactions.

MK welcomed the report, describing it as clear and accessible. She queried progress on the STOMP programme, noting that although it was referenced within the report, the Committee had not previously received a detailed update on its outcomes. In response, ST confirmed that substantial work had been undertaken through the programme but had not previously been reported through QSC. SThi will provide a dedicated STOMP update to a future Committee meeting to provide assurance on outcomes and impact.

Action: Subha Thiyagesh

The Committee received assurance regarding medicines governance, electronic prescribing developments, medication safety and medicines optimisation. Members welcomed the completion of the EPMA rollout, the implementation of the Electronic Prescription Service and the Trust's positive reporting culture in relation to adverse drug reactions.

It was resolved to RECEIVE and NOTE the D&T Annual Report.

QSC/26/117 Patient Safety Oversight Report Q1 (agenda item 16)

CJ presented the Quarter 1 Patient Safety Oversight Report, advising that there had been no Never Events during the reporting period and no new significant concerns beyond those already under review.

Sustained improvements in self-harm incidents had continued since November 2025, while falls, medication errors, violence and aggression incidents and pressure ulcers remained within expected variation. Members noted that 27 service users accounted for 59% of inpatient falls, highlighting the importance of targeted interventions. Missed medication doses and inconsistent EPMA use remained areas of focus. Two SWARM reviews and three after-action reviews had been completed under PSIRF arrangements, with recurring themes including deterioration, care planning, risk formulation, therapeutic engagement, communication and documentation.

CW sought assurance regarding whether locum and agency staff had access to EPMA. CJ confirmed that appropriate access arrangements and training mechanisms were in place to ensure systems could be used by authorised temporary staff.

CW also asked how learning from incidents occurring outside the Trust was incorporated without creating additional burden. CJ advised that learning was routinely reviewed through regional patient safety networks, national reports and regulatory outputs. ST added that national medicines and patient safety alerts were also reviewed through governance structures and disseminated across services.

MK welcomed the inclusion of ethnicity data within the report but noted that the ethnicity profile of violence and aggression incidents appeared different from other patient safety indicators. She requested further analysis to better understand the position. CJ advised that further

review and analysis of ethnicity data relating to violence and aggression incidents will be undertaken through the ongoing violence and aggression reduction work.

CJ confirmed that equality data completeness continued to improve and that further work would support more sophisticated analysis of patient safety outcomes.

The Committee received assurance regarding patient safety governance arrangements, welcomed the continued reduction in self-harm incidents and the embedding of PSIRF methodologies, and agreed that medication safety, violence and aggression, documentation and equality-related analysis should remain areas of ongoing focus.

It was resolved to RECEIVE and APPROVE the Patient Safety Oversight Report Q1

QSC/26/118 Learning from Healthcare Deaths (agenda item 17)

Item 17: Learning from Healthcare Deaths

CJ presented the report, advising that there had been 513 deaths following contact with Trust services within 180 days. Of these, 110 had been reported on Datix, 69 were within scope for review and 41 were outside scope.

The majority of deaths reviewed related to Community Mental Health Services, reflecting the Trust's service model. 12 deaths involved people with a learning disability and/or autism, 11 adult deaths had been referred for LeDeR review, and five Structured Judgement Reviews remained in progress. CJ highlighted an ongoing challenge in obtaining LeDeR review outcomes from some partner organisations and advised that work was underway to improve information sharing. Emerging learning from mortality reviews was identifying themes around early intervention and substance misuse-related deaths.

NM sought clarification on whether difficulties obtaining LeDeR reviews were a new issue and emphasised the importance of external learning and independent assurance. CJ advised that this had been a longstanding challenge and confirmed discussions with system partners were ongoing to improve the consistency of information sharing.

NM also queried why the monthly mortality review process had previously ceased and expressed concern that mortality review should remain a core element of governance. CJ explained that mortality discussions had become absorbed into other governance arrangements during a wider review of meetings and duplication but had since been re-established when a dedicated forum was recognised as necessary. She assured members that no other significant governance gaps had been identified following her wider governance review.

MK welcomed the re-establishment of the mortality review process but commented that members would benefit from greater understanding of how mortality reviews operate, how learning is identified and how actions are monitored. SThi advised that the Trust was reviewing its wider patient safety governance structure and highlighted that mortality reviews had already helped identify themes, including substance misuse-related deaths, which were informing quality improvement work.

A future report will be brought to the Committee outlining the mortality review process, governance arrangements, learning mechanisms and assurance routes.

Action: Caroline Johnson

CJ confirmed that work would continue to strengthen family involvement, equality monitoring and thematic analysis arising from healthcare deaths. Ongoing mortality review work will

continue to inform improvement activity relating to community deaths, early intervention and substance misuse themes.

The Committee received assurance that appropriate arrangements remained in place for reviewing deaths, identifying learning and supporting improvement, whilst recognising the need to strengthen external learning processes and provide greater visibility of mortality review governance.

It was resolved to RECEIVE and APPROVE the Learning from Healthcare Deaths Report

QSC/26/119 PSIRF Plan (agenda item 18)
It was noted that this report was brought forward and was taken in the July Committee.

QSC/26/120 Internal Audit Reports (agenda item 19)
The Committee was advised that no internal audit reports had been submitted for consideration at this meeting.

QSC/26/121 Completion of Actions for Internal Audits (agenda item 20)
CJ presented an update on progress against internal audit recommendations. The Committee were advised that there were no new internal audits for review; however, progress continued to be monitored against previously agreed actions.

In relation to the Safer Staffing Internal Audit, CJ reported that four of the five recommendations had been formally closed by 360 Assurance. The remaining action remained on track for completion by 31 December and continued to be monitored through existing governance arrangements. Members also noted that biannual establishment reviews were now embedded within routine workforce governance processes.

CJ advised that all actions arising from the Care Plans and Risk Assessments Internal Audit had been agreed for closure by 360 Assurance. She noted, however, that continued assurance was required to demonstrate sustained improvement in practice. Monthly audit activity would therefore continue until compliance of at least 80% had been consistently achieved.

The Committee received assurance that internal audit actions were largely complete, with robust monitoring arrangements in place to support completion of the remaining action and ensure that improvements are sustained.

It was resolved to RECEIVE and NOTE the Internal Actions report.

QSC/26/122 Safeguarding Annual Report (agenda item 21)
CJ presented the Safeguarding Annual Report, providing assurance that safeguarding governance, leadership, supervision, training and partnership arrangements remained in place across the Trust. Improvements were noted in safeguarding training compliance across all adult and children's safeguarding levels during the year. The report highlighted 555 adult safeguarding incidents, 216 children's safeguarding incidents, 1,165 adult advice contacts and 709 children's advice contacts, demonstrating the scale of safeguarding activity undertaken by the Trust. CJ advised that increased reporting reflected both service demand and improved awareness, with no significant themes or trends causing immediate concern.

CJ highlighted key areas of learning, including the need to strengthen professional curiosity, improve understanding of cumulative risk, maintain focus on self-neglect, mental capacity and

executive functioning, and reinforce the Think Family approach. She noted that domestic abuse remained an important area of focus, with examples of both good practice and opportunities for further improvement identified through case reviews.

CJ advised that demand for specialist safeguarding advice and supervision continued to increase and that feedback from operational services suggested current arrangements could be improved. The safeguarding team will continue working with care groups to develop and co-produce more effective arrangements for accessing specialist safeguarding support and advice.
MK welcomed the report and noted the strong mandatory training performance achieved. She highlighted the planned review of safeguarding capacity and workforce arrangements and expressed interest in understanding the impact of that review when completed.

CJ advised that the workload and demand pressures on the safeguarding team were recognised and that workforce capacity would continue to be reviewed, supported by the recent leadership changes within the team. She noted that the appointment of Gemma Hinchliffe had provided increased stability and strengthened leadership oversight. Review of safeguarding capacity and workforce requirements to continue through existing governance arrangements.

SThi highlighted that safeguarding training performance continued to be monitored through the IPR and recognised the improvements achieved across safeguarding education and compliance.

The Committee received assurance that safeguarding governance arrangements remained effective, welcomed the improvement in training compliance and noted the ongoing work to strengthen safeguarding advice, supervision and workforce capacity arrangements.

It was resolved to RECEIVE and NOTE the Safeguarding Annual Report.

QSC/26/123 Pressure Ulcer Update (agenda item 22)
The report highlighted continuing improvement work focused on holistic care, hydration and nutrition, equipment provision, education, care planning and risk assessment. CJ advised that further work was underway in Barnsley to strengthen understanding of prevalence and incidence reporting and ensure data accuracy.

MK welcomed the revised format of the report and commented that it was easier to follow and provided clearer assurance than previous versions. She noted the positive work being undertaken in Barnsley to improve understanding of prevalence and incidence reporting and supported the continued focus on data quality.

CJ confirmed that the local improvement work would continue and would support greater confidence in community reporting and trend analysis. Work on prevalence and incidence reporting in community services will continue through existing quality improvement arrangements.

The Committee received assurance that pressure ulcer governance arrangements remained effective, welcomed the stable inpatient position and noted the ongoing work to strengthen community data quality and reporting.

It was resolved to RECEIVE and NOTE the Pressure Ulcer Update Report.

QSC/26/124 Medical Appraisal / Revalidation Report (agenda item 23)

SThi presented the annual report and accompanying Statement of Compliance, advising that the report provided assurance that the Trust continued to meet NHS England requirements for medical appraisal and revalidation. It was noted that 189 doctors held a prescribed connection with the Trust, including seven doctors working within Barnsley Hospice. SThi explained that not all doctors were eligible for appraisal during the reporting period due to appraisal cycles, doctors joining or leaving the organisation, and other legitimate reasons.

SThi reported that 97% of eligible doctors had successfully completed appraisal. The small number of outstanding appraisals related to doctors whose appraisals had been delayed or deferred for appropriate reasons and had been authorised through the Responsible Officer process. Eight revalidation recommendations had been made during the year, all of which had subsequently been accepted by the GMC. One revalidation had been deferred to allow additional multi-source feedback to be obtained. SThi explained that the Trust operated a more rigorous approach than the minimum GMC requirement, requesting multi-source feedback every three years rather than once during a five-year revalidation cycle.

SThi outlined the governance arrangements supporting appraisal and revalidation, including the use of the L2P platform, review of minimum data sets, health and wellbeing indicators, appraisal quality assurance processes and the role of the Responsible Officer. She highlighted positive feedback from doctors, with 99% indicating they would be happy to have the same appraiser again, demonstrating confidence in the appraisal process.

MK welcomed the report, describing it as clear and easy to follow. She noted the high appraisal completion rate and the robust explanations provided for the small number of outstanding appraisals, commenting positively on the assurance provided regarding medical revalidation governance.

The Committee received assurance that the Trust continued to operate effective medical appraisal and revalidation processes and agreed to recommend the Annual Report and Statement of Compliance to Trust Board for approval.

It was resolved to RECEIVE and APPROVE the Medical Appraisal / Revalidation Report.

QSC/26/125 Safer Staffing Report (agenda item 24)

CJ presented the outcomes of the six-month safer staffing review and the proposals considered by EMT. The Committee were advised that establishment reviews had identified approximately £1m of potential investment, with EMT supporting targeted investment in areas where there was the strongest evidence of staffing and patient safety need. This included support, in principle, for establishment uplifts within West Yorkshire Forensic Services and additional staffing associated with the Section 136 Suite and Psychiatric Liaison Services.

CJ advised that three proposals had been deferred pending further work. Cheswold Park required review alongside wider service expansion plans and vacancy management; Older People's Services required further consideration alongside the Stepping Stones transformation programme; and Barnsley Services required additional work to assess the effectiveness of the rotational physiotherapy model. A further review of the deferred staffing proposals will be undertaken before final investment decisions are made.

CW sought assurance that bank and agency expenditure had been considered within the review. CJ confirmed that workforce spend had been analysed and factored into the proposals, although reductions would not always be directly offset due to factors such as acuity, maternity cover and training requirements.

NM sought clarification regarding the Committee's role and was advised that the purpose of the report was to provide assurance regarding the safer staffing review process and quality implications, with broader financial decisions progressing through Trust Board governance arrangements.

MK welcomed the report and sought assurance that Quality Impact Assessments had informed the proposals. She acknowledged that wider workforce and financial implications would continue to be considered through Board discussions.

ST advised that the review had been informed by the Mental Health Optimal Staffing Tool (MHOST) and extended beyond minimum safer staffing requirements. Referring to Older People's Services, she advised that workforce requirements would continue to be reviewed alongside transformation work.

The Committee received assurance regarding the safer staffing review process and noted the EMT decisions, including further work on deferred staffing proposals before final decisions are made.

The Committee RECEIVED and APPROVED the Safer Staffing Report.

QSC/26/126 QSC ToR (agenda item 25)
CJ presented the Committee's Terms of Reference. The only proposed amendment related to updating membership arrangements following changes to Non-Executive Director responsibilities, specifically replacing Mike Ford with Celia Weldon within the Committee membership.

The Committee reviewed the proposed amendment and confirmed that the change accurately reflected the revised governance arrangements and Committee membership structure. No concerns or further amendments were raised.

The Committee RECEIVED and APPROVED the update to the ToR

QSC/26/127 Fuller Inquiry Report (agenda item 26)
CJ presented the report outlining the Trust's assessment against the recommendations arising from the Fuller Inquiry and the associated submission to NHS England. Members were advised that, although the Trust does not operate its own mortuary services, it remained important to demonstrate compliance with the relevant recommendations and provide assurance regarding the care of deceased patients and associated governance arrangements.

MK welcomed the report and noted the substantial work required nationally across acute trusts in response to the Fuller Inquiry. She was pleased that the Trust had nevertheless undertaken a formal assessment against all recommendations and maintained oversight of the ethical and governance implications relating to the care of deceased patients.

Members acknowledged the importance of ensuring that standards relating to dignity, respect and care of deceased patients remained visible within governance arrangements despite the absence of direct mortuary responsibilities.

The Committee received assurance that the Trust had reviewed itself against the Fuller Inquiry recommendations, maintained appropriate oversight arrangements and completed the required submission to NHS England.

The Committee RECEIVED and NOTED the Fuller Inquiry Report.

QSC/26/128 Reports from Formal Sub Committee's (agenda item 27)

CJ introduced a new summary report bringing together updates from the Committee's formal sub-committees. She explained that the purpose of the report was to provide a concise overview of key assurance, escalation and governance issues arising from the sub-committee structure and to help members focus on matters requiring attention.

The Committee welcomed the revised format and commented that the summary was much more helpful and accessible, enabling members to focus quickly on the key issues and actions arising from the various groups. The Committee agreed that the new reporting format improved visibility of the main assurance themes and supported more effective oversight.

The Committee received and noted the reports from the formal sub-committees and welcomed the new summary reporting format developed by CJ, agreeing that it provided a clearer and more focused mechanism for receiving assurance from subordinate governance groups.

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

QSC/26/129 Issues and Items to be brought to the attention of Trust Board / Committees **(agenda item 28)**

Alert

- **Patient Flow, OPEL Pressures and Clinically Ready for Discharge Patients**

The Committee remained concerned regarding system pressures, including patient flow challenges, OPEL 4 escalation and the ongoing risks associated with patients who were clinically ready for discharge. Members recognised that many of the underlying causes sat outside the Trust's direct control but agreed that the associated quality and patient safety risks remained significant and should continue to be highlighted to the Board.

- **Restrictive Practice and Seclusion**

The Committee acknowledged the considerable programme of work underway following the external review of restrictive practice and welcomed the emphasis on culture change. However, members agreed that seclusion continued to be a significant area of concern and that the Trust remained an outlier in this area. The Committee agreed that restrictive practice should continue to sit within the "Alert" section of the AAA report pending evidence of sustained improvement.

Advise

- **Happiness Programme Presentation**

Members strongly supported the presentation from Jonny Hall, Business Manager regarding the Happiness Programme and agreed that Trust Board should be invited to hear the presentation directly. The Committee considered the programme to be an excellent example of innovation and patient-centred care. Members advised that the business case should be strengthened through additional outcome measures and supporting evidence to demonstrate measurable benefits alongside the compelling patient stories and case studies already presented.

- **Mortality Review Process**

Members requested that further clarity be provided regarding the mortality review process and governance arrangements. The Committee advised that Board should be aware of the work being undertaken to strengthen mortality review oversight and sought additional assurance

regarding how learning from deaths is identified, reviewed and translated into improvement actions.

- **Violence and Aggression Equality and Diversity Analysis**
  The Committee advised that further analysis would be undertaken regarding the ethnicity profile of violence and aggression incidents. Members noted that the pattern differed from that seen in other safety measures and agreed that understanding this variation would support future assurance.

- **Digital Transformation and Clinical Documentation**
  The Committee wished to highlight the significant work being undertaken to reduce clinical administrative burden through care planning and risk assessment improvements and the potential offered by digital solutions, including ambient voice technology and wider digital transformation initiatives. Members considered this to be an important example of service improvement that should be highlighted to Board.

- **Annual Reports Recommended to Board**
  The Committee advised Board of several annual reports that had received positive assurance, including:

- Safeguarding Annual Report.
- Drugs & Therapeutics Annual Report.
- Fuller Report assurance submission.
- Medical Appraisal and Revalidation Annual Report.

Assure

- **Quality Assurance System Annual Report**
  The Committee received strong assurance that the Quality Assurance System was now embedded across the organisation and was providing a robust mechanism for quality oversight, monitoring and improvement. Members recognised the significant maturity of the programme and its contribution to organisational assurance.

- **Care Plans and Risk Assessments Improvement Programme**
  The Committee received assurance that substantial progress had been made against recommendations arising from the 360 Assurance review. Members welcomed improvements in care planning and risk assessment processes and supported the wider programme focused on reducing clinical administrative burden and strengthening documentation quality.

- **Resuscitation Annual Report**
  The Committee received assurance regarding mandatory training compliance, NEWS2 performance, physical healthcare governance and emergency preparedness. Members particularly welcomed the strong performance reported and the achievement of 100% compliance within the Red Bag Scheme.

- **Medical Appraisal and Revalidation**
  The Committee received assurance regarding the robustness of the Trust's medical appraisal and revalidation arrangements, including the high level of appraisal completion and the effectiveness of governance processes underpinning revalidation.

- **Positive Quality Improvement Activity**
  The Committee recognised the extensive improvement work taking place across the Trust, including work relating to restrictive practice, AHP-led ward initiatives, quality governance and patient safety improvement. Members considered these programmes to provide assurance regarding the organisation's commitment to continuous improvement.

The Committee RECEIVED and NOTED

QSC/26/130 Risk Register Review (agenda item 29)
No further discussion was required in relation to the risk register.

The Committee RECEIVED and NOTED

QSC/26/131 Work Programme (agenda item 30)
CJ advised that the standalone CQC Action Plan item was no longer required on the work programme and could be removed. This was noted earlier in the agenda.

Following earlier discussion regarding care planning, risk assessment and clinical documentation, CJ sought views on whether the Committee wished to maintain oversight of this wider improvement programme. The Committee agreed that ongoing scrutiny was required. The work plan will be amended for quarterly updates on the care planning, risk assessment and clinical documentation improvement programme will be added to the work programme.

Action: Sarah Harrison

The Committee approved the work programme, agreed the removal of the standalone CQC Action Plan item and approved the addition of quarterly reporting on the care planning and clinical documentation improvement programme**.**

The Committee RECEIVED and NOTED

QSC/26/132 Date of the Next Meeting (agenda item 31)

13th October 2026 – MS Teams

South West Yorkshire Partnership Teaching
NHS Foundation Trust

Audit Committee Minutes
Wednesday 14 July 2026
Via Microsoft Teams

Present:	Mike Ford (MF) Natalie McMillan (NM) Martin Neeson (MN)	Non-Executive Director (Chair of the Committee) Non-Executive Director Non-Executive Director
Apologies	Rob Adamson (RA) Estelle Myers (EM) Izzy Worswick (IW) Imran Ahmed (IA)	Deputy Director of Finance Ambassador for Cultural Change and FSUG Deputy Director of Partnerships, Planning and Governance Head of Procurement
In attendance:	Adrian Snarr (AS) Nicola Wright (NW) Caroline Jamieson (CJa) Leanne Hawkes (LH) Lianne Burtoft (LB) Andy Lister (AL) Kevin Gelder (KG) Caroline Johnson (CJ) Paul Foster (PF) Victoria Brain (VB) Jennie Byron (JB) Susan Baines (SB) Julie Hall (JH) Ellaine Flintoff (EF) Jane Wilson (JW)	Director of Finance, Estates and Resources Partner, Deloitte Senior Manager, Deloitte Deputy Director, 360 Assurance Client Manager, 360 Assurance Head of Corporate Governance Deputy Director, Estates & Facilities Nurse / Director of Quality & Professions (item 14.2) Chief Digital & Technology Officer, Digital and Technology Services (item 16) Senior Finance Manager, Costing (item 17) EPRR Adviser (item 18) Head of Financial Accounting (item 22) Deputy Director Business Support (Item 23) Personal Assistant (observing) Personal Assistant (minute taker)

AC/26/42 Welcome, introduction, and apologies (agenda item 1)

The Chair of the Committee, Mike Ford (MF), welcomed everyone to the meeting. The above apologies were noted. MF confirmed that the meeting would be recorded for administration purposes to support minute-taking. Once the minutes had been completed, the recording would not be retained.

AC/26/43 Declaration of interests (agenda item 2)

The Committee noted that there were no new declarations of interest.

AC/26/44 Minutes of the meetings held on the 14th April 2026 and 25 June 2026 (agenda item 3)

The minutes of the Audit Committee meeting held on 14 April 2026 and 23 June 2026 were accepted as a true and accurate record.

AC/26/45 Matters arising and action log from the meeting held on 14 April 2026 & 25 June 2026 (agenda item 4)

The action log was reviewed and updated accordingly.

AC/26/46 Actions delegated to Audit Committee from Trust Board (agenda item 5)

The Committee noted that there were no actions delegated from Trust Board requiring consideration at this meeting.

AC/26/47 Consideration of items from the Organisational Risk Register allocated to the Audit Committee (agenda item 6)

AS presented the Organisational Risk Report (ORR) and highlighted changes since the previous review. Risk 1080 (Cyber Security) had been reclassified from a Strategic to a Security risk, while Risk 1217 had moved from a Strategic to a Business risk following a review of risk appetite. AS advised that, whilst the change to Risk 1217 had no impact on the risk score, the reclassification of Risk 1080 reduced the Trust's risk appetite and increased the gap between the current risk score and appetite. He noted that, given the nature of cyber threats, further reductions in risk scores remained challenging despite ongoing improvement work.

AS also highlighted Risk 1159 (Fire Safety), noting that while there had been no change to the Trust's assessment of the risk, a recent significant fire at a neighbouring mental health trust reinforced the importance of maintaining vigilance and considering any relevant lessons learned.

MF sought clarification on the relationship between fire risks associated with the estate and those arising from patient behaviour, referring to recent Quality and Safety Committee (QSC) discussions regarding a fire incident involving a lithium battery. AS explained that the Trust managed both environmental fire risks and risks associated with deliberate fire-setting, which required different but related oversight arrangements.

MN supported the reclassification of the cyber security risk, noting that it aligned with current best practice.
NM highlighted Risk 1887 (Freedom to Speak Up) and queried whether a proposed reduction in the risk score remained appropriate in light of findings from the recent culture review. AL advised that EMT had reviewed the matter and agreed the reduction was premature; consequently, the risk score would remain unchanged at nine when reported to the Board.

The Committee discussed the challenge of aligning cyber security risks with the Trust's risk appetite and agreed that further work was required to ensure a coherent approach to cyber assurance reporting. AS and AL to review cyber assurance reporting arrangements and strengthen the alignment between cyber security reporting, the Organisational Risk Register and Board assurance processes, including how cyber risk is reflected within wider Board assurance reporting.

ACTION: Adrian Snarr/Andrew Lister

6.1 Capacity of organisation to deliver change – position statement

AS provided an update on work to assess the Trust's capacity to support Place-Based Provider Collaboratives and wider NHS system changes. He advised that current work was focused on the governance, due diligence and assurance arrangements required should the Trust become the lead or host provider for Kirklees Place. This included assessing quality, financial and contractual risks, alongside the resource implications of undertaking both initial due diligence and ongoing oversight. AS noted that the position remained fluid and discussions were ongoing regarding the level of support available through the Integrated Care Board (ICB) and the capacity required within provider organisations.

AS reported that parallel work was continuing through the Place-Based Provider Collaborative programme to establish the strategic direction for place arrangements, including consideration of how the ICB Integrated Team could support the Trust's role as a place-based lead organisation.

MN noted that oversight of place-based arrangements had been allocated to the new Transformation, Innovation and Sustainability Committee and highlighted the importance of alignment between that Committee's work and Audit Committee assurance requirements.

MF acknowledged that pressures associated with the integration of Cheswold Park had reduced as arrangements became embedded within business-as-usual operations. However, he remained concerned about the cumulative impact of provider collaboratives, ICB restructuring and wider system transformation, particularly in the context of reduced corporate capacity, and emphasised the need for a formal assessment of organisational capability and capacity.

AS agreed and noted that, alongside increasing system demands, the Trust had delivered significant reductions in corporate resources through the Efficiency and Financial Management Programme. He recognised the importance of understanding both organisational capability and capacity when assessing the sustainability of future change programmes. AS to present a paper at the October meeting setting out the Trust's assessment of organisational capacity and capability to support ongoing system transformation, provider collaborative developments and place-based responsibilities, including associated risks and assurance arrangements.

ACTION: Adrian Snarr

It was RESOLVED to NOTE the updates in relation to the Organisational Risk Register and Capacity of Organisation to Deliver Change

AC/26/48 Triangulation of risk, performance and governance (agenda item 7)

AL presented the Triangulation Report, which compares the Organisational Risk Register (ORR), Board Assurance Framework (BAF) and Integrated Performance Report (IPR). The report demonstrated improved alignment across the three frameworks, with all ORR risks now reflected within either the BAF or IPR. There remained one Red risk relating to cyber security and 27 Amber risks, of which 22 remained outside risk appetite.
AL highlighted that 31 of the 32 ORR risks were now linked to the IPR, with the remaining Freedom to Speak Up risk no longer associated with a performance measure. He also reported improved alignment between the ORR and BAF following changes agreed by the Board in April 2026.

MN welcomed the report and commented that it was clear and easy to follow.
MF noted the improved triangulation but reiterated concerns that data security mandatory training alone did not provide sufficient assurance regarding cyber security risk. AL acknowledged the challenge and noted the need to balance meaningful assurance reporting with the public nature of the IPR. AS agreed that further consideration was required to strengthen cyber security assurance reporting.

ACTION: Adrian Snarr

NM queried the proposed reduction in Risk 1887 (Freedom to Speak Up) in light of findings from the recent culture diagnostic review. AL advised that EMT had since reconsidered the matter and agreed the reduction was premature; consequently, the risk score would remain unchanged when reported to the Board.

It was RESOLVED to RECEIVE the Triangulation of risk, performance, and governance report.

AC/26/49 Declaration of Interest Annual Update (agenda item 8)

AL presented the annual update on the Trust's Declaration of Interests process. He advised that, although the report suggested some declarations had not been updated since April 2025, the Trust had achieved full compliance in October 2025 and the annual declaration process had recommenced in February 2026.

Since publication of the report, compliance had improved, with 74 declarations outstanding. Reminder notices had been issued and outstanding returns were being actively followed up. AL advised that EMT had agreed a revised escalation process whereby persistent non-compliance would be managed through Executive Directors, and expressed confidence that full compliance would be achieved within the coming weeks.

MF noted that compliance levels were lower than at the same stage in the previous year and sought assurance that this did not indicate a wider concern. AL advised that fewer reminder notices had been issued this year due to capacity pressures within the team but confirmed that targeted follow-up activity was underway.
MF also sought clarification regarding the definition of financial interests. AL explained that these could include external or secondary employment as well as other financial relationships.

The Committee welcomed the strengthened escalation process and the actions being taken to secure full compliance.

It was RESOLVED to NOTE the annual update on declarations of interest.

AC/26/50 Risk Management Procedure (agenda item 9)

AL presented the revised Risk Management Procedure, which had been reviewed as part of the routine three-year review cycle and updated following completion of the Internal Audit review. He advised that the document had been substantially revised to provide clearer guidance, strengthen governance requirements and improve alignment with current risk management processes. The revised procedure addressed five of the six Internal Audit recommendations, with further work required in relation to data analytics and reporting.

NM welcomed the changes but highlighted the importance of ensuring staff understood the purpose of risk management, rather than simply how to complete risk registers. She stressed that effective implementation would require training and support alongside the revised procedure. MF agreed and emphasised the importance of communication and engagement to ensure the changes translated into improved practice.

AL advised that the revised procedure would be launched through the Organisational Management Group, supported by briefing materials and targeted training where required. He confirmed that the Trust's online risk management training package would form part of the implementation approach and that feedback would continue to be sought from staff following rollout.

MF sought clarification regarding the approval process. AL confirmed that approval would ordinarily sit with the Organisational Management Group, but that the procedure had been presented to Audit Committee due to its governance significance. MF also suggested that 360 Assurance review the revised procedure to ensure it adequately addressed the Internal Audit findings. AL confirmed he intended to discuss this with 360 Assurance colleagues.

ACTION: Andy Lister

It was RESOLVED to APPROVE the revised Risk Management Procedure and NOTE the arrangement in place to support implementation.

AC/26/51 External audit plan, risks and control measures progress update (agenda item 10)

CJa provided a verbal update on the completion of the Trust's 2025/26 external audit work. She reported that, following presentation of the ISA 260 report at the previous Audit Committee meeting, there had been no subsequent changes to the accounts. The audited

accounts were signed on the following Thursday and submitted to NHS England on the Friday in accordance with required deadlines.
CJa advised that Deloitte had subsequently completed its National Audit Office reporting requirements and had now issued the Auditor's Annual Report, which summarises the work undertaken during the audit, including commentary on the Trust's Value for Money (VFM) arrangements and recommendations to management. The issue of the Auditor's Annual Report marked the completion of Deloitte's work for the 2025/26 audit cycle.

MF welcomed the update and requested that Audit Committee members receive a copy of the final Auditor's Annual Report in advance of the planned member briefing session later in the year, to enable members to review the findings in detail before the wider discussion.

ACTION: Adrian Snarr

It was RESOLVED to NOTE the update and completion of the 2025/26 External Audit process

AC/26/52 Procurement report update (agenda item 11)

AS presented the Procurement update report and highlighted that tender waivers would no longer be used for university placements, as tuition fees were nationally set and the waiver process provided no additional procurement value. He also advised that the new master vendor arrangement for agency doctors was now operational and would strengthen compliance with agency rate controls and procurement assurance arrangements.
In addition, AS informed the Committee that a similar master vendor arrangement for Estates services was being launched with procurement solutions provider, Constellia. He explained that the arrangement was intended to improve resilience within the Estates supply chain and support delivery of the Trust's capital programme.

MN supported the revised approach to university-related tender waivers, agreeing that the current process offered limited value where pricing and provider choice were effectively fixed.

IT was RESOLVED to NOTE the Procurement update

AC/26/53 Treasury Management Update (agenda item 12)

The Committee noted the Treasury Management update report and there were no questions raised.

IT was RESOLVED to NOTE the Treasury Management Update

AC/26/54 Losses and special payments Update (agenda item 13)

The Committee noted the Losses and special payments report and there were no questions raised.

IT was RESOLVED to NOTE the Losses and special payment update

AC/26/55 Internal Audit Update (agenda item 14)

LB presented the Internal Audit Progress Report and provided an update on delivery of the 2025/26 and 2026/27 Internal Audit Plans. Two reports from the 2025/26 Plan, Risk Management and Risk Assessment and Care Planning, were being presented to the Committee. The Waiting List Management audit was at final draft stage and the Equality, Diversity and Inclusion audit had reached initial draft stage.

For the 2026/27 Plan, LB reported that the Data Security and Protection Toolkit audit had been completed and reported to the June Audit Committee. Progress had also been made in agreeing Terms of Reference for Quarter 1 and Quarter 2 audits. LB advised that

implementation of audit actions remained positive, with all actions due to date completed.

AS advised that consideration was being given to replacing the planned Freedom of Information and Subject Access Request audit with a review of controls relating to inappropriate access to patient records, following recent high-profile incidents nationally and increased scrutiny from NHS England.

MF questioned whether replacing a previously approved audit was appropriate, noting that the Internal Audit Plan had been developed based on the Trust's identified risks and available audit resources. He also highlighted the importance of Freedom of Information compliance and the potential impact of removing this area from the plan.

MN queried whether the proposed change reflected an emerging gap in the Trust's risk assessment process, given that inappropriate access to records had not previously been identified as a significant risk. NM sought clarification on the implications of removing the Freedom of Information and Subject Access Request audit and noted this was likely to attract further scrutiny.

AS acknowledged these concerns and confirmed that the implications of the proposed change would need to be clearly articulated in future governance reporting. He noted that Freedom of Information performance had been affected by recent staff sickness and recognised that the original audit may have identified further areas for improvement.

MF concluded that the discussion highlighted the importance of ongoing consideration of Internal Audit capacity, audit planning and Non-Executive Director involvement in shaping future audit priorities.

Risk Management Audit

LB presented the Risk Management Audit, which received a Moderate Assurance opinion following a review of risk management arrangements across four Care Groups. The audit identified findings relating to the consistency of risk review arrangements, the management of risk actions and Care Group risk reporting, including variation in review frequencies, action ownership and reporting processes.

MF expressed surprise at the Moderate Assurance rating, noting that the Trust was generally regarded as having strong risk management arrangements. AL advised that the findings primarily reflected variation in practice below Board and Committee level and highlighted the need for greater consistency across Care Groups.

AS noted that the introduction of the Moderate Assurance category provided greater opportunity to identify improvements and should not be viewed as a poor outcome. LH added that the rating reflected genuine opportunities to strengthen arrangements and that assurance opinions were subject to internal quality review.

MN welcomed the findings, noting that whilst risk management appeared strong at organisational level, some variation at Care Group level was not unexpected. He supported the recommendations as a means of improving consistency and governance.

The Committee agreed that the audit provided constructive assurance and identified practical opportunities to strengthen risk management arrangements across the organisation.

It was RESOLVED to NOTE the Internal Audit progress update and NOTE the Moderate Assurance opinion and findings of the Risk Management Audit

AC/26/56 Counter fraud progress Update (agenda item 15)

MD presented the Counter Fraud Progress Report, highlighting the launch of the *Fraudulent Times* newsletter and a phishing awareness briefing to strengthen fraud awareness across the organisation. She also reported ongoing work with the Learning and Development Team to enhance counter fraud training.

MD advised that six fraud alerts had been issued during the reporting period, with no significant issues identified to date. Some responses remained outstanding due to organisational changes within HR, and distribution lists were being updated accordingly. She further reported that two reactive investigations remained open, including one awaiting information from a third party.

MF expressed concern that responses had not been received for all fraud alerts and emphasised the importance of ensuring appropriate review and response processes were in place. Particular attention was given to an alert relating to the Mutually Agreed Resignation Scheme (MARS). MD clarified that the alert related to the recruitment of individuals who had previously left another NHS organisation under a MARS arrangement. MN noted that the matter had also been considered by the People and Resources Committee and highlighted the importance of ensuring appropriate governance arrangements were in place. AS agreed that suitable checks and controls should be maintained to identify and manage any associated risks.

AS and MD to review the controls and assurance arrangements relating to MARS-related recruitment risks and ensure appropriate governance arrangements are in place.

ACTION: Adrian Snarr/360 Assurance

Counter-fraud annual report 2025-26

MD presented the Counter Fraud Annual Report for 2025/26, providing an overview of counter fraud activity and compliance with NHS Counter Fraud Authority requirements. She reported that the Trust had achieved an overall Green rating against the Counter Fraud Standards for Providers framework and had submitted its annual return within the required timescales. Benchmarking information showed that the most common fraud referral related to working whilst off sick, consistent with wider NHS trends.

MF noted that the report contained no unexpected findings and no further comments were raised by the committee.

IT was RESOLVED to NOTE the Counter fraud progress update and also NOTE the 2025/26 annual report

AC/26/57 Systems Development Board Update (agenda item 16)

Paul Foster (PF) presented the Systems Development Board update and highlighted progress across the Trust's digital programme. Key developments included completion of the SystmOne Community Services migration into the Integrated Neighbourhood Teams Service Unit, successful adoption of SystmOne and Electronic Prescribing and Medicines Administration (ePMA) at Cheswold Park Hospital, rollout of the Bridgit care application to support bedside observations, expansion of digital communications with service users, implementation of the Electronic Prescription Service within Mental Health Community Services, and continued development of the Patient Knows Best portal.

PF also reported that clinical safety testing of Lexacom Ambient Voice Technology had been completed, with deployment planned to a small number of early adopter services following final governance approval. In addition, the Trust was leading a regional Electronic Patient Record procurement collaborative across West and South Yorkshire organisations.

MN welcomed the progress reported and expressed interest in the future digital development pipeline.

MF commended the breadth of work delivered and observed that strategic oversight of digital transformation would sit more naturally within the remit of the newly established Transformation, Innovation and Sustainability Committee. NM echoed this view and thanked PF and his team for the significant progress achieved.
AS confirmed that future oversight of digital transformation reporting was likely to transfer to the Transformation, Innovation and Sustainability Committee, whilst cyber security reporting would remain within the remit of Audit Committee.

It was RESOLVED to NOTE the Systems Development Board update and the significant progress made across the Trusts digital transformation programme.

AC/26/58 National Cost Collection submission (agenda item 17)

Victoria Brain (VB) presented the National Cost Collection Update and provided assurance regarding the process for preparing and submitting the Trust's 2025/26 National Cost Collection return. She advised that an extension to the submission deadline had been approved by NHS England due to a combination of factors, including new national costing requirements, technical issues with the national submission platform and workload pressures following her return from maternity leave. A workaround had been identified and the submission had successfully passed validation, with final sign-off expected shortly.

AS advised that the delay did not reflect concerns regarding the quality of the costing methodology but highlighted the increasing complexity of national costing requirements and the growing demands associated with patient-level costing and deconstructing block contracts. He noted that National Cost Collection outputs would continue to be considered through the Finance, Investment and Performance Committee, whilst Audit Committee oversight focused on assurance regarding the submission process.

MF sought assurance that the approved extension would not have any adverse consequences for the Trust. AS confirmed that NHS England had authorised the extension and no regulatory concerns were anticipated. MF also noted the limited independent verification of costing outputs in recent years and commented that additional assurance would provide further confidence given the complexity of the process.

VB advised that NHS England was developing a costing assurance toolkit to support more structured assurance activity in future years and confirmed that the Trust would utilise this once available.

The Committee welcomed the update and the proactive engagement with NHS England in managing the challenges encountered.

IT was RESOLVED to NOTE the report and ASSURANCE provided regarding the National Costing Submission process

AC/26/59 EPRR update (agenda item 18)

Jennie Byron (JB) presented the (Emergency Preparedness, Resilience and Response (EPRR) update and reported continued progress against the 58 EPRR Core Standards. She advised that some standards had been reclassified from Green to Amber following a more robust review of evidence and assurance requirements, rather than any deterioration in preparedness.

JB highlighted progress in the training and exercising programme, delivery of Initial Operational Response training, completion of infrastructure resilience improvements at Cheswold Park Hospital, approval of the revised EPRR Policy and implementation of a new Business Continuity Management System incorporating business impact assessments, continuity plans, exercising schedules and assurance arrangements.

MF sought clarification regarding the implications of partial compliance with the EPRR standards. AS advised that, whilst compliance was referenced within the NHS Standard Contract, there was limited evidence of formal consequences for organisations not achieving full compliance. JB noted that some of the standards were primarily designed around acute trusts and could present challenges for mental health and community providers.

MF also queried the standards rated Red, particularly those relating to business continuity. JB explained that these largely reflected work underway to implement the new Business Continuity Management System and align supporting frameworks and documentation. She confirmed that the Trust was working towards at least partial compliance and aspired to achieve substantial compliance.

MN sought assurance that standards had not simply been reclassified and specifically queried progress regarding Chemical, Biological, Radiological, and Nuclear (CBRN) preparedness. JB advised that significant progress had been made through rollout of Initial Operational Response training and development of a draft CBRN response plan.

The Committee welcomed the progress made and the focus on delivering meaningful improvements in organisational resilience.

It was RESOLVED to NOTE the EPRR update and progress against the EPRR Core Standards

AC/26/60 Premises Assurance Model (PAM) update (agenda item 19)

AS presented the annual Premises Assurance Model (PAM) submission. The Trust achieved a high overall level of compliance; however, changes to the national assessment methodology now effectively measure organisations against 100% compliance, with any lower score categorised as non-compliant. Members noted that this did not always reflect the overall strength of performance where consistently high levels of assurance were being achieved.

The principal factor affecting the Trust's compliance score related to medical device maintenance. Compliance had subsequently improved above the required threshold, although this improvement fell outside the reporting period and was therefore not reflected within the submitted return.

MF noted that overall compliance remained strong but sought clarification on performance compared with previous years. He also commented that previous reports had included more detailed information on individual compliance categories, which had assisted Committee scrutiny.

AS agreed that future reports would benefit from additional detail to provide greater context regarding areas of non-compliance and the underlying drivers of performance.

MF also queried the practical implications of failing to achieve full compliance where overall performance remained high. AS advised that, as with several other assurance frameworks, the consequences of not achieving 100% compliance were not always clearly defined where strong overall assurance remained in place.

The Committee supported the proposal to enhance future reporting to provide greater context regarding areas of non-compliance and performance trends.

It was RESOLVED to NOTE the PAM update

AC/26/61 Annual Place assessments (agenda item 20)

AS presented the 2025 PLACE Assessment results, with separate reports provided for Trust sites and Cheswold Park Hospital to improve visibility of performance. Overall scores remained consistently high, although several domain scores had reduced slightly, largely reflecting the impact of the Cheswold Park Hospital results.
Lower scores at The Dales were attributed to the limitations associated with a leased PFI-managed estate, where the Trust has limited influence over facilities and maintenance services. The forthcoming expiry of the PFI arrangements may provide opportunities to improve support arrangements.

In relation to Cheswold Park Hospital, AS advised that lower scores had been anticipated due to estate and environmental challenges. He reported that two allocations of £3m capital funding had been secured to support safety and environmental improvements over the next two years, which were expected to contribute to improved PLACE scores. Food and catering were identified as key areas for improvement and an improvement programme was already underway with Dietetics and operational teams.

MF noted that, despite the generally high scores, the reports contained important messages regarding patient experience and the estate environment. He questioned whether sufficient visibility was being provided regarding progress against improvement actions. MN agreed that the results demonstrated the need for targeted investment at Cheswold Park Hospital and welcomed the planned capital programme.

NM queried how assurance would be provided between annual PLACE assessments that identified areas for improvement, particularly in relation to food and environment. AS acknowledged this and advised that consideration would be given to how progress could be reported through the governance structure. He also confirmed that future Estates reporting would be reviewed to provide clearer assurance regarding improvement activity.

AL confirmed that PLACE reports would continue to be presented to Board for information alongside the PAM submission.

It was RESOLVED to NOTE the Annual Place assessments update

AC/26/62 Health and Safety update (agenda item 21)

AS presented the Health and Safety Update and reported progress in improving utilisation of lone worker devices and compliance with Health and Safety Audits. Audit completion rates had increased from 89% to 91%, although a number of services had still not completed the required self-assessment. AS advised that additional assurance visits and support would continue where returns were not submitted.

MF noted recurring non-compliance within a small number of services and questioned whether greater managerial accountability was required. It was confirmed that two services had failed to complete the required audit returns for a second consecutive year.

Concern was also expressed that only 53% of services had undertaken a fire evacuation drill within the previous 12 months. AS advised that work was underway to strengthen fire evacuation arrangements, particularly within inpatient services, and that learning from recent exercises at Newton Lodge was being used to improve practice elsewhere.

MF further noted that some measures within the report were difficult to interpret and did not always provide meaningful indicators of compliance or risk.

MN drew attention to the work systems, risk assessment and incident reporting section of the audit, noting that it remained the only area with compliance below 80%, and requested further detail regarding the nature of the non-compliance and associated risks. AS acknowledged the point and agreed to provide additional analysis.

ACTION: Adrian Snarr

The Committee noted the progress made in improving audit completion rates and lone worker device utilisation and emphasised the need to maintain focus on risk assessment, incident reporting and fire safety arrangements.

Health and Safety Annual Report

AS presented the Health and Safety Annual Report, summarising health and safety performance and compliance activity during 2025/26. He highlighted improvements in audit completion rates and ongoing work to strengthen lone worker device compliance, fire safety arrangements and local governance.

MF commented that some measures within the report reflected activity rather than assurance and suggested that future reporting focus more clearly on key risks, compliance and assurance. MN reiterated concerns regarding compliance levels for work systems, risk assessments and incident reporting. AS acknowledged the issue and confirmed that further analysis would be provided through the action arising from the Health and Safety update.

The Committee recognised the progress made during the year and emphasised the need to maintain focus on risk assessment, incident reporting and fire safety arrangements.

It was RESOLVED to NOTE the Health & Safety update and NOTE the Health and Safety Annual Report

AC/26/63 Risk assessment and care planning update

Caroline Johnson (CJ) provided an update on progress against the Internal Audit review of Risk Assessment and Care Planning. A dedicated working group had been established and immediate action taken to address the findings, including revisions to the policy following identification of unintended barriers to compliance. Increased leadership oversight and engagement with services had contributed to early improvements in compliance data.

The next phase of work would focus on improving the quality of risk assessments and care planning. In response to staff feedback, a training programme was being developed to strengthen understanding of risk formulation and support greater consistency in practice.
MN sought clarification regarding identified constraints within SystmOne. CJ advised that discussions were ongoing with the SystmOne Team regarding potential improvements to templates and system functionality.

NM welcomed the pace of progress and emphasised the importance of maintaining momentum to ensure improvements translated into practice. MF echoed these comments and noted that the Committee would expect ongoing improvement to be reflected through routine performance and assurance reporting.

It was RESOLVED to NOTE the update and progress being made in response to the Internal Audit Review of Risk assessment and Care Planning

AC/26/64 Draft Charitable Funds update (agenda item 22)

Susan Baines (SB) presented the draft Charitable Funds Accounts for 2025/26. She advised that the accounts had been reviewed by the Charitable Funds Committee in June and were currently with the Independent Examiner, with no significant issues raised to date. The final accounts would be presented to the Charitable Funds Committee in September

2026 for approval.

MF sought clarification on the approval process and SB confirmed that approval rested with the Charitable Funds Committee rather than Audit Committee. MF noted that any further comments from members could be submitted directly to SB prior to finalisation.

It was RESOLVED to NOTE the Draft Charitable Funds annual report and accounts and timetable for the completion and approval

AC/26/65 Oversight of Covid 19 public enquiry update (agenda item 23)

Julie Hall (JH) presented an update on the Covid 19 Public Inquiry and reported progress across the Inquiry modules, including learning emerging from Module 3 relating to healthcare services. She advised that the associated organisational risk had been stepped down to operational level following progress made through the Inquiry process and the absence of any significant concerns arising from the Trust's involvement.

MF queried why the report continued to be presented to Audit Committee following the de-escalation of the risk. JH and AL advised that continued oversight remained appropriate given the importance of information governance, records management and any future implications arising from the Inquiry.

JH reported that future Inquiry activity would include modules relating to care services and highlighted work underway with the EPRR team to incorporate learning from Module 3 into future emergency preparedness and resilience arrangements. MF welcomed this approach and noted the opportunity to strengthen organisational preparedness for future major incidents.

It was RESOLVED to NOTE the Oversight of COVID-19 Public Inquiry Update and the arrangements in place to embed emerging learning from the Inquiry.

AC/26/66 Annual work plan (agenda item 24)

MF presented the Annual Work Plan and advised that no substantive amendments were proposed. He noted that the plan continued to provide appropriate coverage of the Committee's responsibilities and would form part of the handover arrangements for his successor as Audit Committee Chair.

Before closing the meeting, NM thanked MF on behalf of the Committee for his leadership, professionalism and commitment as Chair of Audit Committee. MF thanked Committee members, advisers and officers for their support and contribution to the work of the Committee.

It was RESOLVED to NOTE the Annual Work Plan Update.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Minutes of the Finance, Investment & Performance Committee
Held on 20 July 2026
(Virtual meeting, via Microsoft Teams)

	Jayne Brown (JB)	Chair of the Trust
Attendees	Gary Ellis (GE)	Non-Executive Director (Chair)
	Rokaiya Khan (RK)	Non-Executive Director
	Adrian Snarr (AS)	Director of Finance, Estates & Resources
	Mike Gill (MG)	NHS Alliance (Observing)
	Adele Fox (AF)	Chief Operating Officer
	Sue Barton (SB)	Deputy director of strategy, inclusion and change (item 5)
	Mel Wood (MW)	Head of performance and business intelligence
Apologies:	Rob Adamson (RA)	Deputy Director of Finance

FIP/26/19 Welcome, introduction, and apologies (agenda item 1)
The Chair, Gary Ellis (GE), welcomed members to the meeting and extended a particular welcome to Mike Gill, NHS Alliance, who was attending as part of the Trust's Well-Led Developmental Review. Apologies for absence were received from Rob Adamson (RA). Members were advised that the meeting was being recorded for administrative purposes and that the recording would be deleted once the minutes had been finalised.

FIP/26/20 Declarations of interest (agenda item 2)
There were no declarations of interest reported in the meeting

FIP/26/21 Minutes from previous Committee meetings held on 22 June 2026 (agenda item 3)
There were no issues raised and the minutes of the previous meeting on the 22 June 2026 were accepted as a true and accurate record.

FIP/26/22 Finance Matters arising from previous meeting held on 22 June 2026 (agenda item 4)

FIP/26/23 Annual Review of Trust Strategy (agenda item 5)
Sue Barton (SB) presented the first annual review of the Trust Strategy and Strategic Measurement Framework, advising that it had been developed to assess delivery of the Trust's strategic aims and support consideration of whether the strategy was being successfully delivered. The review concluded that good progress had been made during the first year, whilst identifying areas for further development. Partner feedback had now been received and would be incorporated into the version presented to Board.

Committee Members welcomed the report and framework. Jayne Brown (JB) commented that the ambition element felt less developed than other areas and encouraged further consideration of how organisational stretch and ambition could be articulated across key areas of work. Adele Fox (AF) noted that many existing programmes were already ambitious in scale and complexity, whilst Rokaiya Khan (RK) suggested focusing on a small number of priority areas where the Trust could demonstrate additional ambition. JB also welcomed the question-and-answer format but cautioned against creating an "echo chamber", recommending that future reports place greater emphasis on opportunities for improvement alongside achievements. SB welcomed the feedback and advised it would inform future development of the report and framework.
GE welcomed the report as a strong foundation and noted that it had prompted valuable discussion regarding strategic delivery and organisational priorities. In discussing delivery of the strategy, GE highlighted that the Trust had delivered £28.2m of efficiency savings during 2025/26 and sought clarification regarding the change in the reported year-end financial position. AS explained that,

following audit review, a number of accruals had been challenged and it was agreed that the criteria for an obligating event had not been met in relation to the provision for Band 2–3 bank nurse back pay. Removal of the approximately £2m accrual resulted in the forecast surplus increasing from around £0.14m to just over £2m. AS confirmed that the revised position had been scrutinised by Audit Committee, reflected in the audited accounts and discussed with NHS England prior to submission.

The Committee noted the positive progress made against the Trust Strategy and Strategic Measurement Framework, whilst recognising the need for continued development of the ambition and challenge elements of future reporting.

FIP/26/24 Items delegated to Finance, Investment and Performance Committee from Trust Board agenda item 6)

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

FIP/26/25 Performance (agenda item 6)

6.1 Finance, Investment and Performance Risk Register

Adrian Snarr (AS) presented the risks within the Committee's remit and advised that all risks had been reviewed since the previous meeting, with no changes proposed to risk scores.

The Committee noted the ongoing risks associated with financial sustainability, delivery of the Value for Money (VFM) programme, capital planning and Integrated Care Board (ICB) structural changes. Mitigating actions included oversight of unfunded cost pressures, delivery of workforce reduction and temporary staffing plans, review of loss-making services, and work to strengthen capital planning and reporting. It was also noted that the development of place-based provider collaboratives and reductions in ICB capacity remained areas requiring ongoing monitoring.

GE sought assurance regarding the relationship between workforce reduction plans and delivery of the Trust's strategic ambitions. AS advised that workforce efficiencies, including reductions in sickness absence and training costs, formed part of the approved VFM programme and that success would ultimately be measured through delivery of planned headcount reductions and achievement of the required financial run rate.

JB emphasised that ambition and financial sustainability should not be viewed as mutually exclusive and suggested that service redesign and innovation could support both strategic ambitions and cost reduction. Members also discussed whether the current risk ratings fully reflected the financial challenges facing the Trust. AS advised that whilst the Trust remained financially sustainable, delivery of the current year's financial plan was proving challenging and requiring close management, with some reliance on non-recurrent measures. He stressed the importance of ensuring the Board had a clear understanding of both the current position and the scale of the challenges ahead.

RK queried whether the target risk scores remained realistic in the current financial environment. AS acknowledged that the targets were challenging but considered them both realistic and necessary to support delivery of the Trust's wider ambitions and priorities. AF highlighted the significant scale of savings required across care groups and emphasised the importance of balancing financial improvement with the continued delivery of safe, high-quality services.
GE agreed, reiterating that whilst financial sustainability remained essential, quality and patient safety must remain the overriding priority.

The Committee noted the current risk position, recognising the ongoing financial challenges facing the Trust, the mitigating actions in place and the importance of maintaining a clear focus on quality and patient safety.

6.2 May Integrated performance dashboard

Mel Wood (MW) presented the May Integrated Performance Report (IPR), noting that it had previously been considered by Board and that no additional matters were being escalated to Committee. Members were advised that work on the June IPR was already underway and that performance had moved on since the reporting period covered by the report.

GE sought assurance regarding workforce pressures within the Calderdale and Kirklees Single Point of Access (SPA) service, particularly vacancies and increasing demand for urgent assessments. AF advised that recruitment to clinical posts remained a priority and had not been restricted. She explained that current pressures reflected a combination of vacancies and sickness absence and highlighted the positive impact of a Quality Improvement (QI) programme implemented to address previous performance concerns. MW confirmed that performance against the 14-day assessment target continued to exceed the required 80% standard, and that current service pressures were not impacting delivery of the target.

The Committee welcomed the assurance provided regarding Single Point of Access (SPA) performance and noted the continued monitoring and improvement work underway within the service.

6.3 National Oversight Framework 26/27

Mel Wood (MW) presented the updated NHS Oversight Framework (NOF) report, advising that further national guidance had provided greater clarity regarding the metrics that would apply to the Trust. The framework now comprised 25 scoring metrics and five contextual metrics, and the report had been updated to include benchmarking against high-performing organisations.

Current modelling indicated that the Trust remained on track to achieve an overall NOF rating of 1 or 2, with an indicative score of 1.6. Two areas were currently forecast to score 3: paired outcome measures for people accessing mental health services and temporary staffing costs. Further work was underway to refine local forecasts and clarify a small number of national metrics ahead of Quarter 1 results, expected in September 2026.

Committee members discussed the temporary staffing measure and noted that the national methodology focused on overall temporary staffing usage rather than associated premium costs, meaning the Trust's staff bank arrangements were not distinguished from premium-rate agency usage. AF welcomed the report and noted that, whilst the NOF provided an important improvement focus, the Trust remained subject to a wider range of mental health performance measures and national reporting requirements.

RK sought clarification regarding the paired outcome measures indicator. MW explained that current performance was largely influenced by recording practices and data quality rather than clinical activity. AF confirmed that service users were receiving the required contacts and interventions, but outcomes were not always being recorded consistently. A Quality Improvement programme was underway to improve compliance and data quality.

GE welcomed the progress made in developing the Trust's understanding of the framework and the inclusion of benchmarking information to support assurance and performance improvement.

The Committee noted the updated NHS Oversight Framework report, the forecast organisational position, and the ongoing work to improve performance in relation to temporary staffing and outcome measure recording.

6.4 ADHD/ASD/LD Care Group Deep Dive

Adele Fox (AF) presented the ADHD, ASD and Learning Disability (LD) Care Group Deep Dive report, highlighting strong performance across workforce, quality and financial measures despite increasing demand. Members noted that ADHD and ASD services continued to perform well, with no agency

spend and minimal bank usage, whilst Learning Disability services faced ongoing challenges in recruiting specialist staff where demand exceeded commissioned capacity.

Demand for ADHD and ASD services continued to exceed commissioned capacity. However, clinical triage arrangements were helping to slow waiting list growth and manage demand more effectively. Members noted that Calderdale had recently invested in this approach and that work was underway with commissioners and independent providers to develop additional assessment and treatment pathways, including medication support.

The Committee also noted strong workforce indicators across ADHD and ASD services, including low sickness absence, high appraisal compliance and robust supervision arrangements. AF attributed this to strong leadership and a culture of innovation and service improvement. Whilst Learning Disability services had experienced some challenges in recording supervision following changes to reporting requirements, plans were in place to address this.

RK welcomed the positive workforce indicators achieved within a service experiencing sustained demand and noted that the strong performance in relation to supervision and sickness absence reflected positively on the leadership and culture within the service. AF agreed and highlighted the continued commitment of the leadership team to innovation and service improvement.
GE welcomed the positive report and the significant achievements delivered by the care group despite ongoing demand pressures.

The Committee noted the ADHD, ASD and Learning Disability Care Group Deep Dive report, recognising both the positive performance achieved across workforce, quality and financial measures and the continued challenges associated with demand growth and specialist workforce capacity.

6.5 Waiting List Report

Adele Fox (AF) presented the Waiting List Report, highlighting continued demand pressures across a number of services, particularly ADHD and ASD pathways. It was noted that clinical triage arrangements were helping to slow waiting list growth and improve prioritisation, and that work continued with commissioners and independent providers to increase assessment and treatment capacity.

Within CAMHS, quality improvement activity was delivering positive results across all localities. Waiting times in Wakefield had improved significantly, whilst Barnsley had reduced long waits to a single child waiting over 12 months. Performance challenges remained within Kirklees due to increasing demand, workforce pressures and higher utilisation of crisis services. Further work was underway to understand the causes of variation between localities. Members also noted continued strong performance within Learning Disability Services and sustained improvements in Paediatric Cardiology services, although AF cautioned that performance remained dependent on a small specialist workforce.

Committee members discussed challenges arising from ADHD shared-care arrangements in Barnsley. AF advised that a growing number of GP practices were declining to participate in shared-care arrangements, resulting in patients remaining under secondary care services for longer and creating additional capacity pressures. GE highlighted the potential impact on both service users and waiting times. JB suggested engagement through Local Medical Committees, Primary Care Networks and neighbourhood arrangements, alongside the provision of additional support and training where appropriate. AF confirmed that discussions with commissioners were ongoing and agreed to provide a further update.

ACTION: Adele Fox

RK welcomed the inclusion of equality data but questioned whether the conclusion that there was no evidence of disproportionate impact fully reflected the experiences of some communities. AF agreed that data alone did not always explain underlying causes and confirmed that further work was

underway to understand whether deprivation and population diversity were influencing demand and access patterns. GE also welcomed the work being undertaken to understand variation in CAMHS waiting times and whether successful approaches in Wakefield could be replicated elsewhere.

The Committee noted the Waiting List Report, recognising the ongoing demand pressures across several services whilst acknowledging the improvements achieved through quality improvement activity, clinical triage arrangements and targeted service developments. The Committee also noted the ongoing work to address ADHD shared-care challenges and better understand variations in demand and access across localities.

FIP/26/26 Finance (agenda item 7)

7.1 Financial context – NHS England (month 2)

AS presented the regional financial context report, noting that the Trust was now receiving regional reports in place of the previous ICB-focused reporting arrangements following changes to NHS England and ICB structures. Whilst further ICB reporting was expected to resume, much of the current information duplicated the regional position and its future value would be reviewed.

Committee members noted that the North East and Yorkshire region was currently the sixth worst-performing region nationally from a financial perspective and faced increasing financial challenge. Whilst North Yorkshire and Humber remained the most challenged system, West Yorkshire was also experiencing significant financial pressures that were likely to influence future regional performance and oversight arrangements.

Attention was drawn to the workforce data, which showed the Trust's whole-time equivalent workforce remained below plan at Month 2, although pay expenditure was above plan and had therefore been flagged as an adverse variance within regional reporting. This was largely attributable to the nationally agreed Agenda for Change (AFC) pay award and associated pay pressures. Members noted that delivery of the Value for Money (VFM) programme remained heavily dependent on reducing pay expenditure through workforce-related initiatives.

The Committee also noted that the Trust continued to perform positively against agency expenditure targets but remained challenged in relation to bank staffing expenditure. Whilst many organisations nationally were experiencing similar difficulties in reducing temporary staffing costs, the Trust would need to deliver its own planned reductions to achieve its financial objectives.

GE welcomed the update and noted that, whilst the Trust generally remained below the regional radar compared with some organisations, the workforce and pay position reinforced the importance of maintaining strong oversight of delivery against financial plans. Committee members recognised that the pressures being experienced across the region reflected the challenging financial environment facing all NHS organisations.

The Committee noted the NHS England Month 2 Financial Context report and the continued focus required on workforce expenditure, temporary staffing usage and delivery of the Trust's VFM programme.

7.2 Month 3 Finance Report

Adrian Snarr (AS) presented the Month 3 Financial Performance Report, advising that whilst the Trust remained on plan overall and most key financial indicators remained green, the underlying financial position continued to be challenging. Members noted that the reported position had been supported by a number of non-recurrent measures and that the underlying run rate remained behind plan, largely due to pay expenditure pressures. AS emphasised that the current position could not rely indefinitely on non-recurrent measures and that maintaining grip on workforce expenditure would be critical to delivery of the financial plan.

The Committee received an update on workforce expenditure and temporary staffing. Whilst substantive staffing remained broadly in line with plan, forecasts indicated workforce expenditure could increase above planned levels if additional controls were not introduced. Members noted that delivery of the Trust's financial plan remained heavily dependent on reducing bank spend and delivering planned workforce efficiencies.

GE sought assurance regarding the ability of the Temporary Staffing Group to oversee wider workforce pressures and support delivery of the required savings. AF advised that additional measures were being implemented, including a peripatetic workforce model to improve staff deployment and reduce reliance on temporary staffing. She also reported successful recruitment within the Mental Health Care Group, with further recruitment activity continuing within Forensic Services.

JB welcomed the additional controls being introduced but sought assurance regarding alignment between workforce and financial reporting, emphasising the importance of a clear and consistent understanding of workforce establishment, staffing levels and expenditure. AS confirmed that workforce and finance data were routinely reconciled and agreed that future reporting should clearly demonstrate the relationship between workforce and financial metrics.

JB also sought clarification regarding the actions being taken to strengthen financial grip and control. Members heard that measures under consideration included tighter vacancy controls, review of temporary staffing usage, implementation of revised mandatory training arrangements and continued oversight of fixed-term appointments. AS emphasised the importance of a cumulative approach to workforce cost control and robust governance of temporary staffing expenditure. JB further stressed the importance of identifying additional contingency mitigations at an early stage, rather than waiting for uncertainty regarding existing schemes to crystallise. AS acknowledged the need to continue developing further mitigating actions alongside delivery of the existing financial plan.

RK queried whether the Mutual Agreed Resignation Scheme (MARS) would contribute to workforce savings. AS advised that expressions of interest were being assessed and any approved applications would be required to demonstrate a clear financial benefit, including a positive impact within 2026/27. In reviewing the Value for Money (VFM) programme, members noted that corporate savings were over-delivering and helping to offset pressures elsewhere. Workforce-related savings remained categorised as high risk due to their scale and reliance on reducing temporary staffing expenditure. Non-pay savings were generally delivering in line with, or above, plan. Positive progress was also noted in reviewing historically loss-making services, particularly within the Balancing Physical Health Care Group, where detailed plans and commissioner engagement were supporting a more sustainable financial position.

GE sought assurance regarding the balance of recurrent and non-recurrent savings and the extent to which high-risk schemes could be converted into lower-risk delivery plans. AS advised that work was continuing to strengthen the recurrent position and reduce reliance on one-off measures. Whilst all required schemes had been identified within the financial plan, further work was needed to provide assurance that workforce efficiencies would be delivered in line with planned trajectories.

AF highlighted the significant scale of savings required across care groups and emphasised that delivery of the VFM programme must continue to be balanced against maintaining patient safety and quality of care.

The Committee noted the Month 3 Financial Performance Report and VFM update, recognising the challenging financial position, the continued reliance on workforce-related savings and temporary staffing reductions, and the actions being implemented to strengthen delivery of the Trust's financial plan.

7.3 Financial Forecast

Adrian Snarr (AS) presented the financial forecast, noting that it remained early in the financial year and reflected a range of best-case, most-likely and downside scenarios. Committee members noted that the forecast incorporated known risks and mitigations, alongside a number of potential opportunities, including funding associated with the Older People's Strategy, workforce assumptions, reduced out-of-area placements and collaborative arrangements within CAMHS. Further work was underway to validate these assumptions and determine the extent to which they could be reflected in future forecasts.

AS advised discussions continued with commissioners regarding funding linked to the Older People's Strategy and that the Yorkshire and Humber CAMHS collaborative was forecasting an underspend following significant performance improvement. Discussions were underway regarding the potential return of the Trust's share of those resources.
AF highlighted the ongoing pressures associated with older people's services, noting that Barnsley had not invested in the Older People's Strategy transformation programme or commissioned dementia beds, creating both operational and financial pressures which were being managed through the Value for Money (VFM) governance arrangements.

JB sought assurance regarding the extent to which mitigations had already been built into the forecast and challenged whether sufficient contingency planning was underway. AS confirmed that the forecast reflected the identified VFM programme and known mitigating actions but agreed that additional contingency plans would be required should delivery assumptions not be achieved. He advised that further work was underway to test the robustness of the financial plan, validate assumptions and identify additional mitigations where required. AS also noted an emerging regional focus on organisational run-rate performance, reinforcing the need to ensure expenditure trajectories remained sustainable.

JB welcomed this approach but stressed the importance of identifying potential additional mitigations at the earliest opportunity rather than relying solely on existing plans. AS agreed and advised that the next one to two months would be critical in determining confidence levels around delivery of planned savings and whether further interventions would be required.

Committee members recognised the significant work being undertaken across the organisation to support delivery of the financial plan. JB acknowledged the considerable effort being made by teams across the Trust and noted that the financial challenges facing SWYPT reflected the wider pressures being experienced across the NHS.

The Committee noted the financial forecast and associated risk assessment, recognising the challenging financial environment and the continued reliance on a number of mitigations to support delivery of the financial plan. Members supported the ongoing development of additional mitigations and contingency measures and emphasised the importance of maintaining close oversight of delivery against the plan, with particular focus on the underlying financial run-rate and the achievement of recurrent savings.

7.4 Delivering the NEY 2026/27 Financial Plan

Adrian Snarr (AS) presented an update on the emerging NHS England regional approach to delivering the 2026/27 financial plan, noting that the paper had been received shortly before publication of the agenda and had not yet been fully considered by the Executive Management Team. Committee members heard that increasing financial pressures across the North East and Yorkshire region, alongside changes to NHS England and ICB operating models, were driving a significant shift in regional oversight arrangements.

The Committee noted the introduction of a new regional risk stratification framework, under which organisations would be categorised according to financial performance, governance and delivery confidence. Based on current criteria, AS advised that the Trust would be expected to fall within the

lowest-risk category, reflecting its balanced financial plan, strong governance arrangements and track record of financial stewardship. However, workforce expenditure and delivery of workforce-related savings would continue to be closely monitored by the region.

Committee members were advised that the emerging regional approach placed greater emphasis on financial grip, organisational run-rate performance and detailed oversight. Whilst previous national approaches had focused on earned autonomy for high-performing organisations, the new framework reflected a more interventionist model, with the level of scrutiny determined by an organisation's risk rating.

AS also provided an update on work being undertaken by Simon Worthington to support development of a revised financial improvement methodology. The approach focused on detailed run-rate analysis, risk-adjusted forecasting and a clearer distinction between genuine efficiency savings and technical or non-recurrent measures. Although initially developed for financially challenged organisations, it was now being considered for wider adoption across the region.

JB reflected on recent discussions at the Chairs and Chief Executives meeting, highlighting the challenge of balancing organisational ambition, innovation and transformation with increasing levels of external assurance and scrutiny. JB supported proactive consideration of the methodology and suggested that, regardless of whether implementation became mandatory during 2026/27, elements were likely to become embedded in future years. AS agreed and emphasised the importance of preparing in advance, noting that some aspects, including weekly workforce reporting and more granular financial monitoring, would require significant changes to current reporting arrangements. However, early adoption would place the Trust in a stronger position should the requirements become mandatory.

The Committee acknowledged Simon Worthington's work to promote greater transparency between organisations and regulators, recognising the importance of creating an environment where Trusts can openly discuss financial risks and challenges.
GE welcomed the update and requested that further information be shared as regional requirements become clearer.
The Committee noted that the emerging framework represents a significant shift in the oversight and management of financial performance across the region.

FIP/26/27 Investment (agenda item 8)

8.1 Capital Focused project update

Kevin Gelder (KG) presented the update and advised that strengthening capital planning and reporting was a key priority following his recent appointment. He welcomed the opportunity to discuss how future reporting could best support the Committee's oversight role.
The Committee received an update on the Trust's major capital schemes, including the Older People's Strategy (OPS), Brook Ward refurbishment and the North Kirklees Hub development at Beckside Court.

In relation to the OPS, KG reported progress in resolving outstanding design and procurement issues. Following recent discussions with Kier, project managers and cost consultants, there was increasing confidence that most key risks had been addressed. Work was progressing towards agreement of the Guaranteed Maximum Price (GMP), with the final cost submission expected by 14 September 2026. Subject to cost consultant review and approval through governance processes, construction was expected to start in November 2026. Limited enabling works were also being explored ahead of the main contract award.

The Committee noted that planning approval for the Brook Ward refurbishment at Cheswold Park was expected by the end of July 2026. KG advised that the scheme formed part of the Trust's wider estates strategy and would address both ward refurbishment requirements and underlying water infrastructure

issues. Current indications were that the available safety funding would be fully utilised during the year.

KG also updated members on the North Kirklees Hub development at Beckside Court. Investigative work had identified significant fire safety and building regulation compliance issues relating to the staircase. Consultants were developing a proposed solution and quantifying the associated costs. Although landlord responsibilities remained under discussion, members noted that the Trust held a full repairing lease and was therefore responsible for a substantial proportion of the remediation work. The project team continued to assess the financial and operational implications.

AS provided further financial context, advising that expected slippage in the OPS programme would bring the capital programme back into balance following previously reported pressures. He also confirmed that NHS England funding approval had been secured for the Beckside Court scheme, enabling expenditure to be brought forward into the current financial year.

AF queried whether the approved funding represented additional capital resource for the Trust. AS clarified that it primarily enabled accelerated delivery in the current year, although it ultimately represented additional investment in the capital programme.

GE acknowledged the progress made, recognising the challenges of delivering major capital schemes within a constrained capital environment. He emphasised the need to maintain robust governance as the OPS progressed towards final approval and implementation.

FIP/26/28 Any other business (agenda item 9)
There were no further items to discuss.

GE thanked members for their attendance and contributions. He noted that the Committee had considered a particularly busy agenda and welcomed the high standard of papers and discussion, which had enabled members to give thorough consideration to the issues presented.

South West Yorkshire Partnership Teaching
NHS Foundation Trust

Minutes of the Finance, Investment & Performance Committee
Held on 17 August 2026
(Virtual meeting, via Microsoft Teams)

	Gary Ellis (GE)	Non-Executive Director (Chair)
	Rokaiya Khan (RK)	Non-Executive Director
	Adrian Snarr (AS)	Director of Finance, Estates & Resources
	Rob Adamson (RA)	Deputy Director of Finance
	Chris Lennox (CL)	Director of Services Mental Health and Children & Young People Mental Health
Apologies:	Jayne Brown (JB)	Chair of the Trust
	Adele Fox (AF)	Chief Operating Officer

FIP/26/29 Welcome, introduction, and apologies (agenda item 1)

The Chair of the Committee, Gary Ellis (GE), welcomed everyone to the meeting. The above apologies were received. The meeting is being recorded for administrative purposes and would be deleted after the minutes were completed.

FIP/26/30 Declarations of interest (agenda item 2)

There were no declarations of interest reported in the meeting.

FIP/26/31 Items delegated to Finance, Investment and Performance Committee from Trust Board (agenda item 3)

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

FIP/26/32 Finance (agenda item 4)

4.1 West and South Yorkshire financial context

Rob Adamson (RA) presented an update on the regional financial position and emerging NHS England assurance arrangements. It was reported that the financial position across the region continued to deteriorate and that NHS England had introduced additional assessment tools and scrutiny processes, with particular focus on workforce expenditure, pay controls and efficiency delivery.

RA outlined the revised assurance framework, including a shift from "earned autonomy" to "earned intervention". Organisations delivering their financial plans would retain greater autonomy, whilst those moving off plan would be subject to increasing intervention. It was explained that one of the assessment measures related to variances against plan and that there would be an increased focus on underlying run-rate performance.

The regional Provider Assurance Model (PAM) was discussed, which is intended to assess recurrent financial performance and distinguish between recurrent and non-recurrent measures. RA advised that the model would be used to assess the sustainability of organisations' financial positions and was expected to become an increasingly important component of regional assurance arrangements.

Adrian Snarr (AS) advised that the Trust currently remained rated green but was close to the threshold for amber status. It was explained that the Trust's use of non-recurrent actions to support delivery of its financial position could become more visible through the PAM methodology and that future assessments were likely to place greater emphasis on underlying recurrent performance.

Rokaiya Khan (RK) queried the realism of maintaining a break-even position in light of existing financial pressures and wider system challenges. AS acknowledged the challenge and advised that the revised assurance arrangements were specifically intended to test the sustainability of organisations' financial positions and expose reliance on non-recurrent solutions.

GE referenced discussions arising from a recent NHS England Finance Committee Chairs network meeting and highlighted the increasing focus on aligning financial, workforce and quality oversight. He sought views on whether further consideration should be given to how assurance across Trust committees is triangulated. AS advised that the Trust already undertook significant triangulation through Board reporting but had not yet seen evidence of equivalent alignment within regional assurance processes.

AS further advised that organisations subject to increased intervention could be required to provide additional reporting, including more frequent workforce information. Work was underway between Finance and the People Directorate to understand the reporting requirements and how these could be supported locally.

4.2 Month 4 finance report

RA presented the Month 4 Finance Report, advising that the Trust had delivered a deficit broadly in line with plan for July and remained marginally ahead of plan year to date. However, it was emphasised that delivery of the position had required the use of non-recurrent measures totalling approximately £600k across the first four months of the financial year.

RA advised that whilst the Trust's underlying run rate had improved marginally during July, the pace of improvement was insufficient to match the planned trajectory. As a consequence, non-recurrent actions had been required to maintain the year-to-date position. AS advised that whilst such actions were necessary in-year, they were not sustainable over the longer term.

AS outlined the NHS England focus on run-rate performance and the implications of the new Provider Assurance Model. AS highlighted that the underlying financial position would become increasingly visible through revised assurance arrangements and that reliance on one-off measures would be more readily exposed.

RA identified workforce as the principal driver of financial pressure. The Trust had utilised approximately 25 more full-time equivalent posts than planned during the month and associated workforce expenditure continued to exceed plan. RK sought clarification regarding the increase in staffing numbers and whether this reflected expected recruitment activity. RA and CL explained that targeted recruitment had been undertaken, particularly within inpatient services, and that temporary additional costs arose through onboarding, mandatory training and the time required before reductions in temporary staffing could be fully realised. Whilst recruitment was expected ultimately to reduce reliance on temporary staffing and improve quality and continuity of care, AS highlighted that workforce variances had been adverse in three of the first four months of the year and were making a significant contribution to the financial pressures being experienced.

RA further advised that both West Yorkshire and South Yorkshire Provider Collaboratives continued to experience higher than anticipated activity levels and demand, resulting in forecast overspends. AS advised that further work was underway to review forecasting methodologies and ensure assumptions relating to admissions and discharges were sufficiently robust.

Temporary staffing expenditure was also considered. RA reported that, whilst expenditure remained above plan, forecast assumptions anticipated reductions during the remainder of the year as recruitment initiatives became established. Delivery of the forecast reduction was dependent upon successful recruitment and the associated reduction in temporary staffing expenditure.

RA reported that non-pay expenditure remained broadly well controlled, although timing issues had resulted in some significant monthly movements, including expenditure associated with the IT laptop replacement programme. Training, education and pharmaceutical expenditure had increased during the month, whilst other areas had shown reductions.

The Value for Money (VfM) Programme was reviewed to assess whether reported delivery adequately reflected the underlying financial position. RA advised that whilst reported VfM performance remained positive, some schemes reflected cost avoidance or expenditure substitution rather than reductions in underlying run-rate expenditure. AS acknowledged the challenge of presenting a position where most financial indicators remained green despite the significant underlying financial pressures facing the Trust, explaining that emerging NHS England methodologies increasingly focused on recurrent cost reductions and underlying run-rate performance. He noted the disconnect between the reported indicators and the underlying financial pressures reflected in the Trust's run-rate position.

GE welcomed the additional detail provided on care group variances and sought assurance regarding the actions being taken to address areas reporting financial pressure. RA advised that all care groups were subject to ongoing scrutiny through recovery planning arrangements and that discussions were taking place regarding opportunities to secure recurrent improvements. AS stressed the importance of avoiding unintended consequences from further savings measures and ensuring that actions taken did not adversely impact service delivery or transfer workload into clinical roles.

The balance sheet position was reviewed, including accrued income balances. RA advised that accrued income had increased primarily due to agreed income associated with Cheswold Park that had not yet been received. AS highlighted that increasing accrued income balances should remain an area of focus and challenge, noting the importance of timely recovery of outstanding income.

AS provided an update on the capital programme and advised that revised cost estimates for the OPS scheme were expected to exceed the original business case assumptions due to inflationary pressures and project developments. AS further reported that the Trust had secured a £2m capital allocation through the surplus incentive scheme, which would support future capital planning and provide additional flexibility within the medium-term financial plan.

4.3 Financial forecast

RA presented the Month 4 financial forecast and advised that the baseline forecast position had improved by approximately £3m since Month 3. This reflected a combination of non-recurrent benefits, improved performance in some areas and refinements to workforce forecasting assumptions. Whilst the movement was positive, RA emphasised that significant financial risks remained and that further mitigating actions would be required to achieve the planned breakeven position.

RA outlined the development of revised forecasting methodologies to align with the emerging NHS England Provider Assurance Model (PAM). A comparison was provided between the Trust's traditional forecast, the PAM-based run-rate forecast and the detailed baseline forecast. The PAM methodology indicated an underlying deficit position of £7.9m, whilst the detailed baseline forecast indicated a deficit

of £11.6m. RA advised that the purpose of the revised approach was to provide greater visibility of the Trust's underlying run-rate position and the gap requiring mitigation during the remainder of the year.

GE welcomed the use of the revised forecasting presentation and commented that it provided a clearer understanding of the scale of improvement required in the Trust's underlying run rate to achieve the planned financial position by year end.

RA outlined the forecast risks and mitigations, advising that significant uncertainty remained around delivery of a number of assumptions. A more detailed breakdown of workforce-related mitigations had been incorporated within the forecast to improve transparency and demonstrate the contribution expected from individual initiatives. RA advised that, whilst forecast scenarios had improved since Month 3, the most likely scenario continued to indicate a financial deficit and did not yet demonstrate delivery of a breakeven position. Further interventions would therefore be required during the remainder of the financial year.

AS advised that the forecast incorporated a combination of intelligence from finance managers, assumptions regarding delivery and a number of technical judgements. It was emphasised that transparency regarding non-recurrent interventions and forecasting assumptions would be maintained through ongoing reporting to the Committee. AS acknowledged that a gap remained between the current forecast position and the planned breakeven position and advised that demonstrable improvements in run-rate performance would be required over the coming months to maintain confidence in delivery of the financial plan.

GE questioned whether the current governance arrangements around staffing expenditure remained sufficiently focused on the key drivers of financial pressure. AS advised that consideration was being given to bringing substantive and temporary staffing oversight together within a single forum, enabling a more integrated approach to workforce planning, vacancy management and temporary staffing expenditure. It was reported that greater understanding had now been developed regarding the principal drivers of temporary staffing expenditure, including sickness, training requirements and patient acuity.

RK commented on the importance of understanding the point at which alternative mitigations may be required should the forecast trajectory fail to improve. RK also welcomed the clearer articulation of the relationship between value for money delivery, workforce performance and the underlying financial position.

AS outlined the work underway to address workforce pressures and temporary staffing expenditure, including sickness, training-related backfill requirements and staffing pressures associated with patient acuity. Chris Lennox (CL) provided assurance that actions were being taken to manage inpatient occupancy levels safely, reduce avoidable pressure on inpatient services and support more effective utilisation of staffing resources.

Medical staffing and on-call arrangements were also discussed. AS advised that reviews were underway to assess whether alternative approaches to on-call rotas could maintain service and safety requirements whilst reducing financial pressures associated with temporary medical staffing.

GE queried whether the Trust's teaching status had resulted in increased training expectations and associated expenditure. AS advised that there was currently no evidence of increased training demand arising from teaching trust status, but that the designation was supporting recruitment by strengthening the Trust's reputation as a training organisation.

AS concluded by advising that, whilst delivery of the financial plan remained challenging, the focus remained on securing sustainable improvements in run-rate performance and implementing further mitigations where required.

GE reflected that the revised reporting and forecast presentation had provided greater clarity regarding the Trust's underlying run-rate position and the scale of improvement required to achieve the planned year-end breakeven position.

FIP/26/33 Any other business (agenda item 5)

There were no further items to discuss.

GE thanked colleagues for their contributions and closed the meeting.

South West Yorkshire Partnership Teaching
NHS Foundation Trust

Minutes of the Finance, Investment & Performance Committee
Held on 23 September 2026
(Virtual meeting, via Microsoft Teams)

	Jayne Brown (JB)	Chair of the Trust
Attendees	Gary Ellis (GE)	Non-Executive Director (Chair)
	Rokaiya Khan (RK)	Non-Executive Director
	Adrian Snarr (AS)	Director of Finance, Estates & Resources
	Rob Adamson (RA)	Deputy Director of Finance
	Adele Fox (AF)	Chief Operating Officer
	Kevin Gelder (KG)	Deputy Director of Estates & Facilities
	Mel Wood (MW)	Head of performance and business intelligence
Apologies:		

FIP/26/34 Welcome, introduction, and apologies (agenda item 1)

The Chair, Gary Ellis (GE), welcomed members to the meeting. Members were advised that the meeting was being recorded for administrative purposes and that the recording would be deleted once the minutes had been finalised. No apologies for absence were received.

FIP/26/35 Declarations of interest (agenda item 2)

There were no declarations of interest reported in the meeting

FIP/26/36 Minutes from previous Committee meetings held on 20 July and 17 August 2026 (agenda item 3)

The minutes of the meetings held on 20 July and 17 August 2026 were approved as a true and accurate record.

FIP/26/37 Matters arising from previous Committee meetings held on 20 July and 17 August 2026 (agenda item 4)

Adrian Snarr (AS) updated the Committee on the action tracker, advising that ongoing actions had been reviewed to clarify the required outcomes and expected completion dates. He also provided updates on the following actions:

FIP/26/08 - AS advised that discussions with Kevin Gelder (KG) had identified a need to strengthen the Trust's approach to capital planning. Although there was grip and control of the overall programme, improvements were required to support earlier identification and management of slippage and provide more timely reporting to the Committee. KG was leading this work, and incremental improvements were expected as the revised approach developed.

FIP/25/81 - AS confirmed that an established Quality Impact Assessment process was in place for Value for Money (VFM) schemes. However, VFM oversight reporting had not always made clear whether the QIA had been reviewed and approved or whether any caveats or concerns required further monitoring. Future VFM reports would provide clearer assurance that a QIA was in place for each scheme, together with relevant information arising from the review and any requirement for reassessment where the scheme changed.

FIP/25/82 - AS advised that the review of the FIP Terms of Reference was required to ensure appropriate consideration of equality, diversity and inclusion and the new committee arrangements. JB confirmed that a wider review of all Board committee terms of reference and membership was planned. It was agreed that the FIP review would be incorporated into this programme, with AS liaising with the Andy Lister and JB to progress the work.

FIP/25/62 – The committee agreed to close this action, noting that routine activity reporting added limited value where activity did not affect contractual income. Any future reporting requirements to be considered through work on deconstructing block contracts and the developing relationship between activity and income.

GE sought an update on when the revised cost of the Older People's Strategy would be presented to Trust Board. KG advised that a firm estimate was expected by the end of September, with the Guaranteed Maximum Price (GMP) anticipated on 20 October. AS confirmed that the proposal was expected to be presented to Trust Board in October and would include the implications of the increased cost for the wider capital programme and how this could be managed within future capital allocations.

In relation to the existing ADHD business case action, AF proposed bringing together a number of South Yorkshire commissioning pressures for discussion with the Integrated Care Board. JB supported a collective discussion but emphasised that the individual pressures should remain clearly segmented and prioritised. This would enable commissioners to determine their priorities and ensure that responsibility for decisions about commissioned provision remained with the ICB.

The Committee noted the progress made in reviewing and clarifying the outstanding actions.

FIP/26/38 Items delegated to the Finance, Investment and Performance Committee from Trust Board (agenda item 5)

GE confirmed that there were no items delegated from Trust Board for consideration at this meeting.

FIP/26/39 Performance (agenda item 6)

6.1 Finance, Investment and Performance Risk Register

AS presented the risks within the Committee's remit and proposed increasing the score for risk 1957, relating to the impact of ongoing unfunded pressures on the Trust's financial viability. Although the Trust's planned savings were broadly being delivered, additional pressures were emerging which were affecting the overall financial position. These included costs associated with the provider collaborative and other services where funding did not reflect the activity being delivered.

GE highlighted the continuing financial impact of inflation and nationally agreed pay awards, particularly given the Trust's high proportion of pay expenditure. AS confirmed that the related risk remained on the risk register and advised that the different impact of national funding arrangements across NHS sectors continued to be raised nationally. He noted the potential for the approach to be reviewed in future years, although no change had been confirmed.

Rokaiya Khan (RK) sought clarification regarding the distinction between the two financial risks currently scored at 12. AS explained that risk 1957 related to services and activity for which the Trust was not sufficiently funded and therefore required engagement with commissioners regarding additional funding or service expectations. The second risk concerned actions within the Trust's control to reduce expenditure and deliver the required savings within its existing financial envelope.

The Committee noted the current risk position, agreed that the two risks represented distinct areas of financial exposure and supported the proposed increase in the score for risk 1957.

6.2 Update on Activity Reporting linked to Deconstruction of Block contracts

Rob Adamson (RA) presented an update on the national work to deconstruct block contracts, which aimed to link mental health funding more closely to activity and quality. The latest assessment, based on 2024/25 activity and a revised national pricing methodology, indicated that the Trust's costs would exceed the income received under the proposed model. This contrasted with the previous year's exercise, which suggested that the Trust would have received additional funding for activity delivered above commissioned levels.

RA explained that the revised outcome was principally affected by a national productivity assumption applied to the proposed prices. The result appeared inconsistent with the Trust's national cost collection data, which indicated that its services cost less than the national average.

AS advised that mental health and community trusts across the region had identified similar concerns. These included the productivity assumption, technical aspects of the methodology and the quality and depth of activity data available across the sector. Although the current exercise had highlighted significant risks, block contracts also presented challenges because funding did not increase when activity levels rose. Further national work would therefore be required to identify a workable approach to introducing greater variability into contractual income.

Adele Fox (AF) queried whether greater recognition would need to be given to patients requiring complex packages of care and higher staffing levels. AS explained that the current coding arrangements did not capture sufficient detail about patient complexity, acuity or resource requirements. Mel Wood (MW) confirmed that diagnostic information was recorded for inpatient episodes, but the coding was not sufficiently detailed to support differentiated pricing. AS advised that mental health and community services remained many years away from achieving the level of coding sophistication used within acute services.

6.3 National Oversight Framework 26/27

Mel Wood (MW) presented the Quarter 1 NHS Oversight Framework results, advising that the Trust had retained a segmentation score of 1. Direct comparison with the previous year was limited because of changes to the framework, which now included 25 scoring metrics applicable to the Trust.

The Trust ranked fifth among 58 providers and was one of only eight non-acute trusts to achieve a segmentation score of 1. Its average metric score was 1.84, within the threshold of below 1.94 for segment 1. MW advised that performance would continue to be monitored monthly.
The Trust ranked first for two metrics: community service waits exceeding 52 weeks and the proportion of intermediate care beds occupied by patients without criteria to reside. Performance had also improved for sickness absence and face-to-face contact within 24 hours of urgent referrals to mental health crisis teams.

RK welcomed the Trust's overall position but highlighted that the aggregated score could mask areas of concern, including paired outcome measures and the proportion of children and young people waiting over 104 weeks. She sought assurance that these areas were understood and subject to appropriate improvement work.

AF confirmed that quality improvement programmes were in place for the areas of concern and that access and waiting times remained Trust priorities. In relation to paired outcome measures, she explained that performance was affected by inconsistent completion and recording of the final outcome assessment with the patient. Work was underway to improve compliance. AS added that the Trust's wider Integrated Performance Report provided oversight of a broader range of measures than those included within the national framework.

AS highlighted that, although the metrics had changed and were not directly comparable with the previous year, the highest-performing organisations remained broadly consistent. He noted that the Trust continued to perform exceptionally well compared with its peers and that the introduction of a fixed threshold had resulted in relatively few trusts achieving segment 1.

GE queried the Trust's position for the percentage of clinical trials established within 90 days. MW advised that the Trust had forecast a score of 1 for this measure and was working with the Research and Development Team to understand the difference between the forecast and the reported result. The Trust anticipated achieving a score of 1 going forward. GE noted that the reported position did not appear consistent with expectations for a teaching trust and requested that it continue to be monitored.

6.4 Estates Deep Dive

Kevin Gelder (KG) presented the Estates and Facilities Deep Dive report, advising that the report covered a broader range of measures than those currently included within the Integrated Performance Report (IPR). He welcomed feedback on the information required to support the Committee's future oversight.

Compliance with planned legal and statutory maintenance requirements remained at 100%, and performance for urgent reactive maintenance was above target. However, prioritising statutory and urgent work, together with additional demands arising from work at Cheswold Park, was affecting delivery of routine maintenance, where performance was approximately 30%.

AF and JB sought assurance regarding maintenance arrangements at PFI-managed sites, particularly the Dales, and whether service standards reflected the requirements of mental health services. KG advised that further work was required to review the Service Level Agreements, compare them with the Trust's standards and identify any gaps. AS noted that the current PFI arrangements limited flexibility but advised that opportunities to improve service responsiveness would arise when the contracts ended and revised arrangements could be negotiated. Members also discussed variation in environmental quality across Trust sites and recognised the challenges presented by increasing costs and competing priorities.

JB suggested that the Board should take a wider interest in the capital programme, including its pace, priorities and the implications of the anticipated increase in the cost of the Older People's Strategy. AS advised that PLACE assessments remained broadly positive, although some environmental hotspots had been identified and negative feedback was increasing.
The Committee agreed that the available evidence should be considered collectively to provide a balanced understanding of the condition of the Trust's estate.

GE sought clarification regarding statutory compliance at Cheswold Park in light of the previously reported water issues. KG confirmed that statutory testing requirements were being met. The concern related to water quality at the point of use, which was being managed through dosing, remediation, ongoing testing and risk assessment.

KG reported that 150 ligature-related maintenance requests had been recorded during the reporting period, with three outstanding at month end. These had subsequently been completed. Access to wards was the most common reason for delay, and the Estates Team was working with matrons to ensure that identified work could be completed promptly.
Approximately 21,000 maintenance requests were received each year. KG also highlighted the impact of damage to the estate, particularly within seclusion rooms, which could result in significant repair costs and facilities being unavailable for extended periods. A task and finish group was examining patterns of damage and the specifications for seclusion rooms, Section 136 facilities and extra-care areas.

Further pressure arose where Estates staff were required to accompany contractors because services could not provide an escort. KG advised that this represented the equivalent of one whole-time post over the course of a month.
In relation to sustainability, KG advised that the Trust's Estates Returns Information Collection submission had been completed and would support calculation of the Trust's carbon footprint. Energy use was expected to represent the largest element of this work.
Performance for the servicing of medical devices was improving month by month but had not yet reached the required 100%. High-risk equipment, including defibrillators, was being prioritised. KG emphasised that services were responsible for locating equipment and making it available for servicing. Cleaning performance remained strong following the introduction of revised functional risk standards and new monitoring software.

FIP/26/40 Finance (agenda item 7)

7.1 Financial context – NHS England (month 4)

RA presented the NHS England Month 4 financial context, advising that the overall financial position remained challenging. The North East and Yorkshire region was behind plan, with West Yorkshire reporting a significant deficit of £16.3m, largely arising within the acute sector. He highlighted the continuing national and regional focus on workforce efficiency and temporary staffing. The Trust's agency expenditure remained low, although its bank expenditure continued to feature among the higher levels reported regionally. As the other mental health providers within the region were in a similar position, further benchmarking beyond immediate peer organisations was required to understand the reasons for the variation.

AS advised that the Month 5 information had been received after preparation of the paper and did not materially change the overall position. The North East and Yorkshire region remained an outlier nationally, with West Yorkshire continuing to experience financial pressure. He explained that the additional regional data provided opportunities to identify areas requiring further review. Although the Trust's overall agency usage was low, it had one of the highest-cost individual agency packages in the region.
RA clarified that the difference between the highest-cost packages was small, but acknowledged the importance of understanding and responding appropriately to the information presented.

The Trust's bank fill rate was the second highest in the region, despite having the third highest overall use of bank staff. AS questioned whether the Trust's ability to fill requested shifts contributed to its higher bank expenditure, compared with organisations where shifts remained unfilled. He advised that the emerging data would be considered through Executive and Value for Money governance arrangements to determine whether further action was required or whether it supported the work already underway.

GE sought clarification regarding the reported productivity measure and how it had been calculated. AS advised that the Trust appeared less favourable in Month 4 because of movement during the period, although its relative position remained positive. He expressed caution regarding the interpretation of the measure because of the significant variation between organisations and the difficulty in explaining some of the reported results.

RK queried whether the regional and West Yorkshire deficits could adversely affect the Trust despite its comparatively strong financial performance. AS advised that there was no direct impact provided the Trust delivered the financial plan it had submitted. However, there could be indirect consequences if resources were directed towards more financially challenged organisations or commissioners had less capacity to invest in new services. He confirmed that the Trust was expected to deliver its own agreed plan and was not currently being asked to improve its position to offset deficits elsewhere.

7.2 Month 5 Finance Report

RA presented the Month 5 Finance Report, advising that, although most reported financial indicators remained green and the Trust was ahead of plan, the underlying position remained extremely challenging. The Trust had recorded a year-to-date deficit of approximately £2.2m and an in-month deficit of £0.2m. The reported position included approximately £0.9m of non-recurrent mitigations, indicating an underlying year-to-date deficit of around £3m before these measures.
Additional commissioner funding relating to the Older People's Strategy workforce had been confirmed during the month and incorporated into the Trust's baseline position. However, significant financial pressures remained within the provider collaboratives because of increased service demand and associated costs. AS stressed that these pressures formed part of the Trust's overall financial position and could not be viewed separately from the requirement to deliver the agreed organisational plan.

Excluding the provider collaboratives, the Trust had achieved an in-month surplus, although the year-to-date position remained in deficit. RA advised that the focus was therefore on improving the

underlying run rate and identifying the further measures required to support delivery of the current year's plan and provide a sustainable basis for future years.

AS reported that the Trust had operated broadly in line with its workforce plan during the month, which represented an improvement on the earlier part of the year. However, current forecasts indicated that planned recruitment could move the Trust away from the agreed workforce trajectory during the second half of the year. Discussions were taking place with Executive colleagues regarding tighter controls over recruitment, including the potential for restrictions on corporate vacancies. AS recognised that controls within operational services were more complex because of the need to consider quality and patient safety.

JB sought greater clarity regarding the actions required to improve the financial position and questioned whether the Trust had a deliverable recovery plan. Concern was expressed that the current position relied heavily on discussion and analysis rather than implemented actions. AS acknowledged the challenge and advised that further work was underway with budget holders to strengthen controls, challenge forecast expenditure and identify additional mitigations. He recognised that substantive action, rather than technical accounting adjustments, would be required to improve the underlying position.

RK sought assurance regarding the management of bank staffing expenditure and whether lessons from agency controls could be applied more widely. AS and RA advised that agency expenditure related to a small number of individually managed posts, whereas bank expenditure was more complex and predominantly linked to inpatient services. Although expenditure had reduced compared with the previous year and approval controls were in place, further work was required to translate improved understanding of the causes of bank usage into sustained reductions. Members emphasised the need to move from analysis to decision-making where sufficient information was available.

GE highlighted that the workforce position for the month was broadly in line with plan and questioned why the Trust would allow staffing levels to increase during the remainder of the year. He suggested that maintaining the current workforce level could contribute significantly towards closing the financial gap and asked for a clearer explanation of any factors preventing this.

AS agreed that the position required further consideration outside the Committee and proposed a discussion involving AS, JB, GE and the Chief Executive to establish a shared understanding of the financial position, the actions available and the point at which a revised forecast might need to be declared. JB supported the proposal and emphasised that the Board required assurance that everything within the Trust's control had been considered, including potentially difficult options. GE confirmed that the Committee's Alert, Advise and Assure report would provide a more robust account of the financial pressure and the need for action.

ACTION: Adrian Snarr

RA advised that non-pay expenditure remained below plan and work continued to secure further improvements. In relation to the Value for Money programme, delivery during the first half of the year had benefited from reductions arising from measures introduced during the previous year. The second half of the plan relied more heavily on new schemes reducing the underlying run rate, and delivery of these elements remained a significant risk. Although no savings were recorded as unidentified, some schemes remained categorised as high risk.

The capital position continued to be monitored closely, particularly the Older People's Strategy and the Cheswold Park programme. Accrued income had increased, although discussions were underway with commissioners to secure payment, with most NHS commissioner income expected to be received during Month 7. The Trust also continued to perform positively in paying suppliers promptly.

7.3 Financial Forecast

RA presented the financial forecast. The most likely scenario indicated a year-end deficit of approximately £4.3m, reflecting current expenditure trends, provider collaborative pressures, identified mitigations and a number of accounting judgements. RA emphasised that the Trust still needed to reduce its underlying run rate and that technical accounting adjustments would not remove the underlying financial pressure. Further decisions could potentially reduce the forecast gap.

The forecast included a provision of approximately £3m for the regrading of Band 5 to Band 6 staff, although the final cost, timing and extent of any back pay had not yet been agreed. Current information suggested that a decision might not be reached before the end of the financial year, creating the potential for the accounting treatment to be reconsidered.

AS advised that the provision for Band 5 to Band 6 regrading remained subject to uncertainty regarding the final cost, timing and extent of any back pay. Whilst the accounting treatment could potentially be reconsidered, he emphasised that this would defer rather than remove the underlying financial pressure. Members discussed the potential approach to back-pay arrangements and agreed that benchmarking with neighbouring trusts would be important before the Trust's position was finalised.

ACTION: Adele Fox

JB sought assurance regarding the capacity and approach being applied to the financial pressures within the provider collaboratives, including engagement with commissioners and the regional team. AS advised that work was being finalised to establish the additional funding required in relation to Cheswold Park. The intention was to present a comprehensive assessment to the regional team because there might only be one opportunity to secure the necessary support. He advised that further work was also required to address the underlying commissioning position within the South Yorkshire provider collaborative. The departure of an experienced commissioning lead had created a potential capacity gap, and consideration was being given to how expertise within the West Yorkshire arrangements could provide additional support. AS also highlighted the need to engage the regional team regarding the sustainability of the current position and the respective responsibilities of the lead provider and its partners.

JB acknowledged the challenges within the South Yorkshire arrangements and agreed that the collaborative had not yet developed the same level of partnership working as that seen elsewhere. She emphasised the importance of pursuing the funding position robustly rather than assuming that commissioners would address the pressure without challenge.

AF advised that the projected increase in the care group pay run rate was not solely attributable to additional recruitment. It also reflected substantive staff returning from maternity or sickness absence. She reported that the Mental Health Care Group's inpatient workforce was expected to be fully established by the end of October, which should support a further reduction in temporary staffing expenditure.

GE concluded that delivery of the Trust's break-even plan remained extremely challenging and that difficult decisions would be required. Given the sensitivity of the forecast and the options under consideration, he indicated that a more detailed discussion would be required at the private Trust Board meeting. The financial pressures and the need for a more robust response would also be reflected in the Committee's Alert, Advise and Assure report.

7.4 VFM update

AS advised that a number of challenging schemes remained in development, including the medical workforce review. Work was underway to improve understanding of medical staffing arrangements, productivity and associated payments, with several options under consideration to deliver sustainable savings. He advised that decisions would be required in a number of difficult areas and emphasised the importance of implementing changes which delivered sustainable benefits and avoided the need for further restructuring at a later stage.

JB recognised that delivery of the more challenging schemes would require executive and Board support and emphasised the importance of communicating the scale of the financial challenge across the organisation. AF highlighted the need to demonstrate more clearly the productivity benefits arising from digital initiatives and other transformation programmes and how these translated into operational and financial improvement.

7.5 Costing update

AS presented the costing update and confirmed that the Trust's National Cost Collection submission had been completed. He advised that the costing function had experienced capacity challenges during the previous year while its substantive lead was on maternity leave, highlighting the vulnerability associated with a small specialist team. Following her return, improvements had been made to the latest submission within the time available.

AS explained that the Trust's historic cost index scores had been 91, 89 and 89, with a score below 100 indicating that the Trust's costs were lower than the national average. The overall results therefore continued to indicate that the Trust was comparatively efficient. However, he cautioned against relying solely on the headline index, noting that service-level analysis showed changes in the relative cost position of some services, including community services. As interim support had been used to complete the previous year's submission, further analysis would be required to determine whether this reflected a genuine movement in costs or differences in the costing approach.
AS identified neurorehabilitation and stroke rehabilitation as areas with consistently high costs, where income did not fully cover expenditure. He advised that the return of the substantive costing lead would enable renewed use of patient-level costing information, a refreshed review of loss-making services and more detailed analysis to support future decision-making.

The Committee received assurance that the submission had been completed and that the overall scores continued to demonstrate that the Trust was financially efficient when compared with national average costs.

FIP/26/41 Investment (agenda item 8)

8.1 Mental Health Investment Standards

AS presented the Mental Health Investment Standard (MHIS) update and advised that the detailed supporting information tracked the implementation of schemes funded in previous years. There was often a delay between agreeing the funding and scope of a scheme and recruiting the required workforce. Overall, implementation remained on track.

AS reported that the level of new service development in 2025/26 had reduced significantly. As previously funded schemes became fully established, they would be removed from the MHIS tracker and monitored through the Trust's core service reporting arrangements.
Although the MHIS remained in place and further investment was expected in future years, the national requirements had changed. AS advised that future funding was likely to focus on a limited number of national priorities, including NHS Talking Therapies, Mental Health Support Teams and Individual Placement and Support services.

AS noted the challenges affecting Talking Therapies performance across South and West Yorkshire. Where further investment became available, he anticipated that commissioners were likely to prioritise this area to support improvement. There might also be some targeted investment in other services, but significant wider investment was not expected as part of the 2026/27 planning process.
The Committee noted the MHIS update, the progress made in implementing previously funded schemes and the reduced level of new investment. It also recognised that future investment was likely to be concentrated on a limited number of national priority areas.

FIP/26/42 Any other business (agenda item 9)

9.1 Pharmaceutical contract

AS presented the Pharmaceutical Services Contract update and explained that, under the current Scheme of Delegation, contracts within the relevant financial threshold required review by FIP before being submitted to Trust Board for approval. FIP did not have delegated authority to approve the contract. He questioned whether this additional stage added sufficient value where a contract was still required to proceed to Trust Board. RA explained that the arrangement had originally been intended to allow FIP to undertake more detailed scrutiny before Board consideration. It was agreed that this would be reconsidered as part of the forthcoming review of the Standing Financial Instructions and Scheme of Delegation.

GE sought clarification regarding whether Rowlands and Speeds had been considered through the procurement process. AS advised that Speeds did not appear to be included on the national framework and had previously indicated that it did not wish to continue providing the service. Its capacity had been limited to Cheswold Park rather than provision of a Trust-wide service. AS also advised that previous feedback regarding the service provided by Speeds had not been positive.
AS explained that Rowlands was familiar with the Trust and other NHS organisations and provided a broader model of pharmaceutical support, including an element of clinical oversight rather than solely a medicines delivery service.

In response to a question regarding the overall value of the contract and how this compared with previous arrangements, AS confirmed that the value of approximately £2.3m covered the full term of the contract and included provision for relevant price increases. Overall expenditure on externally provided pharmaceutical services was expected to reduce slightly, including savings associated with the Cheswold Park element.

The Committee supported the proposed Pharmaceutical Services Contract and its onward submission to Trust Board for approval. It was agreed that the relevant provisions within the Standing Financial Instructions and Scheme of Delegation would be reviewed to determine whether future contracts requiring Board approval also required prior consideration by FIP.

FIP/26/43 Meeting evaluation (agenda item 10)

GE advised that he would prepare the Committee's Alert, Advise and Assure report promptly to enable its inclusion within the Trust Board papers. He confirmed that the report would provide a robust account of the financial position and the need for greater urgency and action. GE would share the draft with AS and JB before it was finalised.

JB emphasised that the report should clearly address how the Trust would move beyond continued discussion and make the decisions required to improve the financial position. She stressed that Trust Board required a clear and deliverable plan, rather than further reliance on existing measures or a general commitment to try harder.

AS advised that, subject to agreement from the Chief Executive, the Alert, Advise and Assure report could be shared with Executive colleagues ahead of the Trust Board discussion. This would enable the financial challenges and the expectations arising from the Committee's discussion to be considered at the forthcoming Delivering Best Value meeting.

JB thanked Executive colleagues for responding constructively to the robust challenge. She acknowledged that the discussion had been difficult and emphasised the importance of maintaining open communication as the Trust worked through the financial position.

GE reflected on the particularly busy agenda and welcomed the high standard of papers and discussion, which had enabled the Committee to give the issues presented thorough consideration.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 10.1

Private/Public paper:	**Public**		
Title:	**Board Assurance Framework (BAF) Quarter 2 – 2026/27**		
Lead Director:	**Dawn Lawson – Director of Strategy, Inclusion and Change/Deputy Chief Executive**		
Mission/values:	The BAF is part of the Trust's governance arrangements and an integral element of the Trust's system of internal control, supporting the Trust in meeting its mission and adhering to its values.		
Purpose:	To provide Trust Board with assurance that a system of control is in place to identify potential risks to the delivery of the Trust's strategic objectives. The paper provides an update in relation to the current status of strategic risks, including progress on actions.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	All risks		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The Board Assurance Framework allows Trust Board members to monitor risks against the Trust's strategic objectives and in doing so enables the Board to assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term. This in turn contributes to the objectives of the Integrated Care Partnerships, Integrated Care Boards, and place-based partnerships.		
Any background papers / previously considered by:	Reviewed quarterly by the Executive Management Team (EMT). Quarterly reports to Trust Board. The BAF was considered at EMT on 8 October 2026		

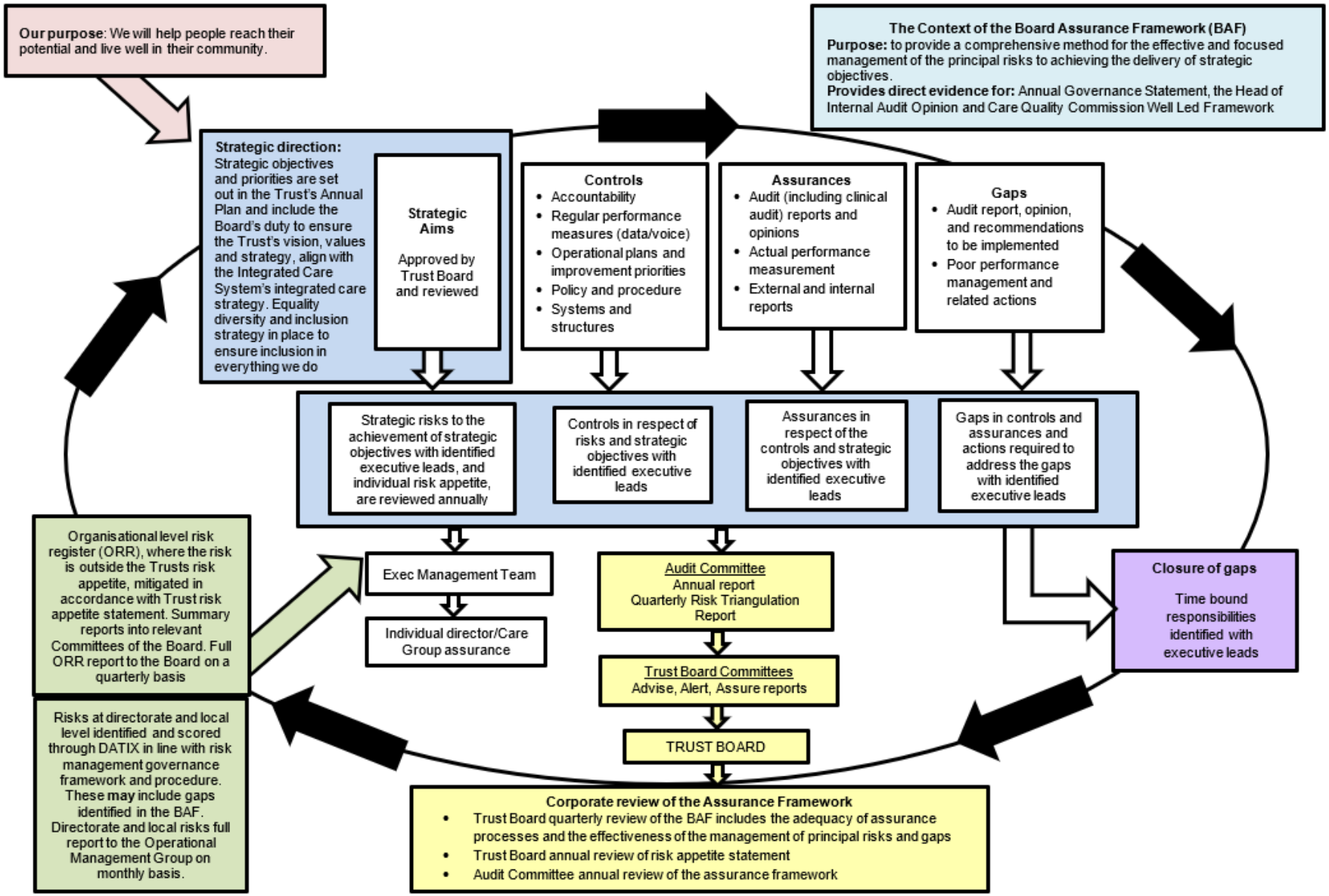
With **all of us** in mind.

Executive summary:	The Board Assurance Framework (BAF) provides the Trust Board with a simple and comprehensive method for effective and focused management of the risks to meeting the Trust's strategic objectives. The BAF is used by Trust Board to provide assurance on the management of strategic risks, and against the delivery of the Trust's strategic objectives, in addition to supporting the Board to identify areas where there is need for more focused attention, which in turn informs agendas for Board Committees, or development sessions. The Q2 2026-27 BAF report is presented to Board aligned to the Trust's 2026/27 strategic aims.  As part of the Head of Internal Audit Opinion process, the Trust's BAF is reviewed by the Trust's internal auditors, 360 Assurance, after each quarterly presentation to Trust Board. The Trust has 16 strategic risks for Q2 of 2026/27: • We will live our values – 2 • We will be the best we can be: • Best Quality - 4 • Best Place to Work and Learn – 1 • Best Partner - 4 • Best Value - 2 • We will be ambitious - 3 **<u>Quarter 2 2026/27</u>** In line with normal process the head of corporate governance has met with all executive directors to review BAF controls and assurances to ensure they remain relevant and up to date, making any changes where required. Any gaps in control and assurance and associated actions have also been reviewed. Where actions have been completed, where appropriate, controls and assurances have been added to the relevant BAF risks. Appendix 1 shows the application of risk appetite according to risk type through a table showing risks, their risk category, risk appetite and proposed rating. On 8 October 2026, following individual director review, the Executive Management Team (EMT) reviewed the BAF for Quarter 2 2026/27 to consider changes to the operating environment and risk scores since the last report to Trust Board in July 2026.

	The following matters were considered for their potential impact upon on the Trust's strategic risks: • Achievement of NOF segmentation 1 in Q1 26/27 • NHS 10-year plan and impact on the Trust and regional and national structures • Financial performance and the challenge to achieve break even in H2 • National NHS performance environment • Continued high demand for inpatient beds • Place provider partnership and integrated care board demand on senior leadership capacity All strategic risks were reviewed with a particular focus on the below: **1.1 Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience.** Executive Management Team noted the recent significant assurance rating on the equality, diversity and inclusion (EDI) internal audit outcome. It was acknowledged that while this outcome reflects that the Trust has satisfactory reporting and governance arrangements in place, the outcome is not directly related to staff or service user experience. The EDI operations group is currently working on a reporting framework for the Quality and Safety Committee and therefore it is proposed that the assurance rating for this risk should remain as "adequate" while this work continues. **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.** EMT reviewed this risk taking into account that health inequalities and improving access are two of the Trust's priorities for 2026/27. The Trust has developed the foundations for a dedicated health inequalities approach with tools such as the Health Inequities Toolkit which is aligned to the quality improvement methodology. EMT proposed at this time an "adequate" rating for assurance and "unlikely" rating for likelihood are appropriate at this time. **2.4 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.** EMT considered the fact that some Trust services had been operating at OPEL (operational pressure escalation level) on two occasions this year, 4 being the highest level on the OPEL scale. An assurance rating of "adequate" was deemed appropriate at this time given the controls in place and the Trust's management of demand to date. The likelihood rating of "likely" was also proposed to continue to be accurate at this time and it was noted that spring/summer demand has remained high with the challenge of winter months still to come. These persistent levels of high demand may impact on the likelihood rating in future months.

	5.1 Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively. EMT noted that the Trust is currently in line with plan but the achievement of the Trust financial plan for H2 of 2026/27 will be challenging. The Trust continues to adapt to the integrated care board changes and evolving place provider partnership arrangements. The Trust is taking a conscious decision to proactively manage any potential impact on quality as a result of financial pressures. The Trust is voluntarily completing the regional provider assurance model finance report. This is not being submitted to region but is being submitted to EMT and FIP for oversight. It is proposed that an "adequate" assurance rating is appropriate at this time, but the likelihood score for this risk should move from "possible" to "likely". Board members are asked to note a track changes version of the full BAF is available in the reading room on Team Engine.
Recommendation:	**Trust Board members are asked to:** • **DISCUSS** this report. • **RECEIVE** the updates to strategic risks • **APPROVE** the Board Assurance Framework and proposed ratings for Q2.

Board Assurance Framework – Structure and Process



Board Assurance Framework (BAF) – 2026/27

Overview of current assurance and likelihood ratings:

The individual risk assurance and likelihood ratings are summarised below:

Strategic Aim	Strategic risk	25/26		2026/27							
		Q4		Q1		Q2		Q3		Q4	
		A	L	A	L	A	L	A	L	A	L
1. We will live our values	1.1 Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience.	A	L	A	L	A	L				
	1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience.	A	P	A	P	A	P				
2.Be the best we can be: Best Quality	2.1 Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy.	A	U	A	U	A	U				
	2.2 The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.	A	P	A	P	A	P				
	2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents.	S	P	S	P	S	P				
	2.4 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.	A	L	A	L	A	L				
2. Best Place to work and learn	3.1 Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.	A	U	A	U	A	U				
2.Be the best we can be: Best partner	4.1 Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place	A	L	A	L	A	L				
	4.2 Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.	A	P	A	P	A	P				
	4.3 Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve	A	P	A	P	A	P				
	4.4 Wider demand and finance pressures result in an insufficient focus on environmental sustainability meaning the Trust does not achieve its national net zero targets.	A	P	A	P	A	P				

Strategic Aim	Strategic risk	25/26		2026/27							
		Q4		Q1		Q2		Q3		Q4	
		A	L	A	L	A	L	A	L	A	L
2. Be the best we can be: Best Value	5.1 Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.	A	P	A	P	A	L				
	5.2 Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision.	A	P	A	P	A	P				
3. We will be ambitious	6.1 Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care.	A	P	A	P	A	P				
	6.2 System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience.	A	P	A	P	A	P				
	6.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.	A	P	A	P	A	P				

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

Committees: AC = Audit Committee, QSC = Quality and Safety Committee, FIP = Finance, Investment & Performance Committee, MHA = Mental Health Act Committee, PRC = People & Remuneration Committee CC = Commissioning Committee

EMT = Executive Management Team, OMG = Operational Management Group, MC = Members' Council, ORR = Organisational Risk Register

Controls and Assurance inputs: I = Internal, E = External, P = Positive, N = Negative

Assurance ratings:

Substantial (S)	The assurances noted on the current BAF demonstrate that the controls are effectively managing the risk/cause.
Adequate (A)	Assurances are in place and no material issues have been identified with the effectiveness of controls. Assurances are reflecting the need to fully embed the controls.
Limited (L)	Levels of assurance noted on the current BAF do not demonstrate that the controls in place are not effectively managing the risk/cause. Action is required to address gaps in control and assurance.
None (N)	No assurance can be taken or is available to demonstrate that the current controls are working. Action is required to address/improve controls and provide assurance.

Risk Likelihood ratings:

Rare (R)	This will probably never happen/recur.
Unlikely (U)	Not expected to happen/recur but is possible.
Possible (P)	Might happen/recur occasionally.
Likely (L)	Will probably happen/recur but is not a persistent issue.
Almost certain (AC)	Will undoubtably happen/recur, possibly frequently.

Risk Appetite

Scale Descriptions

Orange Book Risk Appetite Scale Descriptions	Trust risk appetite scale description	BAF assurance Trust Risk appetite score range	BAF likelihood Trust Risk appetite score range
Averse: Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.	**Low**	**Substantial (S)**	**Rare (R)**
Minimalist: Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.	**Moderate**	**Substantial (S)** / **Adequate (A)**	**Unlikely (U)**
Cautious: Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.	**High**	**Adequate (A)**	**Possible (P)**
Open: Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.	**Extreme**	**Limited (L)**	**Likely (L)**
Eager: Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.	**Extreme+**	**None (N)**	**Almost certain (AC)**

Risk Appetite Application

Risk type and description	BAF Risk Appetite Assurance Score Range	BAF Risk Appetite Likelihood Score Range
Clinical Safety and Quality (CSQR)risks: Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce	Substantial → Substantial (S) Adequate (A)	Rare → Unlikely
Business (BR) risks: Risks which might affect the Trust's ability to achieve its plans or damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation.	Adequate	Possible
Compliance (CR) risks: Failure to comply with its licence, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation.	Substantial → Substantial (S) Adequate (A)	Rare → Unlikely
Financial (FR) risks: Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.	Substantial → Substantial (S) Adequate (A)	Rare → Unlikely
Technology (TR) risks: Risks arising from technology not delivering the expected outcomes due to inadequate or deficient system/process development and performance or inadequate resilience.	Adequate	Possible
Information (IR) risks: Risks arising from a failure to produce robust, suitable and appropriate data/information and to exploit data/information to its full potential.	Substantial → Substantial (S) Adequate (A)	Rare → Unlikely
Security (SR) risks: Risks arising from a failure to prevent unauthorised and/or inappropriate access to key Trust systems and assets, including people, platforms, information and resources. This encompasses the subset of cyber security.	Substantial → Substantial (S) Adequate (A)	Rare → Unlikely

Strategic aim 1: We will live our values	Lead Director(s)	Monitoring and assurance	Overall Assurance/Likelihood rating 2026/27							
Links to ORR (risk ID numbers): 1820	As noted below.	EMT, QSC, PRC, Trust Board	Q1		Q2		Q3		Q4	
			A	L	A	L	A	L	A	L
			A	P L	A	P L				

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	Description	Risk Owner	Risk Type	Risk Appetite		Assurance/Likelihood rating	
				A	L	A	L
1.1	**Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience.**	DSC	CSQR	S → S A	R → U	A	L
1.2	**Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience.**	CPO	CSQR	S → S A	R → U	A	P

Rationale for current assurance level (Strategic Aim 1 – We will live our values)

- The Trust's segmentation within the NHS Oversight Framework (NOF) for quarter 1 2026/27 is 1.
- The Trust has in place a People Management / Leadership programme
- Trio model bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery.
- A range of staff networks are in place including REACH (Race, Equality and Cultural Heritage (formerly BAME)), LGBT+, disabilities, and working carers. Staff networks will attend at PRC on rotation and all network meetings are attended by representatives of the People directorate.
- Full-time lead Freedom to Speak Up Guardian is in post, supported by 2 part-time guardians in order to support raising concerns in relation to patient care of staff experience. FTSU themes are triangulated with staff data e.g. staff survey, an annual report is taken through Audit Committee. A Freedom to Speak Up steering group is in place.
- Freedom To Speak Up training in place for all staff and managers to ensure that staff know how to raise concerns.
- We have in place an EDI Action Plan which focusses on addressing WRES and WDES data and findings
- The Trust continues to build on and improve a positive partnership with Staff side, including fortnightly formal meetings with the Chief People Officer and bi-monthly Trust partnership forums including members of EMT.
- A series of engagement events are in place for 2026/27 with recommendations and actions being progressed.
- A full-time diversity and inclusion lead in post to support diversity and inclusion across the Trust.
- Staffing levels are being maintained through the real time monitoring and deployment of staff across functions to ensure safety for all services.

- Values based recruitment and appraisal processes are embedded within the Trust.
- Regular engagement between the chief people officer and the executive team with staff governors to ensure staff voice is represented and gather insight into staff experience.
- Organisational Development team is in place to support and improve staff experience within the Trust.
- Board development programme being developed for 2026/27 which is driven by Trust values and recognises the Board's duty to lead and role model behaviours and culture.
- Trust values are embedded in appraisal and leadership development programmes across the Trust.
- Trust Board discussions are consistently linked to the Trusts values, and all Board members are encouraged to challenge themselves and each other to lead through values and model Trust behaviours.
- #allofus conversations took place in regard to the Trust strategy refresh including great place to work and engagement with Trust staff
- Priorities for 26/27 have been developed and have been integrated into the IPR via EMT and Trust Board.
- Patient experience and engagement survey toolkit in place.
- Accessible Information Standard internal audit actions completed and implemented.
- Trust health inequalities approach developed drawing on the Kings Fund framework and relevant aspects of Core20plus5.
- Clear value proposition for our social prescribing offer in our places.
- The Trust continues to improve insight using the new health inequalities and data interactive tool to inform the health inequalities plan.
- Comprehensive creative and cultural offer through Creative Minds and recovery colleges in each of our places to diverse communities.
- EDI operations group in place to have oversight of the delivery of the EDI strategy (with a supporting Insights group to ensure wider engagement)
- People strategy in place. Approved by Trust Board in December 2025
- People priorities for 2026 for safe and healthy and inclusion and compassion will be rolled out in 2026
- All leaders /managers have two performance objectives in their appraisal in line with the people priorities for 2026
- New appraisal process which puts person at the centre is being rolled out in 2026
- Staff survey engagement scores have been maintained for 2026.
- Equality, diversity and inclusion internal audit outcome - significant assurance

Strategic aim 2: Be the best we can be: Best Quality	**Lead Director(s)**	**Monitoring and assurance**	**Overall Assurance/Likelihood rating**							
			2026/27							
Links to ORR (risk ID numbers): 1530, 1078, 1368, 1568, 1757, 1614, 1689, 1159, 1424, 852, 1888, 2012, 1839, 695, 1650, 1624, 1545	As noted below.	EMT, AC, QSC, PRC, Trust Board	**Q1**		**Q2**		**Q3**		**Q4**	
			A	**L**	**A**	**L**	**A**	**L**	**A**	**L**
			A	**P**	**A**	**P**				

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	**Description**	**Risk Owner**	**Risk Type**	**Risk Appetite**				**Assurance/Likelihood rating**	
				A		**L**		**A**	**L**
2.1	**Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy.**	**COO**	**CSQR**	**S**	**S → A**	**R**	**U**	**A**	**U**
2.2	**The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.**	**DFR**	**IR**	**S**	**S → A**	**R**	**U**	**A**	**P**
2.3	**Failure to create a learning environment leads to lack of innovation and to repeat incidents.**	**DNQ**	**CSQR**	**S**	**S → A**	**R**	**U**	**S**	**P**
2.4	**Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.**	**COO**	**CSQR**	**S**	**S → A**	**R**	**U**	**A**	**L**

Rationale for current assurance level (Strategic aim 2: The best we can be: Best Quality)

- The Trust's segmentation within the NHS Oversight Framework (NOF) for quarter 1 2026/27 is 1.
- Clinical Strategy approved by Trust Board in March 2025
- A band 7 Speech and Language Therapist is in place to take a lead role in our approach to dysphagia.
- Business intelligence development plan is being aligned to Trust strategic objectives and priority programmes including health intelligence data and reporting.
- Trust developing overarching operational data quality improvement plan which will be monitored by the Improving Clinical Information Group (ICIG) and Operational Management Group (OMG)

Rationale for current assurance level (Strategic aim 2: The best we can be: Best Quality)
• Improvement work around the FIRM risk assessment and care planning continues. This is being led by a task and finish group with an anticipated finish date of July 2026, however, further work to embed the changes will then take place. • Waiting list management in SystmOne is complete and a waiting list report is presented to the Finance, investment and performance (FIP) committee on a regular basis. • Integrated Performance Report (IPR) summary metrics re improving the quality and experience of all that we do – IPR for month 5 26/27 shows: Friends & Family (F&F) Test MH – Green F&F Test Community – Green, safer staff fill rates – green, IG confidentiality breaches – green. • Investment in estates and facilities and IT infrastructure. The Trust estates strategy is place. • Clinical services monitor Operational Pressures Escalation Levels (OPEL) to guide our emergency responses. Partnership arrangements are at different stages of development in each of the places in which we provide services. • Data quality and improving access to care work is progressing. • Each care group has a data quality work stream. • Improving access to care workstream is in place and reports to the mental health improvement group and includes a review of waiting list work which references health inequalities. • Staff commitment to the Trust values is evidenced through the excellence awards and regularly reviewed as part of the Trust appraisal and supervision process. • Quality Improvement (QI) culture continues to be embedded with a particular emphasis on our learning from QI approach and application in practice of our Institute for Healthcare Improvement (IHI) training. This includes any response to CQC actions. • Themes from serious incident investigations are identified through the patient safety oversight group and improvements are reported through the Quality and Safety committee. • In the main, positive Friends and Family Test feedback from service users. There is noted variance in areas of low returns and low scores, and solutions are being explored to increase the number of responses. Results continue to be triangulated with other feedback, such as the Insight report and Healthwatch. • Patient Safety Incident Review Framework (PSIRF) established within the Trust. PSIRF includes an enhanced analysis of thematic learning as part of the framework. • Trio leadership model bringing together clinical, operational and governance roles working together at service line level, with shared accountability for delivery. • Regular analysis and reporting of incidents through patient safety oversight group, and quarterly analysis of all incidents through the incident management report through Quality and Safety Committee (QSC) and Trust Board. • Development of trust wide arrangements for learning and improving standards, recognised by CQC and NHSE. The Trust has processes in place to capture learning from innovation and change. • Internal audit reports – asset register and board assurance framework - significant assurance. • The Trust Care Quality Commission (CQC) assessment remains as an overall rating of "good". In May 2023 inspections of forensic and adult mental health inpatient services took place, the outcomes of which were "requires improvement" for both. CQC action plan updates are presented to Trust Board every public performance meeting. In 2019 the CQC conducted a review of the Trust which resulted in an overall rating of "good". • High compliance with internal audit actions. • Bed occupancy and patient acuity has been consistently high, particularly in adult acute, older peoples and psychiatric intensive care units (PICU). • Cyber awareness tested with staff by means of a survey and phishing exercise. • Trauma informed organisation steering group is in place with piloting working with identified teams – senior responsible owners are the chief people officer and chief nurse/director of quality and professions. • "The care group quality and safety report" is presented to QSC meetings to provide assurance on the quality impact of operational pressures in care groups. • Patient safety improvement group in place maintains strategic oversight of themes and learning from patient safety incidents and Trustwide actions. • Care group performance reports provide additional performance information to the Board and are presented in all public meetings. • Medical workforce race equality standard lead (MWRES) in place to work with the Trust equality diversity inclusion (EDI) lead to ensure the Trust is in keeping with national race standards and indicators in the medical directorate. • Patient carer and race equality framework (PCREF) is being rolled out across the Trust. • Triangle of care (TOC) has been rolled out across all inpatient wards and is has been rolled out across community services resulting in the Trusts second star • A comprehensive review of restrictive practice across the Trust is taking place and progress into EMT and quality and safety committee • A new model of women's care is in development following external peer review, draft report is in progress with future reporting to go to EMT and QSC.

Strategic aim 2: Be the best we can be: Best Place to Work and Learn	Lead Director(s)	Monitoring and assurance	Overall Assurance/Likelihood rating							
			2026/27							
Links to ORR (risk ID numbers): 1729, 1157, 1887, 1840, 1151, 1432,	As noted below.	EMT, AC, PRC, QSC, Trust Board, FIP	Q1		Q2		Q3		Q4	
			A	L	A	L	A	L	A	L
			A	U	A	U				

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	Description	Risk Owner	Risk Type	Risk Appetite				Assurance/Likelihood rating	
				A		L		A	L
3.1	**Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.**	CPO	CSQR	S	S → A	R →	U	A	U

Rationale for current assurance level (strategic aim 2: Be the best we can be: Best Place to Work and Learn)
• The Trust's segmentation within the NHS Oversight Framework (NOF) for quarter 1 2026/27 is 1. • Vacancies are present across the Trust with variance dependent on location and service line, but the overall vacancy figure is lower than in previous years. Vacancies are reviewed through a vacancy control process and panels (at local and corporate levels). Turnover is stable. • A recruitment plan for care support workers in in place for 2026/2027 • Temporary staffing scrutiny and management group in place to review overtime and agency and bank usage. • Use of bank for non-clinical roles at standard rates in preference to agency • Medical locums to manage to provide safe cover for any vacancies. • Temporary staffing group is in place to monitor and reduce agency spend across the Trust. • Staff turnover rates have stabilised but vary between care groups and service lines with turnover in inpatient areas presenting the highest numbers. The Trust benchmarks well against peer organisations. • The Trust Care Quality Commission (CQC) assessment remains as an overall rating of "good". In May 2023 inspections of forensic and adult mental health inpatient services took place, the outcomes of which were "requires improvement" for both. CQC action plan updates are presented to Trust Board every public performance meeting. In 2019 the CQC conducted a review of the Trust which resulted in an overall rating of "good". • Changes to the Integrated Performance Report (IPR) to improve oversight and of workforce data at both Board and Board Committee level. • The exit process for leavers from the Trust has now been revised following an internal audit process. Outcomes of exit interviews are reported into People and Remuneration Committee (PRC). • Staff survey results for 2025 have shown the Trust benchmarks well in comparison to similar local organisations and overall shows a positive position. Many of our results compare favourably at a national level. • The Trust has a full board of both executive and non-executive roles. Plans are being developed to recruit to end of term vacancies through Nominations Committee. • People strategy in place. Approved by Trust Board in December 2025. • Updates on the Resident doctor ten-point plan are received by People and Remuneration Committee at every other meeting. • New appraisal process implemented, including removal of rolling target and the introduction of an appraisal window. As of 20 October 2026, 93.8% of colleagues had recorded a completed appraisal.

Strategic aim 2: Be the best we can be: Best Partner	Lead Director(s)	Monitoring and assurance	Overall Assurance/Likelihood rating							
			2026/27							
Links to ORR (risk ID numbers): 275, 812,	As noted below.	EMT, QSC, Trust Board	Q1		Q2		Q3		Q4	
			A	L	A	L	A	L	A	L
			A	P	A	P				

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	Description	Risk Owner	Risk Type	Risk Appetite		Assurance/Likelihood rating	
				A	L	A	L
4.1	**Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place.**	DFR	FR	S → S/A	R → U	A	L
4.2	**Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.**	CEO-DSC	FR	S → S/A	R → U	A	P
4.3	**Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve.**	DSC	BR	A	P	A	P
4.4	**Wider demand and finance pressures result in an insufficient focus on environmental sustainability meaning the Trust does not achieve its national net zero targets.**	DFR	CR	S → S/A	R → U	A	P

Rationale for current assurance level (Strategic aim 2: Be the best we can be: Best Partner)
• The Trust's segmentation within the NHS Oversight Framework (NOF) for quarter 1 2026/27 is 1. • Income arrangements are secured for 2026/27 and will remain predominantly on a block basis until 2027/28. The Trust submission included a longer-term plan including three years of revenue is complete. • Financial arrangements for adult secure lead provider collaboratives in South and West Yorkshire are predominantly on a cost per case and cost and volume basis. We are now entering the last year of contract which expires March 2027.Emerging thinking from NHSE continues to evolve. No definitive outcome confirmed at this stage.. . • The Trust plan continues to forecast for breakeven in 2026/27. • Integrated Performance Report (IPR) summary metrics reflect the strategic priorities for 2026/27. • Cash balance at month 5 of 2026/27 is £57.6m.

Rationale for current assurance level (Strategic aim 2: Be the best we can be: Best Partner)
• Place provider partnership arrangements are establishing in each place and the Trust is fully engaged in all places in the Trusts geography. • Positive well-led results following Care Quality Commission (CQC) review (2019), with revised preparation for the next inspection taking place. • The Trust is lead provider for the adult secure provider collaborative and is a partner in the CAMHS and eating disorder collaboratives in West Yorkshire. The Trust is the lead provider in South Yorkshire and Bassetlaw for the adult secure lead provider collaborative. The Trust is coordinating provider for forensic CAMHS for Yorkshire and Humber region. • Mental health investment standard for 26/27 invested with the Trust continues to be lower than the historic investment • Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. • Standing financial instructions and scheme of delegation are in place, approved by Trust Board and Members Council in January 2025. • Cheswold Park Hospital is now fully integrated into the forensic service line • The Trust Care Quality Commission (CQC) assessment remains as an overall rating of good. In May 2023 inspections of forensic and adult mental health inpatient services took place, the outcomes of which were “requires improvement” for both. CQC action plan updates are presented to Trust Board every public performance meeting. In 2019 the CQC conducted a review of the Trust which resulted in an overall rating of “good”. • Coordinating provider for maternal mental health across Yorkshire and the Humber • The Trust is part of the Mental Health Learning Disability and Autism provider collaborative in the South Yorkshire Integrated Care System. • A range of executive and board arrangements with Trusts, integrated care boards and other stakeholders in each of the places where the Trust operates. • Trust involvement and engagement with West Yorkshire and South Yorkshire Integrated Care Systems, especially on mental health is strong. • The Trust has been involved in the development of place-based plans and priority setting. • Mental health offer well regarded with the establishment of Mental Health Provider Alliance in Wakefield. A similar approach is in place in Kirklees. The Trust is also a member of the mental health partnership in Barnsley and has a formal alliance agreement in place with Barnsley primary care via the Barnsley Healthcare Federation to strengthen the joined-up community offer. • Stakeholder engagement plans in place. • Friends and Family Test feedback from service users, carers and families continues with noted variance in areas of low returns and low scores are being explored. Results continue to be triangulated with other feedback, Insight report and Healthwatch. • The Trust insight report feeds into the Executive Management Team (EMT) meeting (quarterly) • Integrated Performance Report (IPR) summary metrics month 5 26/27 - out of area beds – green, children and young people accommodated on an adult inpatient ward – green, learning disability referrals with completed assessment, care package and commenced delivery within 18 weeks –amber, clinically ready for discharge (previously delayed transfers of care) – red. • Older people’s transformation public consultation completed and received positive feedback with significant engagement and involvement of local communities. Following on from approval, a new governance structure has been established to oversee the implementation phase of work. This is being led by a SWYPFT governance group which oversees the implementation work-strands and reports into the senior governance structures. The start date for capital works has been delayed in order to ensure compliance with new fire safety legislation. • Compliance with the public sector equality duty maintained through Equality Impact Assessments (EIAs) – including a tracker and IPR monitoring monthly. • Approach developed and implemented with Voluntary Community Sector partners in each of our places to strengthen insight involvement and co-production as part of our ‘Connecting people’ approach. • Equality data and insight bank as well as a Trust wide EIA, mental health EIA tool and approach developed.

Strategic aim 2: Be the best we can be: Best Value	Lead Director(s)	Monitoring and assurance	Overall Assurance/Likelihood rating							
			2026/27							
Links to ORR (risk ID numbers): 1080, 1511, 1957, 1114, 1956, 1585, 1217	As noted below.	EMT, AC, CC, FIP, Trust Board	Q1		Q2		Q3		Q4	
			A	L	A	L	A	L	A	L
			A	P	A	P L				

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	Description	Risk Owner	Risk Type	Risk Appetite		Assurance/Likelihood rating	
				A	L	A	L
5.1	**Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.**	COO	BR	A	P	A	L
5.2	**Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision.**	DFR	BR/TR	A	P	A	P

Rationale for current assurance level (Strategic aim 2: Be the best we can be: Best Value)
• The Trust’s segmentation within the NHS Oversight Framework (NOF) for quarter 1 2026/27 is 1. • Income arrangements are secured for 2026/27 and will remain predominantly on a block basis until 2027/28. The Trust submission included a longer term plan including three years of revenue is complete.

Rationale for current assurance level (Strategic aim 2: Be the best we can be: Best Value)
• Financial arrangements for adult secure lead provider collaboratives in South and West Yorkshire are on a cost per case and cost and volume basis. We are now entering the last year of contract which expires March 2027.Emerginthinking from NHSE is a re-tender for contracts from 2027 which presents an element of risk. • The Trust was required to deliver a break-even plan for 25/26 and are on track to deliver this. The Trust plan continues to forecast for breakeven in 2026/27 • Integrated Performance Report (IPR) summary metrics reflect the strategic priorities for 2026/27. • Cash balance at month 5 of 2026/27 is £57.6m. • Partnership arrangements are established within each place. • Positive well-led results following Care Quality Commission (CQC) review (2019), with revised preparation for the next inspection taking place. • The Trust is lead provider for the adult secure provider collaborative and is a partner in the CAMHS and eating disorder collaboratives in West Yorkshire. The Trust is the lead provider in South Yorkshire and Bassetlaw for the adult secure lead provider collaborative. The Trust is coordinating provider for forensic CAMHS for Yorkshire and Humber region. • Mental health investment standard for 26/27 invested with the Trust continues to be lower than the historic investment • Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. • The Trust has an approved digital strategy in place, approved by Trust Board in January 2025. • Digital dictation is now in place across the Trust. • Electronic Prescribing Medicines Administration (EPMA) digital system in place in place to support safe and efficient prescribing and administration. • Standing financial instructions and scheme of delegation are in place, approved by Trust Board and Members Council in January 2025. • Cheswold Park Hospital is now fully integrated into the forensic service line • Digital innovation is part of the Transformation, Innovation and Sustainability Committee workplan.

Strategic aim 3: We will be ambitious	Lead Director(s)	Monitoring and assurance	Overall Assurance/Likelihood rating							
			2026/27							
Links to ORR (risk ID numbers):	As noted below.	EMT, Trust Board, Commissioning Committee	Q1		Q2		Q3		Q4	
			A	L	A	L	A	L	A	L
			A	P	A	P				

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	Description	Risk Owner	Risk Type	Risk Appetite		Assurance/Likelihood rating	
				A	L	A	L
6.1	**Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care.**	DFR	BR	A	P	A	P
6.2	**System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience.**	DSC	BR	A	P	A	P
6.3	**Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.**	DSC	BR	A	P	A	P

Rationale for current assurance level (Strategic aim 3: We will be ambitious)
• The Trust's segmentation within the NHS Oversight Framework (NOF) for quarter 1 2026/27 is 1. • Coordinating provider for maternal mental health across Yorkshire and the Humber. • The Trust is lead provider for the adult secure provider collaborative and is a partner in the CAMHS and eating disorder collaboratives in West Yorkshire. The Trust is the lead provider in South Yorkshire and Bassetlaw for the adult secure lead provider collaborative. The Trust is coordinating provider for forensic CAMHS for Yorkshire and Humber region. • The Chief Operating Officer is the Senior Responsible Owner for Cheswold Park Hospital transition into the Trust. • Integrated Care Boards are in place and are functioning fully and the Trust is maintaining a proactive contribution in each place. • Health and Wellbeing Board place-based plans have been contributed to through board discussions, commented on and where appropriate, agreed. • Active and full membership of Health and Wellbeing Boards. • The Trust is part of the Mental Health Learning Disability and Autism provider collaborative in the South Yorkshire Integrated Care System. • A range of executive and board arrangements with Trusts, integrated care boards and other stakeholders in each of the places where the Trust operates. • Trust involvement and engagement with West Yorkshire and South Yorkshire Integrated Care Systems, especially on mental health is strong. • The Trust has been involved in the development of place-based plans and priority setting.

- The Trust is part of the Provider Collaborative established in Calderdale led by Calderdale and Huddersfield NHS Foundation Trust (CHFT) which focusses on climate, social value and integrated neighbourhood teams.?
- Mental health offer well regarded with the establishment of Mental Health Provider Alliance in Wakefield. A similar approach is in place in Kirklees. The Trust is also a member of the mental health partnership in Barnsley and has a formal alliance agreement in place with Barnsley primary care via the Barnsley Healthcare Federation to strengthen the joined-up community offer.
- Stakeholder engagement plans in place.
- The Board are fully briefed on opportunities presented by the 10 Year Plan for Health.
- The Trust officially launched its Teaching Trust status with the University of Leeds at its annual members meeting on 17 September 2025. The University of Leeds approved the application based on the Trusts strong history of partnership working around student education and research and development. The partnership is one of very few nationally where Teaching Trust status has been achieved by a Trust that provides community services alongside mental health, learning disability, and autism services.
- Trust ambition is part of the Transformation, Innovation and Sustainability Committee (TISC) workplan.
- The Trusts strategy measurement framework has been agreed though TISC and the Board
- Research and Development Strategy approved by Trust Board September 2026.

Strategic risk 1.1 (Strategic Aim 1 - We will live our values)
Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience

Controls (Strategic Risk 1.1 - Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval, including equality impact assessments. Central logs for clinical and corporate procedures developed and new procedure template added to the Policy on Policies. (I)	DNQ / DSC	1.1, 2.1, 4.1, 4.2, 6.2
C15	Equality Diversity and Inclusion Strategy in place for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E, P, N)	DSC	1.1, 1.2, 2.1, 2.4, 3.1, 4.1, 4.3
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data is in place to identify any themes. Assurance via Mental Health Act Committee, Quality and Safety Committee. (E, I)	DSC / DNQ / CMO	1.1, 2.1 4.1, 4.2
C26	Community reporting is available as a tool to enable people to talk to members of their own community about their experience and approach developed and implemented with voluntary and community sector (VCS) partners in each of our places to strengthen insight involvement and co-production. (I, E)	DSC	1.1, 2.1, 4.3
C30	Process to review and assure Equality Impact Assessments (EIAs) with report to Quality and Safety Committee (I). (I)	DSC	1.1, 2.1, 4.3
C33	Service line equality data used to identify the existing target audience to ensure methods and approaches meet the needs of those audiences. (I)	DSC	1.1, 4.3
C34	Provision of information, leaflets and posters which meet the Accessible Information Standard. (I)	DSC	1.1, 4.3
C35	Translation and interpretation service in place as well as inequalities interactive tool. (I)	DSC	1.1, 2.1, 4.3
C47	The Patient Safety Oversight Group meets weekly to review recent patient safety risks. All red and amber incidents from across the organisation are reviewed including the undertaking of proportionate investigations. In addition, all incidents relating to protected characteristics or staffing, irrespective of grading are also reviewed. (P,N,I,E)	DNQ / CMO	1.1, 2.2, 2.4, 3.1
C52	Patient experience reporting includes learning from complaints, concerns, compliments and friends and family test results. (I)	DNQ	1.1, 2.3, 3.1
C53	The Trusts is aligned to the Patient Safety Incident Response Framework (PSIRF) in line with national standards. (I)	DNQ	1.1, 2.3, 3.1
C110	Values-based appraisal process in place with new monitoring arrangements monitored through business intelligence systems and the integrated performance report. (P,N,I)	CPO	1.1, 3.1
C115	Diversity, inclusion and belonging lead in place as part of the Trust's overall leadership and management development arrangements. Workforce elements fall under the CPO. (I)	CPO	1.1, 1.2
C131	Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) process integrated and used at gateways in transformation and change programmes. (P, I)	DSC	1.1, 4.3
C136	Inclusive Leadership Board Development (ILDB) programme on inequalities completed. (P, I)	CPO	1.1, 1.2
C138	Trust wide Equality Impact Assessment together with the inequalities data developing systemic analysis and plans to address Trust inequality priorities. (P, I)	DSC	1.1, 4.3
C155	PRC engagement with staff networks and is reported to Trust Board through the triple A report. (P, I)	DSC	1.1, 1.2
C156	Freedom to Speak up Guardians in place. (P, I)	CPO/DNQ	1.1, 1.2
C157	Values based recruitment processes in place. (P, I)	CPO	1.1, 1.2
C189	Trust Board development programme being developed for 2026/27 building on the leadership through a values-based culture and strengthening delivery of the Trusts strategic objectives. (P, I, E)	CPO/CEO	1.1, 1.2
C191	Trust medical appraisal and revalidation process aligns to general medical council report. (Fair to refer 2019) (P,I,E)	CMO	1.1
C194	Waiting list management tool in SystmOne is in place. (I)	DFR	1.1
C196	Micro aggression guidance is in place, which includes reference to all protected characteristics. (I)	DSC/DNQ	1.1
C212	Medical workforce race equality standard lead (MWRES) in place to work with the Trust EDI lead to ensure the Trust is in keeping with national race standards and indicators in the medical directorate. (P,N,I)	CMO	1.1
C263	Operational equality dashboards now in place (P, N, I)	DSC	1.1, 2.2, 4.3
C264	Patient carer race equality framework (PCREF) implementation plan in place (P,N,I,E)	DSC	1.1, 2.2, 4.3
C265	Health inequalities toolkit in place to reduce barriers to access to services (P,N,I,E)	DSC	1.1, 2.1, 2.3, 4.3
C266	Hearing impaired and deaf toolkit in place to reduce barriers to access to services (P,N,I,E)	DSC	1.1, 2.1, 2.3, 4.3
C269	Care group level patient safety oversight groups (PSOG) in place to review local incidents and learning which then feed into Trustwide PSOG (P,N,I,E)	DNQ/CMO	1.1,2.2, 2.4, 3.1
C270	People strategy in place. Approved by Trust Board December 2025 (P, I, E)	CPO	1.1, 1.2, 3.1, 6.3
C271	A design and planning tool has now been developed to include health inequalities to enable staff to mitigate the impact of health inequalities as business as usual (P,N,I)	DSC	1.1

Controls (Strategic Risk 1.1 - Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C272	An Equality Diversity and Inclusion action plan is place following approval at Trust Board on 28 October 2025. (P,N,I)	DSC/CPO	1.1/1.2
C275	Updated Trust EDI infrastructure in place to ensure delivery of the six new EDI objectives Governance arrangements reconfigured to support this. (P,I)	DSC	1.1/1.2
C276	An equality interactive tool dashboard is now in place which provides insight to ensure improvements and service change. (P,N,I,E)	DSC	1.1, 1.2, 2.1, 2.4, 4.3
C277	As part of NHS England's Mental Health Bill Quality Improvement Plan, the Trust has piloted advance choice documents in the Horizon Centre for the learning disability community to enable them to make decisions about their care prior to their admission as a mental health inpatient. It should be noted the advance choice document is applicable to all mental inpatients not just those with a learning disability. (P,N,I, E)	CMO	1.1,1.2,2.1
C288	The Equality Diversity and Inclusion internal audit report (2026) had a finding of significant assurance (P,I)	DSC	1.1
C289	Trustwide patient safety incident huddles take place on a daily basis to review all Datix incidents across the Trust (P,N,I)	DNQ	1.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Becoming an anti-racist Trust is a strategic objective in our new Equality, Diversity and Involvement Strategy. The Trust has continued to progress implementation of the Patient and Carer Race Equality Framework (PCREF). A PCREF implementation plan and supporting communications plan are in place and being delivered, with an Internal Oversight Group being refreshed and development of an External Advisory Group underway as part of Community Connectors Trust approach. Key supporting infrastructure has also been reviewed and strengthened, including the Trust's EDI Governance Framework; our involvement approach, Equality Impact Assessment (EIA) process, appraisal process, and workforce training arrangements. Work continues to be co-produced with ethnic minority staff, communities and allies to embed anti-racist practice and address racial inequalities across the organisation. Terms of reference for the EDI ops group and all of us in mind insight group are in draft and are being taken through Trust governance processes for approval to ensure EDI is part of everything the Trust does. These will be in approved by the end of November 2026.	January 2027	DSC
The Trust is looking to embed the advanced choice document into the Trust's learning disability and/or autism service dynamic support register (DSR) process which will streamline with care (education) and treatment reviews (C(E)TR). On 1st April 2026 the Trust LD service took over management and responsibility for DSRs and C(E)TRs for Calderdale, Kirklees and Wakefield. Some time is therefore required to get the transition completed and review the process across the three places in more detail. The recent changes within the ICB continue to impact on the pace of this work. Further update to be provided in January 2027.	January 2027	CMO

Assurance (Strategic Risk 1.1 - Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A20	Service user experience and waiting time reports are reviewed by QSC, and MHA. CQC Mental Health Act visits occur on a regular basis and are reported into QSC and MHAC.	Patient experience reports and integrated performance report (IPR) data on access and waiting times included in the new Equality and Inclusion interactive tool. (P) (I)	DNQ	1.1, 2.1, 4.1, 4.2, 4.3
A33	Patient experience (including complaints) reports to Trust Board and QSC.	Annual reports to Board / EMT and quarterly into QSC. (P, N) (I)	DNQ	1.1, 2.1, 2.4
A35	EDI dashboard presented to Quality and Safety Committee	Regular reports and papers provided. (P) (I)	DSC	1.1, 2.1
A52	Annual health inequalities analysis included in the EDI annual report.	Reported into Quality and Safety Committee, (I, E, P,N)	DSC	1.1
A74	Staff survey results reported to Trust Board via People and Remuneration Committee and action plans produced as applicable.	Reported to PRC every other meeting. (P, N) (I)	CPO	1.1, 1.2, 3.1
A80	Healthcare inequalities dashboard.	OMG, EMT, QSC review and also included in IPR. Reviewed by Improving access to care group to focus on activity but allows trends over time to be identified. (I) (P)	DSC	1.1, 2.4
A86	Positive 2025 NHS staff survey results that demonstrate the Trust benchmarks well against peer organisations.	Annual NHS staff survey results monitored by EMT, PRC and Trust Board. (P,N, I, E)	CPO	1.1,1.2
A89	Waiting list report including analysis in relation to protected characteristics.	Reported into FIP committee. (I, E, P, N)	DSC/COO	1.1
A111	PCREF compliance reports	Quarterly national reports to EMT, QSC and NHSE (P,N,I,E)	DSC	1.1, 2.1, 4.3
A115	Summary update from care group Patient Safety Oversight Group's (PSOG)	Weekly updates sent to Trustwide PSOG which is then fed into EMT and QSC and reported into Trust Board via triple A from QSC (P,N,I)	DNQ/CMO	1.1,2.2, 2.4, 3.1
A116	Following WRES and WDES results a clear action plan was produced to address the key findings.Anaction plan was submitted and approved at Board October 2026.	This will be monitored through PRC to ensure delivery of the actions on a quarterly basis (P, N, I , E)	CPO	1.1,1.2
A117	EDI dashboard	Updates on the dashboard will be presented to each Quality and Safety Committee meeting (P,N,I)	DSC/DFR	1.1, 1.2, 2.1, 2.4, 4.3
A122	Trustwide patient safety incident huddles take place on a daily basis to review all Datix incidents across the Trust	Any identified area of concern will be raised to PSOG on a weekly basis. If required issues will be escalated further to QSC. (P, N, I)	DNQ	1.1
A123	Equality, Diversity and Inclusion operations group reporting	Reports into EMT, and relevant sections into PRC and QSC (P,N,I)	DSC	1.1

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
A report is in development to sit alongside the EDI dashboard. The Quality and Safety Committee are to receive an initial draft of the proposed report which is an EDI and health inequalities reporting framework in October 2026. The framework is designed to be an assurance report to go with the EDI dashboard.	January 2027	DSC

Strategic risk 1.2 (Strategic Aim 1 - We will live our values)
Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience.

Controls (strategic risk 1.2 - Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience.)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C15	Equality Diversity and Inclusion Strategy in place for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E, P, N)	DSC	1.1, 1.2, 2.1, 2.4, 3.1, 4.1, 4.3
C103	Education and training governance group in place to agree and monitor annual training plans. (I)	CPO	1.2, 3.1
C115	Diversity, inclusion and belonging lead in place as part of the Trust's overall leadership and management development arrangements. Workforce elements fall under the CPO. (I)	CPO	1.1, 1.2
C136	Inclusive Leadership Board Development (ILDB) programme on inequalities completed, with future board development programme being established. (P, I)	CPO	1.1, 1.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C154	Regular and consistent updates and communications throughout the Trust via the View and The Brief. (P, I)	DSC	1.1, 1.2
C155	PRC engagement with staff networks and is reported to Trust Board through the triple A report. (P, I)	CPO	1.1, 1.2
C156	Freedom to Speak up Guardians in place. (P,I)	CPO/DNQ	1.1, 1.2
C157	Values based recruitment processes in place. (P, I)	CPO	1.1, 1.2
C158	Values based appraisal system. (I, E, P, N)	CPO	1.1
C179	Developed internal transfer system which is now to be promoted and embedded. (P) (I)	CPO	1.1
C189	Trust Board development programme being developed for 2026/27 building on the leadership through a values-based culture and strengthening delivery of the Trusts strategic objectives. (P, I, E)	CPO/CEO	1.1, 1.2
C270	People strategy in place. Approved by Trust Board December 2025 (P, I, E)	CPO	1.1, 1.2, 3.1, 6.3
C271	A design and planning tool has now been developed to include health inequalities to enable staff to mitigate the impact of health inequalities as business as usual (P,N,I)	DSC	1.1
C272	An Equality Diversity and Inclusion action plan is place following approval at Trust Board on 28 October 2025. (P,N,I)	DSC/CPO	1.1, 1.2
C275	Updated Trust EDI infrastructure in place to ensure delivery of the six new EDI objectives Governance arrangements reconfigured to support this.	DSC	1.1/1.2
C276	An equality interactive tool dashboard is now in place which provides insight to ensure improvements and service change. (P,N,I,E)	DSC	1.1/1.2/2.1/2.4/4.3
C277	As part of NHS England's Mental Health Bill Quality Improvement Plan, the Trust has developed advance choice documents for the learning disability community to enable them to make decision about their care as a mental health inpatient before admission. (P,N,I, E)	CMO	1.1,1.2,2.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
The Trust is looking to embed the advanced choice document into the Trust's learning disability and/or autism service dynamic support register (DSR) process which will streamline with care (education) and treatment reviews (C(E)TR). On 1st April 2026 the Trust LD service took over management and responsibility for DSRs and C(E)TRs for Calderdale, Kirklees and Wakefield. Some time is therefore required to get the transition completed and review the process across the three places in more detail. The recent changes within the ICB continue to impact on the pace of this work. Further update to be provided in January 2027.	January 2027	CMO

Assurance (strategic risk 1.2 - Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.2, 2.3, 3.1, 4.1, 4.2, 5.1, 6.3
A74	Staff survey results reported to Trust Board and / or People and Remuneration Committee and action plans produced as applicable.	Reported to PRC every other meeting. (P, N) (I)	CPO	1.1, 1.2, 3.1

Assurance (strategic risk 1.2 - Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A86	Positive 2025 NHS staff survey results that demonstrate the Trust benchmarks well against peer organisations.	Annual NHS staff survey results monitored by EMT, PRC and Trust Board. (P,N, I, E)	CPO	1.1, 1.2
A116	Following WRES and WDES results a clear action plan was produced to address the key findings. EDI action plan was submitted and approved at Board October 2026.	This will be monitored through PRC to ensure delivery of the actions on a quarterly basis (P, N, I, E)	CPO	1.1, 1.2
A117	EDI dashboard	Updates on the dashboard will be presented to each Quality and Safety Committee meeting (P,N,I)	DSC/DFR	1.1, 1.2, 2.1, 2.4, 4.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 2.1 (Strategic Aim 2: Best we can be - Best Quality)
Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy.

Controls (strategic risk 2.1 - Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy.)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval, including equality impact assessments. Central logs for clinical and corporate procedures developed and new procedure template added to the Policy on Policies. (I)	DNQ / DSC	1.1, 2.1, 4.1, 4.2, 6.2
C02	Operational Management Group (OMG) meetings established to identify performance issues and learn from good practices in other areas. Any identified improvements required are rectified in the operational performance, finance, workforce and quality meeting (Monthly) (I)	COO	2.1, 2.3, 2.4, 4.1, 4.2
C03	Senior representation on West Yorkshire and South Yorkshire mental health collaborative and associated workstreams. (I, E)	COO	2.1, 4.1
C04	Senior representation on local partnership boards, building relationships, ensuring transparency of agendas and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction. (I, E)	DSC	2.1, 2.4, 4.1
C06	Trust performance management system in place with KPIs covering national (including NHS oversight framework) and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	2.1, 2.4, 4.1
C08	Formal contract review and negotiation meetings with integrated care boards, NHSE and provider collaboratives underpinned by national agreements to support strategic review of services. (I)	DFR	2.1, 4.1
C15	Equality Diversity and Inclusion Strategy in place for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E, P, N)	DSC/CPO	1.1, 1.2, 2.1, 2.4, 3.1, 4.1, 4.3
C17	Member of South Yorkshire mental health, learning disability and autism programme board. Partner in emerging South Yorkshire provider alliance. (I, E)	DSC	2.1, 4.1
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data is in place to identify any themes. Assurance via Mental Health Act Committee, Quality and Safety Committee. (E, I)	DSC / DNQ / CMO	1.1, 2.1 4.1, 4.2
C21	Framework in place to ensure feedback from customers, both internal and external (including feedback loop) is collected, responded to, analysed, and acted upon. (I, E)	DNQ	2.1, 2.4, 4.2
C26	Community reporting is available as a tool to enable people to talk to members of their own community about their experience and approach developed and implemented with VCS partners in each of our places to strengthen insight involvement and co-production (I, E)	DSC	1.1, 2.1, 4.3
C27	Governors supported to involve people at a locality level, toolkit in place. (I, E)	DSC	2.1, 4.3
C28	Toolkit in place to capture patient stories. (I)	DSC	2.1, 4.3
C30	Process to review and assure Equality Impact Assessments (EIAs)with report to Quality and Safety Committee (I). (I)	DSC	1.1, 2.1, 4.3
C31	Joint Service and Needs Assessment (JSNA) data reflected in all service EIAs. (I)	DSC	2.1, 4.3
C35	Translation and interpretation service in place as well as inequalities interactive tool. (I)	DSC	1.1, 2.1, 4.3
C37	All of us in mind group in place with governance structure (I, P, N)	DSC	2.1
C38	Trust website meets Accessible Information Standard. (I)	DSC	2.1
C40	Photo symbol package available to staff from the communications team for Trust documents and leaflets. (I)	DSC	2.1
C41	Patient experience and engagement toolkit in place. (I)	DSC	2.1
C126	Commissioning intentions are factored into operating plans as part of the planning process. (P, I)	DFR, COO, DSC	2.1, 4.1, 4.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C145	Service user survey results reported to Quality and Safety Committee and Trust Board and action plans produced as applicable. (P, N, I).	DNQ	2.1, 2.4, 4.1, 4.2, 4.3
C148	All services have a baseline Equality Impact Assessment (EIA) in place. (P) (I)	DSC	2.1
C185	Improving access to care priority programme established (P, I)	DSC	2.1

Controls (strategic risk 2.1 - Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy.)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C186	Dashboard and business intelligence tools in place to help address health inequalities (P, I)	DSC	2.1
C204	Chief Medical Officer is the executive sponsor of learning disabilities service for the Trust (P,I,E)	CMO	2.1
C208	All of you campaign – To improve the recording of equality data through campaign, SystmOne improvements and tools on intranet page. (P, I, E)	DSC	2.1
C260	Priority programmes approved by Trust Board April 2026 (P, I)	DSC	2.1, 4.3
C101	The Trust engaged with the national Culture of Care improvement programme during 2024/25 (P,N,I,E) BAU Debs in ORR	DNQ/CMO	2.1
C263	Operational equality dashboards now in place (P,N,I)	DSC	1.1, 2.2, 4.3
C264	Patient carer race equality framework (PCREF) implementation plan in place (P,N,I,E)	DSC	1.1, 2.2, 4.3
C265	Health inequalities toolkit in place to reduce barriers to access to services (P,N,I,E)	DSC	1.1, 2.1, 2.3, 4.3
C266	Hearing impaired and deaf toolkit in place to reduce barriers to access to services (P,N,I,E)	DSC	1.1, 2.1, 2.3, 4.3
C273	Medical devices is now part of the director of finance, estates and resources portfolio as approved by EMT. The medical device safety officer role has been taken on by deputy director of estates. A whole-time band 5 colleague has been appointed to oversee medical device servicing. (P, N, I)	DFR	2.1
C276	An equality interactive tool dashboard is now in place which provides insight to ensure improvements and service change. (P,N,I,E)	DSC	1.1/1.2/2.1/2.4/4.3
C277	As part of NHS England's Mental Health Bill Quality Improvement Plan, the Trust has developed advance choice documents for the learning disability community to enable them to make decision about their care as a mental health inpatient before admission. (P,N,I, E)	CMO	1.1,1.2,2.1
C290	Triangle of care (TOC) has been rolled out across all inpatient wards and is has been rolled out across community services resulting in the Trusts second star (P,I,E)	DNQ	2.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
The Trust is looking to embed the advanced choice document into the Trust's learning disability and/or autism service dynamic support register (DSR) process which will streamline with care (education) and treatment reviews (C(E)TR). On 1st April 2026 the Trust LD service took over management and responsibility for DSRs and C(E)TRs for Calderdale, Kirklees and Wakefield. Some time is therefore required to get the transition completed and review the process across the three places in more detail. The recent changes within the ICB continue to impact on the pace of this work. Further update to be provided in January 2027.	January 2027	CMO
The Trust is working with CKW commissioners to support reduction of waiting lists for Adult ADHD assessments. The process will be to offer people on the waiting list to be assessed by commissioned independent practitioners. The commissioner led standard operating procedure has been devised and SWYPFT services are working to undertake this process. Currently the timescale for completion is still to be determined. The service is now working through any eligible transfers This will be a small number but will continue to review the list. There is also new guidance published that will require ICB to review with services on any changes required.	January 2027	COO
The Trust is mapping itself against the NHSE experience of care framework to establish its priorities for patient experience related activity. Progress will be monitored through the clinical governance group and quality and safety committee. Mapping process completed and reporting to November quality and safety committee. Anticipated timeline for an embedded process is April 2026.	April 2027	DNQ
A new model of women's care is in development following external peer review, draft report is in progress with future reporting to go to EMT and QSC.	January 2027	DNQ

Assurance (strategic risk 2.1- Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	2.1, 2.4, 4.1, 4.2, 4.3, 5.1
A20	Service user experience and waiting time reports are reviewed by QSC, and MHA. CQC Mental Health Act visits occur on a regular basis and are reported into QSC and MHAC.	Patient experience reports and integrated performance report (IPR) data on access and waiting times included in the new Equality and Inclusion interactive tool. (P) (I)	DNQ	1.1, 2.1, 4.1, 4.2, 4.3
A24	Investment Appraisal report – covers bids and tender activity, contract risks, and proactive business development activity.	Quarterly bids and tenders report to Executive Management Team (EMT) and twice yearly to FIP and Trust Board. (P, N) (I)	DFR	2.1, 4.2, 5.1, 6.3
A33	Patient experience (including complaints) reports to Trust Board and QSC	Annual reports to Board / EMT and quarterly into QSC. (P, N) (I)	DNQ	1.1, 2.1, 2.4
A34	Quality strategy and clinical strategy review updates report into QSC.	Routine reports into QSC via IPR and annual report scheduled in 2025/26 work plan. (P) (I)	DNQ	2.1, 2.4
A35	EDI dashboard presented to Quality and Safety Committee	Regular reports and papers provided. (P) (I)	DSC	1.1, 2.1
A110	Insight report	Reported submitted to EMT and EDI operations group March and September each year.	DNQ	2.1
A111	PCREF compliance reports	Quarterly national reports to EMT, QSC and NHSE (P,N,I,E)	DSC	1.1, 2.1, 4.3

Assurance (strategic risk 2.1- Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A117	EDI dashboard	Updates on the dashboard will be presented to each Quality and Safety Committee meeting (P,N,I)	DSC/DFR	1.1, 1.2, 2.1, 2.4, 4.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
There is a new national quality strategy to be published shortly which will inform the refresh of the Trust Quality Strategy which is due at the end of 2026.	January 2027	DNQ

Strategic risk 2.2 (Strategic Aim 2: Best we can be - Best Quality)
The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.

Controls (strategic risk 2.2 - The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C42	Access to the model health system and any other associated national productivity packs to enable effective national benchmarking and support decision making. (E, I)	DFR	2.2
C43	A data warehouse has been established with a business intelligence tool supporting improved decision making and continues to evolve. (I)	DFR	2.2
C44	Digital strategy in place with quarterly report to Executive Management Team (EMT) and twice-yearly report to TISC and Trust Board. (P,I)	DFR	2.2, 5.2
C45	Risk assessment and action plan for data quality assurance in place. (I)	DFR	2.2
C46	Datix Risk management and incident reporting systems support review of all incidents for learning and action. (I)	DNQ	2.2, 2.3, 3.1
C47	The Patient Safety Oversight Group meets weekly to review recent patient safety risks. All red and amber incidents from across the organisation are reviewed including the undertaking of proportionate investigations. In addition, all incidents relating to protected characteristics or staffing, irrespective of grading are also reviewed. (P,N,I,E)	DNQ / CMO	1.1, 2.2, 2.4, 3.1
C48	Improving Clinical Information and Information Governance Group (ICIG) reviews clinical information systems and data quality. (I)	DNQ / DFR	2.2
C49	Internal process to impact assess and review potential new systems from a technical and information governance (IG) standpoint. (I)	DFR	2.2
C50	Improvement processes in place for operational / service level requests / changes, for system-wide changes and developments. (I)	DFR/COO/DNQ/DSC	2.2
C51	National benchmarking data is reviewed at the benchmarking group and then analysed and taken to OMG, EMT and Finance, Investment and Performance Committee. (I)	DFR	2.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meeting stake place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C143	Trustwide Benchmarking Group in place. This is chaired by Director of Finance, Estates and Resources and reports will be regularly provided to FIP to ensure the Trust can assess its current service provision in the context of the wider system. (P, E, I)	DFR	2.2, 4.3
C172	Substantive data quality and waiting list lead in post to ensure the continued development and monitoring of waiting list management across the Trust. (I, P)	DSC	2.2
C207	Trust IPR metrics are aligned to NHS Oversight Framework (P,N,I,E)	DFR	2.2
C269	Care group level patient safety oversight groups (PSOG) in place to review local incidents and learning which then feed into Trustwide PSOG (P,N,I,E)	DNQ/CMO	1.1,2.2, 2.4, 3.1
C278	Digital innovation and programme group (P,N,I)	CMO	2.2
C291	Trustwide patient safety incident huddles take place on a daily basis to review all Datix incidents across the Trust (P,N,I)	DNQ	1.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Performance and Business information (P & BI) are automating integrated performance reporting to release capacity to undertake analytics so that operational teams have actionable data they can use to support decision making. IPR automation of metrics for national people sections of the IPR is complete. Work continues on quality metrics; however, this is taking longer than anticipated due to further work being required on the Datix feed and challenges with capacity to validate metrics across P&BI and the quality team but is being monitored closely. Several quality metrics still require validating due to complexity of the metrics and external dependencies. There are also some new metrics and changes for the 2026/27 report. As a result of the automation work already undertaken, P&BI capacity is being provided into some of the Trust priority programme groups such as inpatient improvement group and improving access to care. This capacity provision is planned to continue and will increase. Reviewed in October 2026, position remains the same, update in January 2027.	January 2027	DFR

Assurance (strategic risk 2.2 - The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
A37	Data quality improvement plan monitored through ICIG, and the Executive Management Team (EMT) deviations identified, and remedial plans requested.	Included in monthly IPR to OMG, EMT and Trust Board. (P) (I)	DNQ/DFR	2.2
A38	Progress against SystmOne optimisation reviewed by Clinical Safety Design Group, EMT, QSC and Trust Board (as required).	Monthly priority programmes item schedule for EMT. Included as part of the IPR to EMT, QSC and Trust Board (as required). (P) (I)	DNQ	2.2
A39	Quarterly Board Assurance Framework and Risk Register report to Board providing assurances on actions being taken.	Quarterly risk register reports to Board. Triangulation of risk, performance, and governance present to each Audit Committee. (P) (I)	DSC	2.2
A40	Data quality focus at OMG and ICIG which is reported into EMT and QSC. Data quality is also referenced in the Brief	Regular agenda items and reporting at ICIG and OMG. (P, N) (I)	DNQ/COO	2.2
A41	Benchmarking reviews and a cyclical approach to care group metrics conducted at Finance, Investment and Performance Committee.	Reports provided regularly. (P) (I)	COO / DFR	2.2
A42	OMG management and governance processes are documented weekly in OMG minutes.	All OMG minutes are presented to EMT on a regular basis. (I) (P)	COO	2.2
A43	Waiting list reporting including health inequalities data.	Reported in OMG quarterly and improving access to care group quarterly (P, N, I)	DSC	2.2, 2.4, 4.3
A115	Summary update from care group Patient Safety Oversight Group's (PSOG)	Weekly updates sent to Trustwide PSOG which is then fed into EMT and QSC and reported into Trust Board via triple A from QSC (P,N,I)	DNQ/CMO	1.1,2.2, 2.4, 3.1
A118	Digital Innovation and Programme Group	Meets every two months and reports regular updates into EMT (P,N,I)	CMO	2.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 2.3 (Strategic Aim 2: Best we can be - Best Quality)
Failure to create a learning environment leads to lack of innovation and to repeat incidents.

Controls (strategic risk 2.3 - Failure to create a learning environment leads to lack of innovation and to repeat incidents)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C02	Operational Management Group (OMG) meetings established to identify performance issues and learn from good practices in other areas. Any identified improvements required are rectified in the operational performance, finance, workforce and quality meeting (Monthly) (I)	COO	2.1, 2.3, 2.4, 4.1, 4.2
C46	Datix Risk management and incident reporting systems support review of all incidents for learning and action. (I)	DNQ	2.2, 2.3, 3.1
C52	Patient experience reporting includes learning from complaints, concerns and compliments. (I)	DNQ	1.1, 2.3, 3.1
C53	The Trusts is aligned to the Patient Safety Incident Response Framework (PSIRF) in line with national standards. (I)	DNQ	1.1, 2.3, 3.1
C54	Quality Improvement network established to provide Trust wide learning platform. (I)	DNQ	2.3, 3.1
C55	Quality Strategy is in place achieving balance between assurance and improvement. (I)	DNQ	2.3
C56	Quality improvement approach and methodology is utilised throughout the Trust underpinned by the model for improvement. (I)	DNQ	2.3, 2.4
C57	Leadership and management arrangements established and embedded at care group and service line level with key focus on being clinically informed and operationally embedded. (I)	COO	2.3, 3.1
C58	Learning lessons reports are shared across care groups via the patient safety learning and improvement group, care group patient safety oversight groups (PSOG's) including post incident reviews, which are included in quarterly and annual patient safety oversight reports. (I)	DNQ	2.3
C59	Risk Management Governance Framework in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training. (I)	CEO/DSC	2.3
C60	Patient safety risk summaries are presented to each Executive Management Team (EMT) meeting supported by monthly reports to OMG, quarterly reports to Quality and Safety Committee and Trust Board (Patient Safety Oversight Report). (I)	DNQ	2.3
C61	Web based platform in place with over 2,000 members providing digital opportunities to share, innovate, collaborate and improve. (I)	DSC	2.3, 5.2
C62	Peer lead worker role in place and training toolkit developed. (I)	DSC	2.3
C139	Process established for the use of improvement case studies which are then shared by the communications team and published on the Trust website. (P, I)	DSC	2.3

Controls (strategic risk 2.3 - Failure to create a learning environment leads to lack of innovation and to repeat incidents)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C161	Learning process in place through the use of processes such as the Situation, Background, Assessment, Recommendation (SBAR) structure to create short learning case studies which are shared with all staff via the Trust headlines. (P, I)	DNQ	2.3
C173	The use of external experts for patient safety incident investigations and reviews when appropriate. (P, N, I, E)	DNQ	2.3
C174	Internal audit report received demonstrating significant assurance against patient safety incident investigations action planning. (P, I, E)	DNQ	2.3
C265	Health inequalities toolkit in place to reduce barriers to access to services (P, N, I, E)	DSC	1.1, 2.1, 2.3, 4.3
C266	Hearing impaired and deaf toolkit in place to reduce barriers to access to services (P, N, I, E)	DSC	1.2, 2.1, 2.3, 4.3
C279	Sexual safety policy in place for both staff and service users (P,N,I,E)	CPODNQ	2.3
C280	Information governance (IG) training and action plan on IG hotspots in place. (Linked to ORR risk 852), Bespoke and ad-hoc training is in place (P,N,I)	DFR	2.3
C281	IG communications campaigns, improvements to information available to staff via the intranet in place, action plans and thematic reviews, including deep dives at Operational management Group. (P,N,I)	DFR	2.3
C282	The Trust met the training requirement for the June 2026 DSPT submission (95.9%) in March 2026 (P,I)	DFR	2.3
C283	The Trust submitted the full DSPT assessment for 2025/26 ahead of the deadline of 30 June 2026 (P,E)	DFR	2.3

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
A strategic approach to the oversight of the learning from previous serious incidents and assurance around the embedding of actions is now part of the work of the Patient Safety Learning and Improvement Group. Following agreement on the scope of incidents to be included in this work and a broader thematic analysis of actions from all serious incidents in the Trust, a report will be ready for review in mid-November and will be presented to QSC in December.	January 2027	DNQ
A comprehensive review of restrictive practice across the Trust is taking place and progress into EMT and quality and safety committee.	January 2027	DNQ

Assurance (strategic risk 2.3 - Failure to create a learning environment leads to lack of innovation and to repeat incidents.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.2, 2.3, 3.1, 4.1, 4.2, 5.1, 6.3
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	2.3, 4.2, 4.3, 5.1, 5.2, 6.3
A22	All red and amber incidents from across the organisation are reviewed through the Patient Safety Oversight Group including the undertaking of proportionate investigations. In addition, all incidents relating to protected characteristics or staffing, irrespective of grading are also reviewed. Dissemination of lessons learnt and good clinical practice across the organisation.	Process in place through the quarterly patient safety oversight reporting including lessons learned to OMG, EMT, Quality and Safety Committee and Trust Board. (P, N) (I)	DNQ	2.3, 4.2
A44	Recent patient safety risk summaries update into each EMT meeting.	Clinical risk scan update into EMT meeting. (P, N) (I)	DNQ	2.3
A45	Assurance reports to Quality and Safety Committee covering key areas of risk in the organisation seeking assurance on robustness of systems and processes in place.	Routine report to each Quality and Safety Committee of risks aligned to the committee for review. (P) (I)	DNQ	2.3
A46	Priority programmes reported to Board and EMT.	Monthly reports to Board / EMT and bi-monthly into QSC. (P) (I)	DSC	2.3, 3.1
A47	Examples of co-production in recovery colleges and Creative Minds	Reports to Charitable Funds Committee (CFC) and to Corporate Trustee for Charitable Funds. Creative Minds produce reports that go to CFC and recovery colleges report into OMG. (P, I)	DSC	2.3
A48	Inpatient structure provides assurance of operational oversight of record keeping. A working group is in place to focus on improving Trust wide clinical record keeping.	Routine matron checks reported through Care Group governance meetings and escalated through governance reports to QSC (as required). The clinical record keeping working group reports into Clinical Governance Group on a regular basis. (P) (I)	COO/DNQ	2.3
A51	Process in place to review and identify learning from national investigations or reports.	Reports go into the clinical governance group (CCG), EMT, QSC and Trust Board (as required). (E, I, P, N)	DNQ	2.3

Assurance (strategic risk 2.3 - Failure to create a learning environment leads to lack of innovation and to repeat incidents.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A90	A Trustwide approach to shared decision making and co-production is in place to support the delivery of personalised care and innovation.	Reports into QSC (E, I, P)	DNQ	2.3
A94	Service improvement work is now aligned with quality transformation and clinical pathways for Mental Health, Learning Disabilities and Autism, forensics and children and young people's services.	Reports through priority programmes into EMT monthly (I, E, P, N)	COO	2.3
A125	Trustwide patient safety incident huddles take place on a daily basis to review all Datix incidents across the Trust	Any identified area of concern will be raised to PSOG on a weekly basis. If required issues will be escalated further to QSC. (P, N, I)	DNQ	1.1, 2.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
A strategic approach to the oversight of the learning from previous serious incidents and assurance around the embedding of actions is now part of the work of the Patient Safety Learning and Improvement Group. Following agreement on the scope of incidents to be included in this work and a broader thematic analysis of actions from all serious incidents in the Trust, a report will be ready for review in mid-November and will be presented to QSC in December.	January 2027	DNQ
There will always be information governance (IG) incidents because organisations rely on people, processes and technology that are imperfect and constantly changing. As data volumes and reliance on digital systems grow, human error is unpredictable, therefore the risk of occasional lapses cannot be eliminated, only mitigated through strong controls, culture and continuous improvement. Controls 280 -283 are in place and have been reviewed and updated where applicable. The mandatory annual DSPT audit by 360 assurance reported as follows: • Overall risk assurance across all five objectives is **low**, which means none of the reviewed outcomes were rated as not meeting minimum achievement levels; and • Confidence level in the veracity of the Trust's DSPT self-assessment/ final submission is **high.** For the sixth consecutive year, the Trust has achieved the highest levels of assurance in the audit assessment. The Trust has completed the self-assessment of the contributing outcomes that were not subject to the audit review and met the minimum achievement levels for each. The DSPT was approved for submission which took place on the 29 June 2026 (deadline 30 June 2026).	January 2026	DFR

Strategic risk 2.4 (Strategic Aim 2: Best we can be - Best Quality) Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.

Controls (strategic risk 2.4 - Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C02	Operational Management Group (OMG) meetings established to identify performance issues and learn from good practices in other areas. Any identified improvements required are rectified in the operational performance, finance, workforce and quality meeting (Monthly) (I)	COO	2.1, 2.3, 2.4, 4.1, 4.2
C04	Senior representation on local partnership boards, building relationships, ensuring transparency of agendas and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction. (I, E)	DSC	2.1, 2.4, 4.1
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR/DSC	2.4, 4.1, 4.2, 5.1
C06	Trust performance management system in place with KPIs covering national (including NHS oversight framework) and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	2.1, 2.4, 4.1
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DSC/CEO	2.4, 4.1, 4.3
C15	Equality Diversity and Inclusion Strategy in place for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E, P, N)	DSC/CPO	1.1, 1.2, 2.1, 2.4, 3.1, 4.1, 4.3
C21	Framework in place to ensure feedback from customers, both internal and external (including feedback loop) is collected, responded to, analysed and acted upon. (I, E)	DNQ	2.1, 2.4, 4.2
C47	The Patient Safety Oversight Group meets weekly to review recent patient safety risks. All red and amber incidents from across the organisation are reviewed including the undertaking of proportionate investigations. In addition, all incidents relating to protected characteristics or staffing, irrespective of grading are also reviewed. (P,N,I,E)	DNQ / CMO	1.1, 2.2, 2.4, 3.1
C56	Quality improvement approach and methodology. (I)	DNQ	2.3, 2.4
C63	Partnership Meeting in place as part of the improving mental health priority programmes, including representatives from community partners and stakeholders. (E, P, N)	COO	2.4
C64	Care closer to home programme incorporating whole system actions with out of area bed reduction reported against trajectory. (I, E)	COO	2.4
C65	Policies and procedures to support safer staffing in place to respond to changes in need. (I)	DNQ	2.4
C66	Trio management system in place monitoring quality, performance and activity on a routine basis. (I)	COO	2.4
C67	Use of trained and appropriately qualified temporary staffing through bank and agency system. (I)	CPO	2.4
C68	Targeted improvement support in place to deliver waiting list management improvement plans to support people awaiting a service / treatment. A workstream for Improving Access to Care is focussing on improving the way that we reduce waits, increase access and reduce inequalites. This reports through the priority programmes. (I) (ORR 1078, 1132)	COO	2.4
C69	Process to manage and report on progress against the CQC action plans. (I)	DNQ	2.4

Controls (strategic risk 2.4 - Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C142	Healthwatch and regulators provide external assurance on standards and quality of care. (I) (P) (N)	DNQ	2.4
C145	Service user survey results reported to Quality and Safety Committee and Trust Board and action plans produced as applicable. (P, N, I).	DNQ	2.1, 2.4, 4.1, 4.2, 4.3
C160	Operational leadership has implemented frequent inpatient staffing meetings to ensure inpatient wards are staffed safely and staff redeployed according to need (P, I)	COO	2.4
C269	Care group level patient safety oversight groups (PSOG) in place to review local incidents and learning which then feed into Trustwide PSOG (P,N,I,E)	DNQ/CMO	1.1,2.2, 2.4, 3.1
C276	An equality interactive tool dashboard is now in place which provides insight to ensure improvements and service change. (P,N,I,E)	DSC	1.1, 1.2, 2.1, 2.4, 4.3
C292	The Trust has a safer staffing policy in place (P,I)	DNQ	2.4

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
The Trust currently does not have safer staffing establishment reviews in place for mental health community services; this is being developed as part of the community services transformation programme. There is a current focus on developing a community caseload management tool, which will provide significant data to inform required establishments by team. It has been agreed in EMT to undertake community establishment reviews from Quarter 1 onwards 2026/27, to enable the caseload management data to be used to provide this additional evidence. This will include Intensive Home-Based Treatment Teams, Core and Enhanced Teams. They continue to embed the caseload management system across the teams. There is project management around this reporting to the transforming clinical pathways group.	January 2027	DNQ

Assurance (strategic risk 2.4 - Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	2.1, 2.4, 4.1, 4.2, 4.3, 5.1
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through OMG, EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	EMT	2.4, 4.1, 4.2, 4.3, 5.2, 6.3
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality assurance system. Reports on these visits are provided to EMT, Quality and Safety Committee (QSC), Trust Board and Members' Council.	Unannounced and planned visits as part of our routine CQC interface. Monthly CQC updates are provided to QSC, and an annual report is presented to the Members Council. Quality walkarounds programme in place for 2026/27 are reported into QSC. (P, N) (E)	DNQ	2.4, 4.1, 4.2
A33	Patient experience (including complaints) reports to Trust Board) and QSC	Annual reports to Board / EMT and quarterly into QSC. (P, N) (I)	DNQ	1.1, 2.1, 2.4
A34	Quality strategy and clinical strategy review updates report into QSC Committee.	Routine reports into QSC via IPR and annual report scheduled in 2025/26 work plan. (P) (I)	DNQ	2.1, 2.4
A49	Quality Assurance System in place through the quality governance team to horizon scan learning from CQC inspection reports from other providers.	Reviewed by EMT to keep appraised of CQC developments and learning in preparation for any forthcoming CQC inspection. (P) (N) (I) (E)	DNQ	2.4
A80	Healthcare inequalities dashboard	OMG, EMT, QSC review and also included in IPR. Reviewed by Improving access to care group to focus on activity but allows trends over time to be identified. (I) (P)	DSC	1.1, 2.4
A81	CAMHS referral monitoring	CAMHS governance group monitors referral and access to monitor pressure on core CAMHS services (P) (N) (I) (E)	COO	2.4
A43	Waiting list reporting including health inequalities data	Reported in OMG quarterly and improving access to care group quarterly (P, N, I)	DSC	2.2, 2.4, 4.3
A88	Transforming clinical pathways oversight group is in place to monitor the improving care priority programmes.	This group reports into OMG and EMT on a bi-monthly basis (P, N, I)	COO	2.4
A95	Care closer to home report	Reported into every EMT meeting (I, E, P, N)	COO	2.4, 5.1

Assurance (strategic risk 2.4 - Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A115	Summary update from care group Patient Safety Oversight Group's (PSOG)	Weekly updates sent to Trustwide PSOG which is then fed into EMT and QSC and reported into Trust Board via triple A from QSC (P,N,I)	DNQ/CMO	1.1,2.2, 2.4, 3.1
A117	EDI dashboard	Updates on the dashboard will be presented to each Quality and Safety Committee meeting (P,N,I)	DSC/DFR	1.1, 1.2, 2.1, 2.4, 4.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
There is a gap in commissioned capacity to meet demand in children's neurodevelopmental services in Kirklees. There is no agreed solution., this remains a national issue. The Trust has changed its pathways to increase capacity and improve flow, but cannot influence future demand, but will continue to work with commissioners to try to resolve issues. The Trust is working with CKW commissioners to establish safe processes to support children on the waiting list for neurodevelopmental services to have access to independent assessments, which will therefore reduce the waiting list. The service is now working through any eligible transfers. This will be a small number but will continue to review the list. There is also new guidance published that will require ICB to review with services on any changes required.	January 2027	COO
In all areas demand for adult ADHD services is beyond commissioned capacity, however, the service is meeting current commissioned activity. This is in line with the national picture. Work is taking place in each ICS to understand the rising demand and agree how this can be addressed. Work continues to be led by the West Yorkshire and South Yorkshire ICS's. An internal triage process in some WY places has been introduced and discussions with commissioners are taking place around service modelling which will feed into the national review project. The Trust is working with CKW commissioners to support reduction of waiting lists for Adult ADHD assessments. The process will be to offer people on the waiting list to be assessed by commissioned independent practitioners. The commissioner led standard operating procedure has been devised and SWYPFT services are working to undertake this process. This work continues and new guidance has been published that will require ICB review with services on any changes required.	January 2027	COO

Strategic risk 3.1 (Strategic Aim 2: Best we can be - Best place to work and learn)
Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.

Controls (strategic risk 3.1 - Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C15	Equality Diversity and Inclusion Strategy in place for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E, P, N) (ORR 773)	DSC/CPO	1.1, 1.2, 2.1, 2.4, 3.1, 4.1, 4.3
C46	Datix Risk management and incident reporting systems support review of all incidents for learning and action. (I)	DNQ	2.2, 2.3, 3.1
C47	The Patient Safety Oversight Group meets weekly to review recent patient safety risks. All red and amber incidents from across the organisation are reviewed including the undertaking of proportionate investigations. In addition, all incidents relating to protected characteristics or staffing, irrespective of grading are also reviewed. (P,N,I,E)	DNQ / CMO	1.1, 2.2, 2.4, 3.1
C52	Patient experience reporting allows staff to learn from complaints, concerns and compliments. (I)	DNQ	1.1, 2.3, 3.1
C53	The Trusts is aligned to the Patient Safety Incident Response Framework (PSIRF) in line with national standards. (I)	DNQ	1.1, 2.3, 3.1
C54	Quality Improvement network established to provide Trust wide learning platform. (I)	DNQ	2.3, 3.1
C57	Leadership and management arrangements established and embedded at care group and service line level with key focus on being clinically informed and operationally embedded . (I)	COO	2.3, 3.1
C108	A leadership and management programme is in place (P,I)	CPO	3.1
C102	Annual learning needs analysis undertaken linked to service and financial plans. (I)	CPO	3.1
C103	Established education and training governance group agrees and monitors annual training plans. (I)	CPO	1.2, 3.1
C104	People processes in place ensuring defined job description, roles and competencies to meet the needs of service, pre-employment checks done regarding qualifications, DBS and work permits. (I)	CPO	3.1
C105	Mandatory clinical supervision and training standards set and monitored for service lines. (I)	DNQ	3.1
C106	Medical leadership programme in place with external facilitation as and when required. (I)	CMO	3.1
C107	People strategy and annual delivery plan approved by PRC. (I)	CPO	3.1
C110	Values-based appraisal process in place with new monitoring arrangements monitored through business intelligence systems and the integrated performance report. (P,N,I)	CPO	1.1, 3.1
C111	Values-based Trust Welcome Event in place covering mission, vision, values, key policies and procedures. (I)	CPO	3.1
C112	Trust Workforce annual plan in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements regarding training, equality and diversity. (I)	CPO	3.1
C113	Good partnership working with a range of Higher Education Institutions (HEIs) to discuss the appropriateness of undergraduate and post graduate programmes. (E)	CPO /DNQ/CMO	3.1
C114	Appraisal process to discuss individuals' intentions regarding future career development with a view to maximise opportunities within the Trust and promote staff retention. (I)	CPO	3.1
C116	Provision of appropriate personal protective equipment (PPE) in line with national guidance. (I)	DNQ	3.1
C117	Access to wellbeing offers. (I)	CPO	3.1

Controls (strategic risk 3.1 - Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C118	Comprehensive Occupational Health Service offer. (P,I)	CPO	3.1
C121	Promotion and accessible offer of flu vaccination programme for all staff within the Trust with clear targets. (I)	DNQ	3.1
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C165	The Trust is a General Medical Council (GMC) sponsor for international fellows which contributes to the sustainable workforce model. (P, E, I)	CMO	3.1
C178	Temporary staffing scrutiny group in place which is chaired by the chief operating officer and chief people officer to ensure agency standards are fully adhered to. (P, I)	COO/CPO	3.1
C180	Diversity, inclusion and belonging lead in place. (P) (I)	CPO	3.1
C183	Wellbeing capacity within the Education, Learning and Organisational Development (ELOD) team is in place. (P, I)	CPO	3.1
C192	Medical appraisal has a wellbeing section which is reviewed by the appraisal and validation team throughout the year (aligns to GMC fair to refer report 2019). (P,I,E)	CMO	3.1
C210	Vacancy oversight procedures are in place with a weekly panel chaired by the Chief People Officer. (P,N, I)	CPO	3.1, 4.1, 5.1
C211	CMO presents a monthly webinar across the Trust to engage medical staff and provide updates on clinical practice, changes across the ICS, wellbeing information and key Trust updates including information from the Brief. (P, I)	CMO	3.1
C220	Enhanced training package for managers in respect of sickness absence implemented following internal audit recommendation to ensure high levels of competence in managing sickness absence. (P, I)	CPO	3.1
C159	Teaching Trust status will allow the Trust to recruit high calibre staff and help promote retention of staff (P,I, E)	CMO	3.1
C269	Care group level patient safety oversight groups (PSOG) in place to review local incidents and learning which then feed into Trustwide PSOG (P,N,I,E)	DNQ/CMO	1.1,2.2, 2.4, 3.1
C270	People strategy in place. Approved by Trust Board December 2025 (P, I, E)	CPO	1.1, 1.2, 3.1, 6.3
C285	Updates on the resident doctor 10-point plan received by People and Remuneration Committee every other meeting (P, N, I)	CMO	3.1
C286	Trust plan approved by Trust Board in January 2026 (P,N,I,E)	CPO/DFR/DSC	3.1, 6.3
C293	New appraisal process implemented, including removal of rolling target and the introduction of an appraisal window (P,N,I)	CPO	3.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Current performance in relation to clinical and managerial supervision is below Trust target across a number of teams since the implementation of the new standards. Therefore a review has been commissioned by OMG of the impact of the changes made and a report is anticipated to be ready towards the end of November 2026	January 2027	DNQ

Assurance (strategic risk 3.1- Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards, identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.2, 2.3, 3.1, 4.1, 4.2, 5.1, 6.3
A46	Priority programmes reported to Board and EMT.	Monthly reports to Board / EMT and bi-monthly into QSC. (P) (I)	DSC	2.3, 3.1
A50	The vacancy oversight group has been established to consider all vacancies across the Trust taking into account finance, quality and safety.	Weekly meetings chaired by chief people officer (P,N, I)	CPO	3.1, 4.1, 5.1
A53	Sickness/absence reporting being closely monitored by the People Directorate business partners and care groups. A sickness reduction plan for 2026/2027 has been developed and signed off by PRC and the Board. (I) (P) (N)	Reported into the People and Remuneration Committee on a quarterly basis as a minimum. (P,N,I)	CPO	3.1
A66	Annual Mandatory Training report goes to PRC and Quality and Safety Committee (QSC) Committee.	QSC Committee receive annual report (P) (I)	CPO	3.1
A67	Appraisal uptake included in IPR.	Monthly IPR goes to the Trust Board and EMT. (P) (I)	CPO	3.1
A68	ESR competency framework for all clinical posts.	Monitored through mandatory training report. (P) (I)	CPO	3.1
A69	Mandatory training compliance is part of the IPR.	Monthly IPR goes to the Trust Board and EMT. (P) (I)	CPO	3.1
A71	Safer staffing reporting is included in IPR and safer staffing reported to Quality and Safety Committee (QSC) and Trust Board.	Monthly IPR goes to the Trust Board and safer staffing reports go to EMT six monthly, QSC and Trust Board. (P)	DNQ	3.1
A72	People Strategy and delivery plan.	Quarterly report to the PRC Committee. (P) (I)	CPO	3.1
A73	Annual appraisal and objective setting in place.	Included as part of the IPR to EMT and Trust Board. (P) (I)	CPO	3.1
A74	Staff survey results reported to Trust Board via, People and Remuneration Committee and action plans produced as applicable.	Reported to PRC every other meeting. (P, N) (I)	CPO	1.1, 1.2, 3.1
A76	Routine scan of NHS based national guidance as part of horizon scanning.	Discussed fortnightly at people leadership team. (PLT). (P, I, E)	CPO	3.1

Assurance (strategic risk 3.1- Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A83	Temporary staffing scrutiny group report providing details of spend, governance arrangements, trends, hotspots and quality assurance.	Reported into PRC and FIP. (P, N, I)	COO	3.1
A113	Teaching Trust Joint Partnership Board (P, I, E)	Meets quarterly and is chaired by the Appointed Associate NED for UoL. (P,N ,I, E)	CMO	3.1
A115	Summary update from care group Patient Safety Oversight Group's (PSOG)	Weekly updates sent to Trustwide PSOG which is then fed into EMT and QSC and reported into Trust Board via triple A from QSC (P,N,I)	DNQ/CMO	1.1,2.2, 2.4, 3.1
A120	Resident doctor 10-point plan updates	Reports are received by People and Remuneration Committee at every other meeting (P, N, I)	CMO	3.1

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
Turnover and retention of staff within the Trust is currently in a good position. Some gaps still exist, particularly in some Health Care Support Worker, and Allied Health Professional and medical roles which have regional and national shortages. This is being closely monitored through temporary staffing group and PRC. Reviewed in October 2026, work continues further update in October 2026.	Janury 2027	CPO
Resident doctor ten-point plan board assurance framework in development in line with national guidance. This was presented to Trust Board in draft in September 2026 with the final version anticipated to be presented to PRC in November 2026 and then Trust Board for approval.	January 2027	CMO/CPO

Strategic risk 4.1 (Strategic Aim 2: Best we can be - Best partner)
Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place

Controls (strategic risk 4.1 - Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval, including equality impact assessments. Central logs for clinical and corporate procedures developed and new procedure template added to the Policy on Policies. (I)	DNQ / DSC	1.1, 2.1, 4.1, 4.2, 6.2
C02	Operational Management Group (OMG) meetings established to identify performance issues and learn from good practices in other areas. Any identified improvements required are rectified in the operational performance, finance, workforce and quality meeting (Monthly) (I)	COO	2.1, 2.3, 2.4, 4.1, 4.2
C03	Senior representation on West Yorkshire and South Yorkshire mental health, learning disability and autism collaborative and associated workstreams. (I, E)	COO	2.1, 4.1
C04	Senior representation on local partnership boards, building relationships, ensuring transparency of agendas and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction. (I, E)	DSC	2.1, 2.4, 4.1
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	2.4, 4.1, 4.2, 5.1
C06	Trust performance management system in place with KPIs covering national (including NHS oversight framework) and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	2.1, 2.4, 4.1
C07	Director leads in place to support revised service offer through priority programmes and work streams, overseen by EMT. (I)	DSC	4.1, 4.2, 4.3
C08	Formal contract review and negotiation meetings with integrated care boards, NHSE and provider collaboratives underpinned by national agreements to support strategic review of services. (I)	DFR	2.1, 4.1
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DSC/CEO	2.4, 4.1, 4.3
C11	Governors' engagement and involvement on Members' Council and working groups, holding Non-Executive Directors (NEDs) to account. (I)	CEO	4.1
C13	Priority programmes supported through programme/change management approach. (I)	DSC	4.1
C14	Project Boards for change programmes and work streams in place, with appropriate membership skills and competencies, project plans, project governance, risk registers for key projects in place. (I)	DSC	4.1, 4.2
C15	Equality, Diversity and Inclusion Strategy in place for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E, P, N) (ORR 773)	DSC/CPO	1.1, 1.2, 2.1, 2.4, 3.1, 4.1, 4.3
C16	Operational leadership arrangements provide a link to each place and have oversight of service pathways to attempt to minimise unwarranted variation. (E)	COO	4.1
C17	Member of South Yorkshire mental health, learning disability and autism programme board. Partner in South Yorkshire provider alliance. (I, E)	DSC	2.1, 4.1
C18	Meetings with Healthwatch organisations in each place. (E)	DSC	4.1
C19	Process and approach in place to for extensive engagement on the Trust's strategic direction. (I, E)	DSC	4.1
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data is in place to identify any themes. Assurance via Mental Health Act Committee, Quality and Safety Committee. (E, I)	DSC / DNQ / CMO	1.1, 2.1 4.1, 4.2
C123	Trust Board strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives. (P, I)	CEO	4.1, 4.2

Controls (strategic risk 4.1 - Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates Trust Action Group (TAG) receive quarterly updates. (P) (I)	CEO	4.1, 4.2, 4.3, 5.2
C126	Commissioning intentions are factored into operating plans as part of the planning process aligned to national guidance. (P, I)	DFR, COO, DSC	2.1, 4.1, 4.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C144	Audit of compliance with policies and procedures in line with approved plan co-ordinated through the quality governance team in line with Trust agreed priorities (P, N, I).	DNQ	4.1, 4.2, 4.3
C145	Service user survey results reported to EMT, Quality and Safety Committee and Trust Board and action plans produced as applicable. (P, N, I).	DNQ	2.1, 2.4, 4.1, 4.2, 4.3
C146	Business cases for expansion / change of services reviewed for approval by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework. (P, N, I).	DFR/COO	4.1, 4.2, 5.1, 6.3
C168	The Executive Management Team (EMT) have reviewed key internal and external meetings to make sure the Trust has effective representation as required. (I, E, P)	DSC	4.1
C181	Operational and care group structures are in place to reflect care pathways (I, P)	COO	4.1, 4.2
C187	Governance arrangements are in each place in both West and South Yorkshire integrated care systems, and in place. These will be subject to effectiveness reviews when required. (E, P, N)	DSC	4.1
C201	South Yorkshire Mental Health Learning Disability and Autism Provider Collaborative in place. (E, P, N)	DSC	4.1
C210	Vacancy oversight procedures are in place with a weekly panel chaired by the Chief People Officer (P,N,I)	DFR	3.1, 4.1, 5.1
C213	Trust clinical strategy in place approved by Trust Board in March 2025. (I, P)	CMO/DNQ/COO	4.1, 4.2
C221	Director of finance, estates and resources attends all West Yorkshire ICS finance meetings and attends South Yorkshire ICS finance meetings when required (P,N,I,E)	DFR	4.1
C267	Director of finance chairs national HFMA (healthcare financial management association) mental health interest group, and along with peers supports dialogue with NHSE to support mental health strategies. (P,E)	DFR	4.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Levels of engagement with primary care networks could differ by place and lead to inconsistent development of services. The Trust is working in partnership to develop the detail of the local transformation development plan. We continue to work with primary care networks in each of our places to harness the benefits of the Additional Roles Reimbursement Scheme (ARRS) mental health practitioners implemented in each place. This is within the context of mental health community transformation in each place. Regional and national conversations are taking place regarding modelling and implementation. The Trust will continue to engage with primary care through the community transformation programme and place based integrated care forums. Work continues and we are awaiting clarity on the national position following the release of the NHS ten-year plan. There is some guidance now around neighbourhood hubs however funding streams are still to be clarified. Reviewed in October 2026 to review again in January 2027.	January 2027	DSC

Assurance (strategic risk 4.1 - Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.2, 2.3, 3.1, 4.1, 4.2, 5.1, 6.3
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	2.1, 2.4, 4.1, 4.2, 4.3, 5.1
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through OMG, EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	DSC	2.4, 4.1, 4.2, 4.3, 5.2, 6.3
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality assurance system. Reports on these visits are provided to EMT, Quality and Safety Committee (QSC), Trust Board and Members' Council.	Unannounced and planned visits as part of our routine CQC interface. Monthly CQC updates are provided to QSC, and an annual report is presented to the Members Council. Quality walkarounds programme in place for 2025/26 are reported into QSC. (P, N) (E)	DNQ	2.4, 4.1, 4.2
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. (P, N) (I).	DFR/DSC	4.1, 4.2, 5.1, 5.2, 6.3

Assurance (strategic risk 4.1 - Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A14	Mental Health Investment Standard income and reporting of performance.	Mental Health Investment Standard agreed with Wakefield, Calderdale, Kirklees, and Barnsley for 26-27 and is reported into FIP. (P) (I) (E).	DFR	4.1, 5.1
A16	Update reports on West Yorkshire and South Yorkshire ICS progress.	Routine report into EMT and Board. (P) (I)	DSC	4.1
A17	Update reports from Barnsley, Calderdale, Kirklees and Wakefield Integrated Partnership and Health and Wellbeing boards.	Update reports into EMT and Board eight times a year. (P, N) (I)	DSC	4.1, 4.2
A19	The Trust is a partner in integrated care partnership arrangements in each place.	Meeting minutes and papers provided and circulated to Trust Board (P) (I, E)	DSC	4.1
A20	Service user experience and waiting time reports are reviewed by QSC, and MHA. CQC Mental Health Act visits occur on a regular basis and are reported into QSC and MHAC.	Patient experience reports and integrated performance report (IPR) data on access and waiting times included in the new Equality and Inclusion interactive tool. (P) (I)	DNQ	1.1, 2.1, 4.1, 4.2, 4.3
A50	The vacancy oversight group has been established to consider all vacancies across the Trust taking into account finance, quality and safety	Weekly meetings chaired by chief people officer (P,N, I)	CPO	3.1, 4.1, 5.1
A97	Outcome of monthly regional finance meetings report into EMT verbally and written report to FIP	Reports presented to EMT when system meetings have taken place and papers reported into FIP (P,N,I,E)	DFR	4.1

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
The Trust have developed a sustainability impact assessment (SIA) so that we are clear of the impact our potential decisions have on this important agenda. The draft has been tested with both a small-scale change and a larger project and the learning incorporated into a revised version. Discussions have taken place to connect the considerations of the sustainability impact with considerations of the equality impact, and a sustainability-related question has been incorporated into the Equality Impact Assessment (EIA) process to strengthen this connection. We are currently exploring how we streamline and digitise the EIA process and will be including the SIA in this work. Progress update in February 2027	April 2027	DSC

Strategic risk 4.2 (Strategic Aim 2: Best we can be - Best partner)
Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.

Controls (strategic risk 4.2 - Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval, including equality impact assessments. Central logs for clinical and corporate procedures developed and new procedure template added to the Policy on Policies. (I)	DNQ / DSC	1.1, 2.1, 4.1, 4.2, 6.2
C02	Operational Management Group (OMG) meetings established to identify performance issues and learn from good practices in other areas. Any identified improvements required are rectified in the operational performance, finance, workforce and quality meeting (Monthly) (I)	COO	2.1, 2.3, 2.4, 4.1, 4.2
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	2.4, 4.1, 4.2, 5.1
C07	Director lead in place to support revised service offer through priority programmes and work streams, overseen by EMT. (I)	DSC	4.1, 4.2, 4.3
C14	Project Boards for change programmes and work streams in place, with appropriate membership skills and competencies, project plans, project governance, risk registers for key projects in place. (I)	DSC	4.1, 4.2
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data is in place to identify any themes. Assurance via Mental Health Act Committee, Quality and Safety Committee. (E, I)	DSC / DNQ / CMO	1.1, 2.1 4.1, 4.2
C21	Framework in place to ensure feedback from stakeholders, both internal and external (including feedback loop) is collected, responded to, analysed and acted upon. (I, E)	DNQ	2.1, 2.4, 4.2
C22	Operational management structure reflects leadership and oversight ensuring consistent delivery of services. (I)	COO	4.2
C78	Chief Medical Officer is the senior responsible owner for West Yorkshire ICS older people mental health workstream which identifies and shares best practice, looks to reduce unwarranted variation in service provision and health inequalities. (P,I,E)	CMO	4.2, 4.3
C123	Trust Board strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives. (P, I)	CEO	4.1, 4.2
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates TAG receive quarterly updates. (P) (I)	CEO	4.1, 4.2, 4.3, 5.2
C126	Commissioning intentions are factored into operating plans as part of the planning process. This is focussed on a place-based planning approach overseen by the introduction of integrated care board (ICBs) (P, E, I)	DFR, COO, DSC	2.1, 4.1, 4.2
C140	The Trust is registered with the CQC, and assurance processes are in place through the DNQ to ensure continued compliance – monthly meeting with CQC local relationship manager and quarterly engagement meetings between DNQ and CQC. (P) (I)	DNQ	4.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meeting take place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C144	Audit of compliance with policies and procedures in line with approved plan co-ordinated through the quality governance team in line with Trust agreed priorities. (P, N, I).	DNQ	4.1, 4.2, 4.3

Controls (strategic risk 4.2 - Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C145	Service user survey results reported to Quality and Safety Committee and Trust Board and action plans produced as applicable. (P, N, I).	DNQ	2.1, 2.4, 4.1, 4.2, 4.3
C146	Business cases for expansion / change of services approved by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework. (P, N, I).	DFR/COO	4.1, 4.2, 5.1, 6.3
C149	Operational structure includes oversight of pathways across the organisation that reach into place and neighbourhoods. Stakeholder collaboration continues as part of this process. (P, N, I).	DSC/COO	4.2
C190	The Trust has been fully engaged in place-based plans including the planning process. (P,I,E)	DSC	4.2
C193	Trust plans are aligned to operational and quality plans through place governance structures (P,I,E)	DNQ	4.2
C181	Operational and care group structures are in place to reflect care pathways (I, P)	COO	4.1, 4.2
C202	Trust clinical strategy in place approved by Trust Board in March 2025. (P,I,)	CMO/DNQ/COO	4.1, 4.2

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Older people's transformation -following approval, a new governance structure has been established to oversee the implementation phase of work. This is being led by a SWYPFT governance group which oversees the implementation work-strands and reports into the senior governance structures. The start date for capital works has been delayed in order to ensure compliance with new fire safety legislation. The Trust is expecting the guarateed maximum price from the contractor in October 2026..	January 2027	CMO /DFR

Assurance (strategic risk 4.2 - Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.2, 2.3, 3.1, 4.1, 4.2, 5.1, 6.3
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	2.1, 2.4, 4.1, 4.2, 4.3, 5.1
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through OMG, EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	EMT	2.4, 4.1, 4.2, 4.3, 5.2, 6.3
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality assurance system. Reports on these visits are provided to the EMT, Quality and Safety Committee (QSC), Trust Board and Members' Council.	Unannounced and planned visits as part of our routine CQC interface. Monthly CQC updates are provided to QSC, and an annual report is presented to the Members Council. Quality walkarounds programme in place for 2025/26 are reported into QSC. (P, N) (E)	DNQ	2.4, 4.1, 4.2
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. (P, N) (I).	DFR/DSC	4.1, 4.2, 5.1, 5.2, 6.3
A17	Update reports from Barnsley, Calderdale, Kirklees, and Wakefield Integrated Partnership and Health and Wellbeing boards.	Update reports into EMT and Board eight times a year. (P, N) (I)	DSC	4.1, 4.2
A20	Service user experience and waiting time reports are reviewed by QSC, and MHA. CQC Mental Health Act visits occur on a regular basis and are reported into QSC and MHAC.	Patient experience reports and integrated performance report (IPR) data on access and waiting times included in the new Equality and Inclusion interactive tool. (P) (I)	DNQ	1.1, 2.1, 4.1, 4.2, 4.3
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	2.3, 4.2, 4.3, 5.1, 5.2, 6.3
A22	All red and amber incidents from across the organisation are reviewed through the Patient Safety Oversight Group including the undertaking of proportionate investigations. In addition, all incidents relating to protected characteristics or staffing, irrespective of grading are also reviewed. Dissemination of lessons learnt and good clinical practice across the organisation.	Process in place through the quarterly patient safety oversight reporting including lessons learned to OMG, EMT, Quality and Safety Committee and Trust Board. (P, N) (I)	DNQ	2.3, 4.2

Assurance (strategic risk 4.2 - Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A23	Benchmarking of services (including model health system) and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment and Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR	4.2, 5.1, 5.2, 6.3
A24	Investment Appraisal report – covers bids and tender activity, contract risks, and proactive business development activity.	Quarterly bids and tenders report to Executive Management Team (EMT) and twice yearly to FIP and Trust Board. (P, N) (I)	DFR	2.1, 4.2, 5.1, 6.3
A26	Trust people strategy in place and to be rolled out in 2026.	Update reports into EMT and People and Remuneration Committee. (P) (I)	CPO	4.2
A119	Longer term planning process	Update reports into EMT and FIP (P,N,I,E)	DFR	4.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 4.3 (Strategic Aim 2: Best we can be - Best partner)
Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve

Controls (strategic risk 4.3 - Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C07	Director leads in place to support revised service offer through priority programmes and work streams, overseen by EMT. (I)	DSC	4.1, 4.2, 4.3
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DSC/CEO	2.4, 4.1, 4.3
C15	Equality, Diversity and Inclusion Strategy in place for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E, P, N) (ORR 773)	DSC/CPO	1.1, 1.2, 2.1, 2.4, 3.1, 4.1, 4.3
C23	Strategic priorities and underpinning programmes supported through robust programme and change management approaches and in line with the Integrated Change Framework. Extensive engagement from communities has been undertaken in the recent strategy refresh and is vital in helping the development of the underpinning programmes (I)	DSC	4.3
C24	All non-training grade senior medical staff participate in a job planning process which reviews priority areas of work against strategic objectives for senior clinical leaders. (I)	CMO	4.3
C25	Participate in national benchmarking activity for mental and community health services and act on areas of significant variance. (I)	DFR	4.3
C26	Community reporting is available as a tool to enable people to talk to members of their own community about their experience and approach developed and implemented with voluntary and community sector (VCS) partners in each of our places to strengthen insight involvement and co-production (I, E) using 'Connecting People'	DSC	1.1, 2.1, 4.3
C27	Governors supported to involve people at a local level. Toolkit in place. (I, E)	DSC	2.1, 4.3
C28	Toolkit in place to capture patient stories. (I)	DSC	2.1, 4.3
C29	Process in place to demonstrate compliance with the public sector equality duty. (I)	DSC	4.3
C30	Process to review and assure Equality Impact Assessments (EIAs)with report to Quality and Safety Committee (I)	DSC	1.1, 2.1, 4.3
C31	Joint Service and Needs Assessment (JSNA) data reflected in all service EIAs. (I)	DSC	2.1, 4.3
C32	Joint Service and Needs Assessment (JSNA) data used to identify involvement approaches. (I)	DSC	4.3
C33	Service line equality data used to identify the existing target audience to ensure methods and approaches meet the needs of those audiences. (I)	DSC	1.1, 4.3
C34	Provision of information, leaflets and posters which meet the Accessible Information Standard. (I)	DSC	1.1, 4.3
C35	Translation and interpretation service in place as well as inequalities interactive tool. (I)	DSC	1.1, 2.1, 4.3
C78	Chief Medical Officer is the senior responsible owner for West Yorkshire ICS older people mental health workstream which identifies and shares best practice, looks to reduce unwarranted variation in service provision and health inequalities. (P,I,E)	CMO	4.2, 4.3
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates TAG receive quarterly updates. (P) (I)	DFR	4.1, 4.2, 4.3, 5.2
C127	Communication leads network established in places and across ICSs (P, I, E)	DSC	4.3
C128	Senior level representation at Health and Wellbeing Boards in each place. (P, E)	DSC	4.3
C129	Ongoing meetings with Healthwatch organisations in each place. (P, I, E)	DSC	4.3
C130	Working with partners such as Healthwatch, public sector colleagues and ICSs to collectively capture and share insight and intelligence and avoid duplication. (P, I, E,)	DSC	4.3
C131	Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) process integrated and used at gateways in transformation and change programmes. (P, I)	DSC	1.1, 4.3
C138	Trust wide Equality Impact Assessment together with the inequalities data developing systemic analysis and plans to address Trust inequality priorities (P, I)	DSC	1.1, 4.3
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C143	Trustwide Benchmarking Group in place. This is chaired by Director of Finance, Estates and Resources and reports will be regularly provided to FIP to ensure the Trust can assess its current service provision in the context of the wider system. (P, E, I)	DFR	2.2, 4.3

Controls (strategic risk 4.3 - Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C144	Audit of compliance with policies and procedures in line with approved plan co-ordinated through the quality governance team in line with Trust agreed priorities. (P, N, I, E).	DNQ	4.1, 4.2, 4.3
C145	Service user survey results reported to Quality and Safety Committee and Trust Board and action plans produced as applicable. (P, N, I).	DNQ	2.1, 2.4, 4.1, 4.2, 4.3
C162	CHATpad is a tablet available on every Trust ward which allows for communication with a loved one, carer, friend, staff member or advocate via zoom and is used to capture patient views using an online survey. The use of tablets is promoted to patients, visitors, carers and advocacy services to retain contact and improve communication. (P, I)	DSC	4.3
C163	Approach to capturing insight and service user feedback from a range of stakeholders in place (insight report) (P, E, I)	DSC	4.3
C164	The EIA tools have been created, including the Trust wide EIA and literature (P, I)	DSC	4.3
C170	Data collection is in line with local and regional direction including Core20plus5 and the NHSE toolkit. An equality interactive tool dashboard has been established and continues to develop insight and ensure this is used to inform improvements and service change including the development of Equality Impact Assessments (EIA's) (I, E, P, N)	DSC	4.3
C171	Health Intelligence support role in place (I, P)	DSC	4.3
C184	Targeted programmes are being delivered through linked charities (I, E, P)	DSC	4.3
C199	Partnership group in place as part of the improving mental health priority programmes, including representatives from community partners and stakeholders. (E, P, N)	COO	4.3
C203	The process through which the Trust engaged and consulted internally and external stakeholders and members of the public to inform the older people's inpatient service transformation programme and Trust strategy refresh. (P, N, I, E)	CMO	4.3
C209	The Trust will continue to roll out the enhanced equality and diversity training to all senior staff identified as essential to job role on a twice-yearly basis. This is being led by the equality and involvement team. (P, I)	DSC	4.3
C260	Priority programmes approved by Trust Board April 2025 (P, I)	DSC	2.1, 4.3
C242	Trust communications approach for health inequalities priorities in place in line with the public sector equality duty. (P,I,E)	DSC	4.3
C263	Operational equality dashboards now in place (P,N,I)	DSC	1.1, 2.2, 4.3
C264	Patient carer race equality framework (PCREF) implementation plan in place (P,N,I, E)	DSC	1.1, 2.2, 4.3
C265	Health inequalities toolkit in place to reduce barriers to access to services (P,N, I, E)	DSC	1.1, 2.1, 2.3, 4.3
C266	Hearing impaired and deaf toolkit in place to reduce barriers to access to services (P,N ,I,E)	DSC	1.1, 2.1, 2.3, 4.3
C268	Accessible information standard updates are reported to Audit Committee (P,N,I)	DSC	4.3
C276	An equality interactive tool dashboard is now in place which provides insight to ensure improvements and service change. (P,N,I,E)	DSC	1.1, 1.2, 2.1, 2.3, 4.3

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

Assurance (strategic risk 4.3 - Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	2.1, 2.4, 4.1, 4.2, 4.3, 5.1
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through OMG, EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	EMT	2.4, 4.1, 4.2, 4.3, 5.2, 6.3
A20	Service user experience and waiting time reports are reviewed by QSC, and MHA. CQC Mental Health Act visits occur on a regular basis and are reported into QSC and MHAC.	Patient experience reports and integrated performance report (IPR) data on access and waiting times included in the new Equality and Inclusion interactive tool. (P) (I)	DNQ	1.1, 2.1, 4.1, 4.2, 4.3
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	2.3, 4.2, 4.3, 5.1, 5.2, 6.3
A43	Waiting list reporting including health inequalities data	Reported in OMG quarterly and improving access to care group quarterly (P, N, I)	DSC	2.2, 2.4, 4.3

Assurance (strategic risk 4.3 - Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A91	West Yorkshire older people's mental health work stream steering groups provides updates	Regular updates from the steering group are presented to West Yorkshire mental health learning disability and autism partnership board (P/N/E)	CMO	4.3
A92	Older people's mental health service transformation updates as part of priority programmes	Regular priority programme highlight reports into EMT. Updates are also presented to QSC and Trust Board (P, N, I, E)	CMO	4.3
A111	PCREF compliance reports	Quarterly national reports to EMT, QSC and NHSE (P,N,I,E)	DSC	1.1, 2.1, 4.3
A114	Accessible information standard updates	Bi-annual reporting to the Audit Committee (P,N,I)	DSC	4.3
A117	EDI dashboard	Updates on the dashboard will be presented to each Quality and Safety Committee meeting (P,N,I)	DSC/DFR	1.1, 1.2, 2.1, 2.4, 4.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 4.4 (Strategic Aim 2: Best we can be - Best partner)
Wider demand and finance pressures result in an insufficient focus on environmental sustainability meaning the Trust does not achieve its national net zero targets.

Controls (strategic risk 4.4 - Wider demand and finance pressures result in an insufficient focus on environmental sustainability meaning the Trust does not achieve its national net zero targets.)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C222	Trust sustainability and responsibility strategy (SRS) in place with annual reporting process to Trust Board (I, E, P)	DSC	4.4
C223	Trust green plan in place (renewed September 2025) and integrated into Trust sustainability strategy (I, E, P)	DFR/DSC	4.4
C224	Carbon impact (tonnes CO2) from business miles is included in the integrated performance report (IPR) (P, N, I, E)	DFR	4.4
C225	Sustainability and Carbon Neutral is included in annual capital programmes	DFR	4.4
C226	Oversight of the Trust sustainability strategy by Transformation, Innovation and Sustainability Committee (P, I)	DSC	4.4
C227	Green Champion Network in place across the Trust (P, I, E)	DSC	4.4
C228	Sustainability metrics monitored via Trust National Greener NHS data, submission (P, N, I, E)	DSC	4.4
C229	Trust lease car scheme ensures use of purchase or lease vehicles that are ultra-low emissions vehicles or zero emission vehicles	CPO	4.4
C230	Non-Executive Director Champion ensures objective oversight of SRS strategy	DSC	4.4

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Following presentation of the sustainability annual report at Trust Board it was identified that Trust gas usage had increased in year 24-25. Following investigation, no evidence of a significant underlying increase in gas consumption across the estate has been identified. It therefore believed the variance is primarily linked to the timing of actual and estimated meter readings and subsequent billing adjustments rather than a material change in operational usage. Action to be closed following submission to October Board.	October 2026	DFR/DSC

Assurance (strategic risk 4.4 - Wider demand and finance pressures result in an insufficient focus on environmental sustainability meaning the Trust does not achieve its national net zero targets.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A87	Annual reporting against the Sustainability and Responsibility Strategy	Annual reporting goes to EMT, Transformation, Innovation and Sustainability Committee and Trust Board (P,N,I,E)	DSC	4.4
A98	Carbon impact (tonnes CO2)	Included in monthly integrated performance reports to Trust Board and published on the Trust website (P, N, I, E)	DFR	4.4
A99	Bi-annual sustainability updates	Bi-annual reporting will report into Transformation, Innovation and Sustainability Committee (P, N, I)	DSC	4.4
A100	Reporting against National Greener NHS data,	Report into Transformation, Innovation and Sustainability Committee (P, N, I, E)	DSC	4.4

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 5.1 (Strategic Aim 2: Best we can be - Best value)
Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.

Controls (strategic risk 5.1 - Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	2.4, 4.1, 4.2, 5.1
C79	Finance managers aligned to Care Groups acting as integral part of local management teams. (I)	DFR	5.1
C80	Standardised process in place for producing business cases supporting full benefits realisation. (I)	DFR	5.1
C81	Standing Orders, Standing Financial Instructions, Scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities. (I)	DFR	5.1
C82	Annual financial planning process, value for money programmes VFMP), Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) process. (I)	DFR/ DNQ/ DSC	5.1
C83	Financial control and financial reporting processes. (I)	DFR	5.1
C84	Regular financial reviews at Executive Management Team (EMT). (I)	DFR	5.1
C85	Patient level costing in place, in addition a process to identify loss making services is in place and scrutinised as part of the value for money group. (P, N, E, I)	DFR	5.1
C86	Weekly Operational Management Group (OMG) chaired by Chief Operating Officer providing overview of operational delivery, services / resources, identifying and mitigating pressures / risks. The OMG workplan has been aligned to focus on the key areas of operational delivery and finance. (I)	COO	5.1, 6.3
C87	Finance, Investment and Performance Committee (FIP) chaired by a non-executive director with recent and relevant financial experience. (I)	DFR	5.1
C133	Annual strategic business and risk analysis to Trust Board ensuring identification of opportunities and threats. Strategic business and risk analysis reviewed by Trust Board. (P) (I)	DSC	5.1
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C146	Business cases for expansion / change of services approved by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework. (P, N, I, E).	DFR/COO	4.1, 4.2, 5.1, 6.3
C197	The Trust is aligned to the NHSE framework for enhanced financial controls. (P, N,I, E)	DFR	5.1
C206	Monthly meeting between the DFR and COO with all care groups to review finance and performance. (P, N, I)	DFR/COO	5.1
C210	Vacancy oversight procedures are in place with a weekly panel chaired by the Chief People Officer (P, N, I)	DFR	3.1, 4.1, 5.1
C214	Revised arrangements for VFMP to include executive directors as SROs reporting into CEO on a regular basis. (P, N,I)	All	5.1
C219	Approval limits reduced to aid additional scrutiny of non-pay expenditure. (P, N, I)	DFR	5.1
C284	Electronic Prescribing Medicines Administration (EPMA) digital system in place in place to support safe and efficient prescribing and administration (P, I)	CMO	5.1,5.2
C294	Enhanced monthly oversight at care group level covering finance, performance chaired by COO and supported by DFR (P,N I)	COO/DFR	5.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Trust has previously not fully achieved its recurrent VFMP (Linked to ORR risk 1076). The Trust needs to continue to fully develop recurrent VFM pipeline including QIA and consider the impact of not having enough recurrent schemes in 2026/27. Plans need to progress to identify further recurrent schemes. Work is ongoing on value for money schemes in order to create financial efficiency – gap remains until the schemes are in place and delivering. FIP review VFM at every meeting. Reviewed in October 2026 and work continues.	January 2027	All execs

Assurance (strategic risk 5.1 - Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.2, 2.3, 3.1, 4.1, 4.2, 5.1, 6.3

Assurance (strategic risk 5.1 - Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	2.1, 2.4, 4.1, 4.2, 4.3, 5.1
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. (P, N) (I).	DFR/DSC	4.1, 4.2, 5.1, 5.2, 6.3
A14	Mental Health Investment Standard income and reporting of performance.	Mental Health Investment Standard agreed with Wakefield, Calderdale, Kirklees, and Barnsley for 26-27 and is reported into FIP. (P) (I) (E).	DFR	4.1, 5.1
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	2.3, 4.2, 4.3, 5.1, 5.2, 6.3
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment and Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any required actions are identified. (P, N) (I, E)	DFR	4.2, 5.1, 5.2, 6.3
A24	Investment Appraisal report – covers bids and tender activity, contract risks and proactive business development activity.	Quarterly bids and tenders report to Executive Management Team (EMT) and twice yearly to FIP and Trust Board. (P, N) (I)	DFR	2.1, 4.2, 5.1, 6.3
A50	The vacancy oversight group has been established to consider all vacancies across the Trust taking into account finance, quality and safety	Weekly meetings chaired by chief people officer (P,N, I)	DFR	3.1, 4.1, 5.1
A58	Monthly focus of key financial and performance issues including VFM delivery, out of area beds and agency costs at Operational Management Group (OMG).	Standing agenda item for OMG (P, N) (I)	COO	5.1, 6.3
A95	Care closer to home report.	Reported into every EMT meeting (I, E, P, N)	COO	2.4, 5.1
A121	Electronic Prescribing Medicines Administration (EPMA) digital system (internal inpatient-implemented) and Electronic Prescription Service (EPS) (external - implementation phase)	Quarterly reports into digital tag (P,I,E)	CMO	5.1, 5.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
Reduction in agency use in 2025/26 was achieved in line with plan, but bank reductions were delivered but not to the level in line with plan. The temporary staffing group continue to review this position on a fortnightly basis with an action plan in place to address the gap. The gap will remain throughout financial year 2026/27 but will be subject to quarterly review to assess delivery. Review again in January 2027.	January 2027	COO/CPO/DFR

Strategic risk 5.2 (Strategic Aim 2: Best we can be - Best value)
Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision

Controls (strategic risk 5.2 - Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C36	Improving access group and improving equalities groups are in place to ensure services are inclusively locking in innovation. (P, I)	DSC/COO	5.2
C44	Digital strategy in place with quarterly report to Executive Management Team (EMT) and twice-yearly report to TISC and Trust Board. (P,I)	DFR	2.2, 5.2
C61	Web based platform in place with over 2,000 members providing digital opportunities to share, innovate, collaborate and improve. (I)	DSC	2.3, 5.2
C95	Director portfolios clearly identify director level leadership for strategic priorities. (P), (I)	CEO	5.2, 6.3
C96	Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (P), (I)	DSC	5.2, 6.3
C97	Integrated Change Team in place with competencies and skills to support the Trust to make best use of its capacity and resources and to take advantage of business opportunities. (P), (I)	DSC	5.2, 6.3
C98	Production of annual plan and strategic plan demonstrating ability to deliver agreed service specification and activity within contracted resource envelope or investment required to achieve service levels and mitigate risks. (P), (I)	DFR/DSC	5.2, 6.3
C99	Robust prioritisation process developed and used which takes into account multiple factors including capacity and resources. Process used to set 202/27 priorities and approved by Trust Board. (P), (I)	DSC	5.2, 6.3
C100	Integrated Change framework contains process for adding to strategic priorities within year which includes consideration as to whether a new programme becomes an additional priority or whether it replaces a current priority. (P), (I)	DSC	5.2, 6.3
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates TAG receive quarterly updates. (P) (I)	CEO	4.1, 4.2, 4.3, 5.2
C134	Workforce strategic groups established and are being reviewed alongside the new operational model and people directorate structure. (P, I)	DHR	5.2

Controls (strategic risk 5.2 - Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C151	Integrated Change Framework includes escalation process for issues / risks to be brought to the attention of the Executive Management Team. (P, I)	DSC	5.2, 6.3
C152	Integrated Change Framework includes gateway reviews at key points and post implementation reviews. Capacity and resources are considered at these key points. (P, I)	DSC	5.2, 6.3
C169	Digital Strategy and Innovation Group meets quarterly to assess potential new and emerging digital opportunities (P, I)	CMO	5.2
C200	Creativity and creative practitioner roles have been implemented in inpatient services with positive outcomes. (I, P)	DSC	5.2
C274	Digital Dictation is now in place across the Trust (P, I)	DFR	5.2
C284	Electronic Prescribing Medicines Administration (EPMA) digital system in place to support safe and efficient prescribing and administration (P,I)	CMO	5.1, 5.2
C295	Digital innovation is part of the Transformation, Innovation and Sustainability Committee workplan (P,I)	DSC	5.2

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
In line with the NHS 10-year plan, digital infrastructure and innovation need to be considered as part of the Trusts estates strategy and planning, service transformation and Trust planning as the Trust progresses into 2026/27 and beyond. These matters have been considered as part of the planning process for 2026/27 and we continue to strive for the best balance between expenditure in physical estates structure and digital infrastructure. Review further in January 2027	January 2027	DSC/DFR

Assurance (strategic risk 5.2 - Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through OMG, EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	EMT	2.4, 4.1, 4.2, 4.3, 5.2, 6.3
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. (P, N) (I).	DFR/DSC	4.1, 4.2, 5.1, 5.2, 6.3
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	2.3, 4.2, 4.3, 5.1, 5.2, 6.3
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment and Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR/COO	4.2, 5.1, 5.2, 6.3
A121	Electronic Prescribing Medicines Administration (EPMA) digital system (internal inpatient-implemented) and Electronic Prescription Service (EPS) (external - implementation phase)	Quarterly reports into digital tag (P,I,E)	CMO	5.1, 5.2
A124	Digital innovation	Digital innovation is reported into EMT and Transformation, Innovation and Sustainability Committee (TISC) on a six-monthly basis (P,I)	DSC	5.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 6.1 (Strategic Aim 3: We will be ambitious)
Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care.

Controls (strategic risk 6.1 - Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care.)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C231	Executive Director Lead for Commissioning (Director of Finance and Resources) (P, N, I)	DFR	6.1
C232	Specialised Mental Health Learning Disability and Autism Commissioning Hubs established in West Yorkshire and South Yorkshire, and manage commissioning functions of the specialised provided collaboratives the Trust leads (adult secure and FCAMHS) (P, N, E)	DFR	6.1
C233	South Yorkshire Adult Secure Provider Collaborative Oversight Group in place to oversee the work of the South Yorkshire Specialised MHLDA Commissioning Hub. (P, N, E)	DFR	6.1
C234	West Yorkshire Provider Collaborative Board in place to oversee the work of the West Yorkshire Adult Secure Provider Collaborative (P, N, E)	DFR	6.1
C235	Commissioning Hubs have dedicated resource for quality oversight (P, E)	DFR	6.1
C236	Annual programme of commissioner quality monitoring visits (P, N, E)	DFR	6.1
C237	Commissioning Committee in place, with clear terms of reference, to provide oversight of Trust's commissioning activities (P, I)	DFR	6.1
C238	Regular AAA report from Commissioning Committee to Board ensures oversight of Trust's Commissioning activity at Board level (P, N, I, E)	DFR	6.1
C239	Established performance reporting arrangements in place to oversee operations (referrals, admissions, occupancy and demographics), finance, contracting and quality (P, N,I E)	DFR	6.1
C240	Commissioning intentions overseen by Commissioning Committee (P, N, I, E)	DFR	6.1
C241	Stakeholder map in place which identifies key Trust representatives to oversee developments in each place. (P, I, E)	DSC	6.1, 6.2
C243	Clinical escalation processes in place to address barriers to patient flow (P, I)	CMO	6.1
C262	Achievement of Level 1 of the Lead Provider Collaborative Quality Maturity Framework (P, I, E)	DFR	6.1
C263	Escalation processes effectively used to resolve discharge delays in adult secure pathways (P, N, I, E)	DFR	6.1
C287	West Yorkshire and South Yorkshire commissioning hub input into the commissioning committee have been aligned (P, I, E)	DFR	6.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Partnership working with ICB at place level and regional level continues to address delays in discharge impacting on adult secure patient care and patient flow. Ongoing dialogue continues with ICB commissioners. On Friday 16 October 2027, Board approved the expression of interest to continue the contract from March 2027 with caveats. Update further in January 2027.	January 2027	DFR/CMO

Assurance (strategic risk 6.1 - Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A101	Annual commissioning intentions for West Yorkshire Adult Secure Provider Collaborative and South Yorkshire and Bassetlaw Adult Secure Provider Collaborative	Reports provided to Commissioning Committee and for approval by Trust Board following scrutiny by Provider Collaborative Board/Oversight Group. (P, I, E)	DFR	6.1
A102	Commissioner quality monitoring feedback monitored and scrutinised through Provider Collaborative Board/Oversight Group, and clear plans in place with providers to address any quality issues	Reports provided to each Commissioning Committee meeting. (P, N, I, E)	DFR	6.1
A103	Performance report to Commissioning Committee provide assurances on quality, contracting and finance and identify emerging issues and actions to be taken.	Reports provided to each Commissioning Committee meeting. (P, N, I, E)	DFR	6.1

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic Risk 6.2 (Strategic Aim 3: We will be ambitious)
System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience.

Controls (strategic risk 6.2 - System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience.)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C241	Stakeholder map in place which identifies key Trust representatives to oversee developments in each place. (P, I, E)	DSC	6.1, 6.2

Controls (strategic risk 6.2 - System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience.)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C245	Framework in place to ensure feedback from stakeholders, both internal and external (including feedback loop) is collected, responded to, analysed and acted upon. (P,N,I,E)	DSC	6.2
C246	Senior/Executive representation at system/place meetings. (P,N,I, E)	CEO/DSC	6.2
C247	Trust Coordination Meeting in place to ensure feedback from system/place meetings and oversight of the Trust contribution. (P,N,I, E)	CEO	6.2
C248	Senior level representation at ICB Board/Committees and Health and Wellbeing Boards in each place. (P,N,I,E)	CEO/DSC	6.2
C249	Senior representation at South Yorkshire MHLDA Partnership Board and West Yorkshire MHLDA Partnership Board (P,N,I, E)	CEO	6.2
C250	Full engagement in West Yorkshire Committees in Common (P,N,I, E)	CEO	6.2
C251	Trust Board strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives. (P,I)	CEO/DSC	6.2
C252	Formal contract negotiation meetings with integrated care boards, NHSE and provider collaboratives underpinned by national agreements to support strategic review of services and promotion of the Trust's role. (P,N,I, E)	DFR	6.2
C253	Agreed Trust priority programmes ensure time and resource focused on key areas, with progress reported to EMT and Trust Board through the Integrated Performance Report (IPR), and report on progress against the Trust Strategy. (P,I)	DSC	6.2
C254	Annual business planning process (P,N,I, E)	DFR/DSC	6.2
C255	Partnership arrangements established within each place. (P,N,I, E)	DSC	6.2
C256	Established Members' Council, with governor representation from each Place supports engagement with our communities and promotion of the Trust's role. (P,N,I, E)	DSC	6.2
C257	Community Connectors support engagement with our communities, and promotion of the Trust role, (P,N,I, E)	DSC	6.2
C258	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (P,N,I, E)	DSC	6.2
C259	Executive Directors act as SROs for some system-wide work programmes. (P,N,I, E)	CEO	6.2

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

Assurance (strategic risk 6.2 - System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience.)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A106	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Regular reports to EMT and Trust Board through the IPR (P, N, I, E)	DSC	6.2
A107	Strong and robust partnership working with local partners, working through integrated partnerships in Barnsley, Calderdale, Kirklees and Wakefield	Regular update and reporting to EMT and Trust Board (P, N, I, E)	DSC	6.2
A108	Lead role in system-wide work programmes and developments	Reports on progress presented to EMT and Trust Board as required. (P, N, I, E)	DSC	6.2
A109	Report on progress against Trust Strategy to EMT and Board evidences progress as planned against strategic aims	Regular update and reporting to EMT and Trust Board (P, N, I)	DSC	6.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 6.3 (Strategic Aim 3: We will be ambitious)
Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions

Controls (strategic risk 6.3 - Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C86	Weekly Operational Management Group (OMG) chaired by Chief Operating Officer providing overview of operational delivery, services / resources, identifying and mitigating pressures / risks. The OMG workplan has been aligned to focus on the key areas of operational delivery and finance. (I)	COO	5.1, 6.3
C95	Director portfolios clearly identify director level leadership for strategic priorities. (P), (I)	CEO	5.2, 6.3
C96	Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (P), (I)	DSC	5.2, 6.3

Controls (strategic risk 6.3 - Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C97	Integrated Change Team in place with competencies and skills to support the Trust to make best use of its capacity and resources and to take advantage of business opportunities. (P), (I)	DSC	5.2, 6.3
C98	Production of annual plan and strategic plan demonstrating ability to deliver agreed service specification and activity within contracted resource envelope or investment required to achieve service levels and mitigate risks. (P), (I)	DFR	5.2, 6.3
C99	Robust prioritisation process developed and used which takes into account multiple factors including capacity and resources. Process used to set 2025-26 priorities. (P), (I)	DSC	5.2, 6.3
C100	Integrated Change framework contains process for adding to strategic priorities within year which includes consideration as to whether a new programme becomes an additional priority or whether it replaces a current priority. (P), (I)	DSC	5.2, 6.3
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C146	Business cases for expansion / change of services approved by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework. (P, N, I, E).	DFR/COO	4.1, 4.2, 5.1, 6.3
C151	Integrated Change Framework includes escalation process for issues / risks to be brought to the attention of the Executive Management Team. (P, I)	DSC	5.2, 6.3
C152	Integrated Change Framework includes gateway reviews at key points and post implementation reviews. Capacity and resources are considered at these key points. (P, I)	DSC	5.2, 6.3
C215	The Chief Operating Officer is the Senior Responsible Owner for Cheswold Park Hospital transition into the Trust. (P,I,E)	COO	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2, 6.3
C217	Cheswold Park Hospital planned integration has been completed and is now part of BAU in the forensic care group. (P,I)	COO/DNQ/CMO	6.3
C218	Cheswold Park Hospital has a clinical and interim managerial structure in place as part of the forensic care group. (P,I)	DNQ/COO/CMO	6.3
C270	People strategy in place. Approved by Trust Board December 2025 (P, I, E)	CPO	1.1, 1.2, 3.1, 6.3
C296	Trust ambition is now included on the Transformation, Innovation and Sustainability work plan. (P,I)	DSC	6.3
C297	Research and development strategy approved by Trust Board September 2026 (P,I,)	CMO	6.3

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
The Trust's workforce plan remains a gap and needs to be developed in order to demonstrate the required skills needed to efficiently and effectively provide commissioned services. This plan needs to be within the financial envelope and meet the clinical strategy. The initial workforce plans for care groups and other services have been developed to support the annual plan submission in February 2026. Establishment reviews have been completed to reflect required changes. Implementation schedule is now being developed with a view to completion at the early Q3.	January 2027	CPO/COO/DNQ/CMO

Assurance (strategic risk 6.3 - Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	1.2, 2.1, 2.2, 2.3, 2.4, 3.1, 4.1, 4.2, 4.3, 5.1, 5.2
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.2, 2.3, 3.1, 4.1, 4.2, 5.1, 6.3
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	EMT	2.4, 4.1, 4.2, 4.3, 5.2, 6.3
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. (P, N) (I).	DFR/DSC	4.1, 4.2, 5.1, 5.2, 6.3
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	2.3, 4.2, 4.3, 5.1, 5.2, 6.3
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment and Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR/COO	4.2, 5.1, 5.2, 6.3
A24	Investment Appraisal report – covers bids and tenders' activity, contract risks and proactive business development activity.	Quarterly bids and tenders report to Executive Management Team (EMT) and twice yearly to FIP and Trust Board. (P, N) (I)	DFR	2.1, 4.2, 5.1, 6.3

Assurance (strategic risk 6.3 - Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A58	Monthly focus of key financial issues including VFM delivery, out of area beds and agency costs at Operational Management Group. (OMG).	Standing agenda item for OMG and Finance, Investment and Performance Committee. (P, N) (I)	COO/DFR	5.1, 6.3
A126	Research and Development strategy report	Annual report into EMT and clinical governance group (P,N,I)	CMO	6.3
A127	Trust strategy measurement framework in place	Annual reports to EMT, TISC and Trust Board (P,N,I)	DSC	6.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**

Q1 BAF risks including Q4 ratings and new risk appetite domains

Strategic Aim	Strategic risk	25/26 Q4 rating		Proposed new risk appetite category and rationale	Category risk appetite for assurance	Category risk appetite for likelihood	If proposal accepted inside or outside of risk appetite based on Q4 rating
		Assurance	Likelihood				
1. We will live our values	1.1 Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience. (DSC)	Adequate	Likely	Clinical Safety and Quality risks: Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce. Rationale - This risk category includes ensuring that equality, involvement and inclusion is central to everything the Trust does to reduce inequalities, tackle stigma and eliminate discrimination.	Substantial-Substantial/Adequate	Rare-Unlikely	Outside of risk appetite for both assurance and likelihood
	1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience. (CPO)	Adequate	Possible	Clinical Safety and Quality risks: Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce. Rationale - This risk category includes ensuring that equality, involvement and inclusion is central to everything the Trust does to reduce inequalities, tackle stigma and eliminate discrimination.	Substantial-Substantial/Adequate	Rare-Unlikely	Outside of risk appetite for both assurance and likelihood
2.Be the best we can be: Best Quality	2.1 Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy.	Adequate	Unlikely	Clinical Safety and Quality risks: Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce. Rationale - This risk category includes ensuring that equality, involvement and inclusion is central to everything the Trust does to reduce inequalities, tackle stigma and eliminate discrimination.	Substantial-Substantial/Adequate	Rare-Unlikely	Outside risk appetite for assurance Inside risk appetite for likelihood
	2.2 The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.	Adequate	Possible	Information risks: Risks arising from a failure to produce robust, suitable and appropriate data/information and to exploit data/information to its full potential.	Substantial-Substantial/Adequate	Rare-Unlikely	Outside of risk appetite for both assurance and likelihood

Q1 BAF risks including Q4 ratings and new risk appetite domains

Strategic Aim	Strategic risk	25/26 Q4 rating		Proposed new risk appetite category and rationale	Category risk appetite for assurance	Category risk appetite for likelihood	If proposal accepted inside or outside of risk appetite based on Q4 rating
		Assurance	Likelihood				
				Rationale - This risk category includes failure to understand and analyse Trust data results in a poor understanding of the communities we serve impacting on service provision.			
	2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents.	**Substantial**	**Possible**	Clinical Safety and Quality risks: Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce. Rationale - This risk category includes risks to meeting recognised clinical and/or environmental standards e.g. FIRM (Formulation informed risk management), record keeping, infection prevention and control, NICE guidance and compliance with Patient Safety Incident Response Framework.	**Substantial-Substantial/Adequate**	**Rare-Unlikely**	**Inside risk appetite for assurance** **Outside risk appetite for likelihood**
	2.4 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.	**Adequate**	**Likely**	Clinical Safety and Quality risks: Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce. Rationale - This risk category includes risks to meeting recognised clinical and/or environmental standards e.g. FIRM (Formulation informed risk management), record keeping, infection prevention and control, NICE guidance and compliance with Patient Safety Incident Response Framework.	**Substantial-Substantial/Adequate**	**Rare-Unlikely**	**Outside of risk appetite for both assurance and likelihood**
2. Best Place to work and learn	3.1 Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience.	**Adequate**	**Unlikely**	Clinical Safety and Quality risks: Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce.	**Substantial-Substantial/Adequate**	**Rare-Unlikely**	**Outside risk appetite for assurance** **Inside risk appetite for likelihood**

Q1 BAF risks including Q4 ratings and new risk appetite domains

Strategic Aim	Strategic risk	25/26 Q4 rating		Proposed new risk appetite category and rationale	Category risk appetite for assurance	Category risk appetite for likelihood	If proposal accepted inside or outside of risk appetite based on Q4 rating
		Assurance	Likelihood				
				Rationale - This risk category includes workforce risk - inability to attract and retain appropriately qualified staff to deliver Trust plans.			
2.Be the best we can be: Best partner	4.1 Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place	**Adequate**	**Likely**	Financial risks: Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income. Rationale - This risk category includes risk of wider financial system pressures on the Trust ability to deliver its own operational and financial plan.	**Substantial-Substantial/Adequate**	**Rare-Unlikely**	**Outside of risk appetite for both assurance and likelihood**
	4.2 Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.	**Adequate**	**Possible**	Financial risks: Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income. Rationale - This risk category includes risk of impact of wider financial system pressures on the Trust's ability to deliver its own operational and financial plan.	**Substantial-Substantial/Adequate**	**Rare-Unlikely**	**Outside of risk appetite for both assurance and likelihood**
	4.3 Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve	**Adequate**	**Possible**	Business risks: Risks which might affect the Trust's ability to achieve its plans or damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation. Rationale – This risk category includes developing partnerships that enhance the Trust's current and future services.	**Adequate**	**Possible**	**Inside risk appetite for both assurance and likelihood**
	4.4 Wider demand and finance pressures result in an insufficient focus on environmental sustainability meaning the Trust does not achieve its national net zero targets.	**Adequate**	**Possible**	Compliance risks: Failure to comply with its licence, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation. Rationale – this risk category includes delivering the Trust Social Responsibility and Sustainability strategy in line with the NHS Long Term and Green plans.	**Substantial-Substantial/Adequate**	**Rare-Unlikely**	**Outside of risk appetite for both assurance and likelihood**
2. Be the best we can be: Best	5.1 Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.	**Adequate**	**Likely**	Business risks: Risks which might affect the Trust's ability to achieve its plans or damage to the Trust's public reputation which could impact on commissioners' decisions to	**Adequate**	**Possible**	**Inside risk appetite for assurance** **Outside of risk appetite for likelihood**

Q1 BAF risks including Q4 ratings and new risk appetite domains

Strategic Aim	Strategic risk	25/26 Q4 rating		Proposed new risk appetite category and rationale	Category risk appetite for assurance	Category risk appetite for likelihood	If proposal accepted inside or outside of risk appetite based on Q4 rating
		Assurance	Likelihood				
				place contracts with the organisation. Rationale – This risk category includes missed opportunities; the Trust fails to identify opportunities for growth impacting on business sustainability and development.			
	5.2 Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision.			1. <u>Business risks:</u> Risks which might affect the Trust's ability to achieve its plans or damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation. Rationale – This risk category includes lack of appropriate Estates and Facilities structures and systems to deliver high quality, modern safe services. And/or 2. <u>Technology risks:</u> Risks arising from technology not delivering the expected outcomes due to inadequate or deficient system/process development and performance or inadequate resilience. • Rationale – this risk category failure to utilise new technology effectively (including AI) reduces quality of service delivery. The risk appetite is the same for both Business and Technology risks.	**Adequate** **Adequate**	**Possible** **Possible**	**Inside risk appetite for both assurance and likelihood**
3. We will be ambitious	6.1 Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care.	**Adequate**	**Possible**	<u>Business risks:</u> Risks which might affect the Trust's ability to achieve its plans or damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation.	**Adequate**	**Possible**	**Inside risk appetite for both assurance and likelihood**

Q1 BAF risks including Q4 ratings and new risk appetite domains

Strategic Aim	Strategic risk	25/26 Q4 rating		Proposed new risk appetite category and rationale	Category risk appetite for assurance	Category risk appetite for likelihood	If proposal accepted inside or outside of risk appetite based on Q4 rating
		Assurance	**Likelihood**				
				Rationale – This risk category includes decisions external to the Trust (e.g. decommissioning) impact on ability to deliver effective services			
	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.	**Adequate**	**Possible**	Business risks: Risks which might affect the Trust's ability to achieve its plans or damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation. Rationale – This risk category includes developing partnerships that enhance the Trust's current and future services, and reputational risk, negative impact on perceptions of service users, staff, and the wider system, including commissioners and providers (in carrying out the role of lead/coordinating provider for services across West and/ or South Yorkshire), and the public.	**Adequate**	**Possible**	**Inside risk appetite for both assurance and likelihood**
	6.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.	**Adequate**	**Possible**	Business risks: Risks which might affect the Trust's ability to achieve its plans or damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation. Rationale – This risk category includes reputational risk, negative impact on perceptions of service users, staff, and the wider system, including commissioners and providers (in carrying out the role of lead/coordinating provider for services across West and/ or South Yorkshire), and the public.	**Adequate**	**Possible**	**Inside risk appetite for both assurance and likelihood**

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 10.2

Private/Public paper:	**Public**		
Title:	**Quarter 2 Corporate / Organisational Risk Register 2026/27**		
Lead Director:	**Dawn Lawson – Director of Strategy, Inclusion and Change/Deputy Chief Executive**		
Mission/values:	The Organisational Risk Register (ORR) is part of the Trust's governance arrangements and an integral element of the Trust's system of internal control, supporting the Trust in meeting its mission and adhering to its values.		
Purpose:	The purpose of this paper is: • To provide assurance that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of key objectives, and that have controls and actions are in place to mitigate those risks. • To ensure Trust Board members are aware of, and have the opportunity to discuss the current level of risk and emerging risks.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	References to the Board Assurance Framework are included in the Organisational Risk Register (ORR) where applicable.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships.	Trust Board members should assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the Integrated Care Partnerships (ICP), Integrated Care Boards (ICB), and place-based partnerships. The organisational risk register recognises risks that have an impact on partnership working and the objectives of integrated care systems including quality of care, addressing health inequalities and achievement of financial and other performance measures.		
Any background papers / previously considered by:	Previous quarterly reports to Trust Board. The Quarter 1 report on the Organisational Risk Register (ORR) was received by Board on 28 July 2026. Assessment of allocated risks is a standing agenda item at all Board Committee meetings. The Executive Management Team (EMT) reviews the organisational risk register at least once a quarter and factors risk into discussions and decision-making. The ORR was reviewed by EMT at its meeting on 8 October 2026.		

With all of us in mind.

Executive summary:

Corporate / Organisational Risk Register

The Corporate/ Organisational Risk Register (ORR) provides Trust Board members with oversight of organisational risks that are significant in nature and have been escalated by the Executive Management Team (EMT).

Meetings have taken place with all Executive Directors in August and September 2026 to review risks, controls and actions prior to reports being presented to Committees.

Risks that could have an impact across the Trust are reported to the Executive Management Team (EMT) monthly as per the Risk Management Framework and a detailed review of the ORR took place at the EMT meeting on 8 October 2026.

Emergent risks have been identified, and draft wording is included below.

The ORR is aligned to the Trust Strategy and the Trusts three strategic aims as below:



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

Emergent Risks

Risk ID	Risk Owner	Description
	Chief People Officer	The Trust's requirement to compare its nursing job profiles with the outcome of NHS Employers review of national nursing job profiles (bands 4-9) could result in finance, recruitment, and retention challenges, and a reduction in staff morale.

Below are two emergent risks that the Trust is assessing at this time:

Risk ID	Risk Owner	Description
	Chief People Officer	As part of the Employment Rights Act, a national consultation is taking place on the approach to zero hours contracted workers, bank and agency staff, as well as substantive staff working bank, which could generate significant administrative, financial and operational burdens across the Trust

Risk level 15+

Risk ID	Risk Owner	Description
1080	Director of Finance	Risk that the Trust's IT infrastructure and information systems could be compromised by cyber-crime leading to a) theft of personal data b) Key system downtime and/or c) Inability to provide safe and high-quality care.

This risk has been reviewed by the Director of Finance with a comprehensive review of the controls and risk actions in place to mitigate against this risk. We believe we have all relevant measures in place at the current time. Trust Board should be aware that cyber-attacks change tactics and methods so the Trust must be continually alert to this environment and the wider global climate and ensure we are able to react with control measures that are available to us. To that end, the risk score remains at 15 (5 catastrophic, 3 possible) but Board views would be welcome to consider whether we have successfully mitigated the risk to warrant a lower risk score.

Risk level: <15 Risks outside the risk appetite

Risk ID	Risk Owner	Description
1511	Director of Finance	Risk that carrying out the role of lead provider for adult secure services across West and/ or South Yorkshire will result in financial, clinical, and other risk to the Trust.

This risk has been reviewed by the Director of Finance and discussed by EMT on 8 October 2026. The risk currently has a score of 12 (4 major, 3 possible). Due to the increased financial pressures related to the sustained increase in demand across adult secure services as well as a reduction in the number of discharges, EMT supported the proposal an increase to the likelihood rating to 4 (likely), raising the risk score from 12 to 16 (4 major, 4 likely).

Risk ID	Risk Owner	Description
1957	Director of Finance	Risk that the Trust's financial viability will be further impacted by ongoing unfunded pressures.

This risk has been reviewed by the Director of Finance and discussed by EMT on 8 October 2026. The risk currently has a score of 9 (3 moderate, 3 possible). Due to sustained financial pressures, continuing contractual uncertainty and the workforce plan not being achieved, EMT supported the proposal to increase the consequence rating to 4 (major), raising the risk score from 9 to 12 (4 moderate, 3 possible).

Risk ID	Risk Owner	Description
1530	Chief Operating Officer	There is a risk that demand for ~~capacity in~~ services will continue to exceed available workforce and service capacity, leading to extended waiting times, reduced responsiveness to need, flow challenges and an inability to consistently deliver timely, safe and effective care. ~~to meet existing waiting lists and current levels of demand and acuity is placing pressure on access to and delivery of services.~~

This risk was reviewed by the Chief Operating Officer and the Quality and Safety Committee on 13 October 2026. The Quality and Safety Committee supported the proposal to merge this risk with risks 1319, 1839 and 2063 as all four risks relate to mental health inpatient flow, capacity and wider system pressures. Subject to approval of the merger of these risks, it is proposed to reword the risk as noted above in order to reflect demand exceeding workforce and service capacity.

1319 risk description: *Risk that there will be no bed available in the Trust for someone requiring mental health admission to hospital therefore, they will need to be admitted to an out of area bed or undesignated bed or remain in an inappropriate environment (until a bed is available).*

1839 risk description: *Lack of provision across the system prevents transferring people that are clinically ready for discharge.*

2063 risk description: *The risk that an increase in the use of none designated beds,136 suites and extra care beds to accommodate patients requiring inpatient care, may negatively impact on patient safety and experience and staff capacity and wellbeing, especially if the use of these areas is prolonged as a result of current levels of demand.*

Risk ID	Risk Owner	Description
2012	Chief Operating Officer	There is a variable and fluctuating risk relating to the capacity and sustainability of service delivery within paediatric audiology services due to resource limitation and audiologist availability which could impact on patient safety

This risk was reviewed by the Chief Operating Officer and the Quality and Safety Committee on 13 October 2026. As the service has maintained a stable level of service delivery for 7 consecutive months and with a substantive audiologist in post, it is proposed to step this risk down to operational level. The risk will continue to be monitored and can be stepped back up if required.

Heat map

Appendix 1 shows the heatmap of the organisational / corporate risk register. In line with best practice the risk scoring, and total risk timelines show a longer-term trend from January 2021 to October 2026. The report shows the current figures for October 2026 and the projection if the proposals are accepted by Trust Board.

A summary of findings are below:

- There are **28 risks** in Quarter 2 2026/27 if the proposals are accepted. This is a reduction in the number of risks from Quarter 1 2026/27 (32).
- The highest number of risks are aligned to the Trust strategic aim, **Best we can be – Best Quality** (14).
- The lowest number of risks are aligned to the Trust objective, **We will be ambitious** (1)
- If the proposed changes are accepted, there will be **2 red risks** aligned to Trust strategic aim **Best we can be – Best Value (**2 in total).
- If the proposed changes are accepted there will be **no red risks** aligned to Trust strategic aims **of Best we can be – Best place to work and learn**, **Best we can be – Best Quality, We will live our values and We will be ambitious.**
- The current accumulative risk score is **309** and this will reduce to **280** if the proposals are accepted, which is a reduction of **29**.

The current average risk score is **9.66** (amber). If the proposed changes are accepted, then this score will increase to **10** (amber).

Recommendation:	**Trust Board members are asked to:** • **REVIEW** and **COMMENT** on the risk register and to confirm they are **ASSURED** that current risk levels are appropriate, considering the Trust risk appetite, and given the current operating environment. • **NOTE** the emergent risks • **APPROVE** the increase in risk score for risks 1511 and 1957 • **APPROVE** the merger of risks 1530, 1319, 1839 and 2063 • **APPROVE** the stepping down of risk 2012

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership Teaching NHS Foundation Trust

Risk appetite:
Clinical Safety and Quality risks (1-6): Risks arising as a result of clinical practice or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain appropriately skilled workforce.
Business risks (8-12): Risks which might affect the Trust's ability to achieve its plans or damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation.
Compliance risks (1-6): Failure to comply with its licence, CQC registration standards or failure to meet statutory duties, such as compliance with health and safety legislation.
Financial risks (1-6): Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.
Technology risks (8-12): Risks arising from technology not delivering the expected outcomes due to inadequate or deficient system/process development and performance or inadequate resilience.
Information risks (1-6): Risks arising from a failure to produce robust, suitable and appropriate data/information and to exploit data/information to its full potential.
Security risks (1-6): Risks arising from a failure to prevent unauthorised and/or inappropriate access to key Trust systems and assets, including people, platforms, information and resources. This encompasses the subset of cyber security.

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

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

Our Strategic Aims

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

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

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

AC = Audit Committee
QSC = Quality and Safety Committee
FIP = Finance, Investment & Performance Committee
MHA = Mental Health Act Committee
PRC = People & Remuneration Committee
CC = Commissioning Committee

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

Corporate/ Organisational Risk Register - Quarter 2, 2026/27

Trust Board meeting: 27 October 2026

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership Teaching NHS Foundation Trust

Risk level 15+

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequence(current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1080	Risk that the Trust's IT infrastructure and information systems could be compromised by cyber-crime leading to a) theft of personal data b) Key system downtime and/or c) Inability to provide safe and high-quality care.	DFR	AC	• Microsoft Windows Defender with Advanced Threat Protection (ATP) • Comprehensive security patching regime in place • Annual penetration testing in place • Disaster recovery and business continuity plans annually tested. • NHS Digital Care Certification and cyber essentials plus standards achieved. • Information Governance mandatory training includes cyber security dimensions. • Data Security and Protection Toolkit (DSPT) standards met. • IT Service performance actively monitored and tightly controlled • Immutable backup functionality implemented. • Data retention policy in place • Annual table-top emergency planning exercise • Multi-Factor Authentication (MFA) in place • Digital Technology Assessment Criteria (DTAC) requirements included in digital/IT procurement process • Deputy Senior Information Risk Owner (SIRO) in place. • Learning process in place from wider NHS cyber-attacks. • Cyber campaign and communications schedule in place • 6-monthly cyber security updates to Audit Committee • Annual Phishing campaign in place • Cyber security phase 2 enhancements include Cheswold Park Hospital. • CPH site fully integrated on the SWYPFT network • Rapid 7 SIEM solution implemented. • Windows 10 migration to Windows 11 completed. • Regular reviews take place to continually assess the Trust position in relation to cyber security through the digital TAG and Audit Committee	5 Catastrophic	3 Possible	15	Security (1-6)	• Following recent external cyber-attacks work is to be undertaken to ensure procurement and supply chain processes involve checking of third-party suppliers cyber security provision. (DFR review November 2026) • Bids for national frontline productivity investment funding in 2026/27 submitted in respect of cyber security, to further supplement the Trust's cyber security capital scheme. These bids have been endorsed (NHS England Regional Team) and approved by NHS England National Review Panel to support enhancing our existing cyber security posture (DFR review March 2027)	October 2027	IM&T Managers Meeting (Monthly) Digital TAG (Quarterly) Executive Management Team (EMT) AC (Monthly) IT Services Department service management meetings (Trust / Daisy) (Monthly) Trust Board	6	Risk level: 15+ BAF SA 2 – Best value	November 2026

Risk level <15 Risks outside the risk appetite

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
275	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners.	DFR DS COO	QSC	• Joint arrangements in place to manage delivery of integrated teams. • Care Group / commissioner forums identify risks of decommissioning • EMT and OMG review key indicators on a monthly basis. • Regular review of contracts with local authorities. • Trust representation at Health and Wellbeing board meetings. • Trust inputs into system and Place based planning across West and South Yorkshire • Annual stakeholder map to Trust Board includes future proposals from Local Authorities • Contracts in place for all Trust Services • "About me" live across all MH community and inpatient SystmOne units • Director of Care Group attends ICB escalation meetings on weekly basis. • Physical health care group meetings in place to support patient flow. • Delivering Best Value Group in place, led by CEO to support VFM group led by DFR.	4 Major	3 Possible	12	1-6 Clinical Safety and Quality risk	• Ongoing assessments to consider financial risk are undertaken each month end (DFR/DS review November 2026). • Impact on Lyndhurst ward identified following review of Calderdale Local Authority plans for 2026/27. Future plans to be established with local authority and ICB. (COO review November 2026) • The Trust needs to review local authority spending plans and engage in consultations (DFR November 2026)	30 April 2027	QSC Care Group (monthly) EMT (monthly) OMG (regular) Trust Board (each meeting through integrated performance report) Annual review of contracts and annual plan at Executive Management Team and Trust Board	6	Risk level: 15+ BAF SA 2 – Best partner	November 2026
1511	Risk that carrying out the role of lead provider for adult secure services across West and/ or South Yorkshire will result in financial, clinical, and other	DFR	CC	• Partnership agreement/risk share in place with NHS providers for West Yorkshire • South and West Yorkshire Commissioning Hubs in place • Monthly financial management and control reports to Provider Collaborative Boards in West Yorkshire and South Yorkshire. • Quarterly contract meetings in place with sub-contracted partners. • Monthly patient safety and quality meetings in West and South Yorkshire. • Clinical Leadership roles in place for West and South Yorkshire • Dedicated provider collaborative risk registers in place • Quality assurance processes in place	4 Major	4 likely	16	1-6 Financial risk	• Trust to continue to engage with NHSE around future contract renewal (DFR review November 2026) • Strategic commissioning work is starting to take place across some of the higher risk pathways across Yorkshire and Humber. Five priority workstreams have been identified and a detailed delivery plan is being developed. (DFR review November 2026) • The Trust needs to look at the re-opening of two wards at Cheswold Park Hospital in order to optimise patient flow (COO/DFR November 2026)	31 March 2027	CC Executive Management Team (monthly) Trust Board	4	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best value	November 2026

	risk to the Trust.			• Trust Commissioning Committee in place • West Yorkshire Sub-contracts in place • Financial efficiency programme for provider collaboratives is in place for 2026/27. Ongoing monitoring to be delivered through the value for money programme.										
1957	Risk that the Trust's financial viability will be further impacted by ongoing unfunded pressures.	DFR	FIP	• Value for money board meet weekly and non-pay review groups in place. • Monthly senior budget holders and management accountant meetings. • Monthly OMG focus on performance and finance. • Mental health investment standard. • Trust fully engaged with ICS finance and funding. • Monthly finance updates presented to EMT and FIP with regular updates to Trust Board. • Trusts financial performance scrutinised through the Finance, Investment and Performance Committee • Future risk modelled into 26/27 medium term financial planning processes.	4 Major	3 Possible	12	1-6 financial risk	• The Trust has a C£3m unfunded pay pressure. Awaiting guidance for 2027/28 planning. (DFR review November 2026) • Sustained financial pressures emerging from specialised provider collaboratives. Trust to continue to engage with NHSE around future contract renewal (DFR review November 2026) • Requirement for the Trust to set contract negotiation perimeters with both ICB's and NHSE (DFR November 2026)	31 March 2027	FIP Executive Management Team (EMT) (monthly) Operational Management Group (OMG) Trust Board	4	BAF SA 2 – Best value The Trust is currently in line with the financial plan to date with a deficit of £2.2m as at month 5 2026/27.	November 2026
1114	Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided	DFR	FIP	• Board, Committee and EMT oversight of value for money schemes. • Value for money board meet weekly and non-pay review groups in place • Active engagement in West Yorkshire and South Yorkshire Systems (ICS) and place-based plans. • Mental Health Investment Standard funding. • Use of national and internal benchmarking information support productivity improvements. • Operational and financial plan in place for 2026/27 • Monthly operational management group focus on performance and finance. • Staff engagement supported by head of communications • Finance update report provided to each FIP meeting. • Delivering Best Value Group in place, led by CEO to support VFM group led by DFR • Integrated Care Board (ICB) level cost controls have been implemented • Draft medium term financial sustainability plan approved by Trust Board and submitted to NHSE. • Development and implementation of Board approved workforce	4 Major	3 Possible	12	1-6 Financial risk	• 2026/27 value for money programme established. Ongoing assessment of risk to delivery of all schemes. (DFR review November 2026) • Mitigation plans are under development to offset any shortfall in VFM programme or unplanned cost pressures. These include MARS, staffing framework and MHIS negotiations. (DFR review November 2026).	31 March 2027	Executive Management Team (monthly) FIP (monthly) Operational Management Group Trust Board (quarterly)	4	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best value	November 2026

				reduction/efficiency plans to support financial planning.										
1530	There is a risk that demand for services will continue to exceed available workforce and service capacity, leading to extended waiting times, reduced responsiveness to need, flow challenges and an inability to consistently deliver timely, safe and effective care.	**COO**	**QSC**	• Trust is a key partner in both Integrated Care Systems to manage demand • Where demand cannot be met escalation is through the Operational Management Group (OMG) via waiting list reports • Staffing flexibility in place to manage changes in demand by ward and/or geographical location. • Regular engagement with commissioners provides opportunity to consider changes required to meet demand. • Regular reports to EMT, OMG and FIP • People waiting are offered contact information should their needs escalate • Waiting lists are reported on SystmOne and reported into FIP • ADHD waiting list initiatives • Deprivation data and ethnicity data is included in waiting list reports into OMG and FIP. • New mental health care plan captures the views of service users and inequalities • OPEL and demand meetings in place in the mental health care group to manage pressures on flow. • Waiting well processes in place • Productivity working group in place to identify opportunities for improvements/efficiencies • Director of Care Group attends ICB escalation meetings on weekly basis in order to escalate patients clinically ready for discharge to enhance patient flow. • Trust alignment to national project for mental health inpatient flow completed. • Quality Improvement project achieving the required standards but remain subject to volatility due to minimal staffing. • Outcomes and learning from getting it right first time (GIRFT) and national project for MH inpatient flow have been implemented to improve access.	3 Moderate	4 Likely	12	1 – 6 Clinical Safety and Quality risk	• Quality Improvement Programmes in place for all services to improve access and waiting times (COO review November 2026) • Meeting with commissioners to redesign some services (eg ADHD access). (COO review November 2026) • Complete a Trust-wide capacity and demand review to identify service-specific constraints, capacity gaps and mitigation plans for services exceeding agreed waiting time standards. (COO review April 2027) • Implement recovery trajectories for services with the longest waiting times, including monthly performance monitoring through OMG, TCP and EMT. (COO review January 2027) • Agree commissioning intentions and service redesign proposals with ICB partners for high-demand pathways, including ADHD, Autism and Community Mental Health services. (COO review December 2026). • Strengthen Waiting Well arrangements through routine risk stratification, clinical review and welfare checks for patients waiting longest for assessment or treatment. (DNQ review December 2026).	March 2027	QSC Executive Management Team (EMT) (monthly) Operational Management Group (OMG) Trust Board	6	Risk level: 15+ BAF SA 2 – Best Quality Actions to manage the impact of demand are within other risk actions, 1614 (staffing), 1319 (inpatient bed for child and adult) 1078 (waiting lists child and adult).	November 2026

1078	There is risk that young people will suffer harm as a result of waiting for treatment or neurodevelopmental assessment in the form of unmet needs, access to services and support which might impact on longer term health, education and social outcomes as well as family life.	**COO**	**QSC**	• Incidents reported on Datix and reviewed through patient safety oversight group • Children waiting for a neurodevelopmental assessment with mental health needs are supported by core (CAMHS) • Children and young people on waiting lists are reviewed frequently and can be prioritised according to their level of need and risk. • Active participation in Integrated Care System - CAMHS work • Performance dashboard in place including ethnicity monitoring to monitor waits. • Children and Young people's governance Group in place • Discussions with Commissioners taken place to ensure that resources are prioritised.	4 Major	3 Possible	12	1-6 Clinical Safety and Quality risk	• Focus on pathway improvements continues, to maximise capacity and improve service user experience. (COO review November 2026) • Working with CKW ICB to establish a transfer to alternative providers to support the waiting list for childrens ADHD and ASD services. (COO review November 2026)	31 March 2027	OMG QSC Executive Management Group – monthly Individual district performance reports reviewed by care group Trust Board	6	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality Investment received within CYP service lines to improve waits and clinical pathways.	November 2026
1368	Risk that there is limited access to CAMHS inpatient beds due to regional and national demand and capacity issues. This could result in young people being cared for in an adult or	**COO**	**QSC**	• Community options continue to be explored. • Protocol in place for admission of children and younger people on to adult wards. • Bed management processes • CAMHS in-reach support to mental health wards and acute hospitals in the event a child is placed there. • Regular report to board (Integrated Performance Report) • Safeguarding team provides scrutiny of all under 18 admissions. • Leeds and York care provider collaborative board and system wide operational cell (West Yorkshire) provides oversight of CYP admissions • System-wide panels review the demand and take action to address delays • Care, Education, Treatment Reviews (CETR) are in place for children with learning disability and autism.	3 Moderate	3 Possible	9	1-6 Clinical Safety and Quality risk	• SWYPFT to continue to be part of provider collaborative to support system wide improvement. (COO review November 2026)	April 2027	QSC Executive Management Team (EMT) (monthly) Operational Management Team (OMG) Trust Board	4	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality	November 2026

	secure wards or secure CAMHS estate impacting on the quality and experience of their care.			• Escalation process with partners in place where an appropriate solution for a child is not available. • Person centred plan put in place when children are admitted to adult beds • Trust involvement across West Yorkshire ICS in relation to Tier 4 beds • A pathway is in place for children and young people to access secure beds. • Children and young people's mental health transformation programme in place across the West Yorkshire system to develop alternatives to inpatient care. • Whilst waiting for bed availability young people will be risk assessed and supported by the Trust									
1757	Failure to maintain and monitor medical devices to the required standard in line with relevant legislation may lead to patient harm.	**DFR**	**QSC**	• The Electrical Biomedical Medical Engineering (EBME) equipment / infection prevention and contract is in place • Equipment registers in place • Purchasing process in place • Medical devices and safety alert group monitor EBME compliance figures quarterly • Medical devices intranet pages in place • Medical devices lifecycle flowchart in place • Medical Devices Policy In place. • Monthly updates are provided to Care Group leads for monitoring • Quarterly update provided to OMG and EMT • Trustwide servicing programme • Weekly review of the asset register data for medical devices • Medical devices annual report governance process in place. • Servicing contracts for medical devices in place. • Update to EMT and QSC at bi-monthly intervals, as per QSC workplan. • Monthly dedicated performance reports in place with Mid Yorkshire as main contractor. • Estates and Facilities oversee the servicing contract. • Central database cleansing completed and approved by the Medical Devices group. • Workforce for medical devices in place. • Process in place to ensure robust oversight of medical devices. • Medical device compliance included in IPR from April 2026	4 Major	3 Possible	12	Compliance (1-6)	• All Care groups requested to review equipment schedules. (DFR review November 2026). • At the end of 2026 any annually serviced medical devices not seen or found for two years will be deactivated from PLANET, with reactivation available if later presented for servicing. (DFR review March 2027) • New deputy director of estates appointed. Therefore, controls related to the role of medical devices safety officer moved back to an action whilst a review is undertaken. (DFR review November 2026)	February 2027	Clinical governance / care group clinical governance QSC Safety and resilience Task Action Group Operational Management Group (OMG) Medical Devices Task Action Group Executive Management Team (EMT) Trust Board	6	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality Trustwide compliance improved to 88%. Consideration will be given to review score once there is confidence in a sustained improvement.	November 2026

				• EMT report now includes risk classification of all medical devices and compliance by category and type.										
1614	National staff shortages in some clinical staff groups resulting in vacancies which could lead to the delivery of potentially reduced quality, unsafe and / or reduced services, increased out of area placements, breaches in regulations or inability to recruit to newly commissioned services.	**DNQ** **CPO**	**PRC**	• All Datix reports relating to staffing issues go to the weekly patient safety oversight group and escalated to Executive Management Team as appropriate. • Inpatient transformation programme taking place to improve clinical pathways and patient experience • Internal reporting includes waiting lists, length of stay, complaints, concerns and compliments • Quality Walkarounds in place to ensure staff and service user voice is heard • Use of temporary staffing to address staffing issues where there is clinical need • Safer staffing groups to ensure oversight and escalation of staffing and recruitment. • Safer staffing levels for inpatient services agreed and monitored. • Freedom to speak up process in place • Quality focused updates from inpatient areas are presented to the Clinical Governance Group • Safe practice protocol during seclusion and restraint in place when working with reduced substantive staff • SafeCare in place in Forensics and Barnsley Mental Health Inpatients, Calderdale and Kirklees adult rehab/recovery and older people services • Recruitment and retention plan agreed • Monthly safer staffing reports to Trust Board and Operational Management Group via Integrated Performance Report • Biannual safer staffing report to QSC and Trust Board • Medical staff bank in place. • Allied Health Professionals master agency contract in place. • Staff redeployment process in place • Marketing of the Trust as an employer of choice. • Workforce planning processes include development of new clinical roles and business cases. • A careers microsite is now live • The care certificate for all new nonregistered support workers available	4 Major	2 Unlikely	8	1-6 Compliance risk	• Learning from SafeCare implementation in Forensics is being reviewed to inform the approach to implementation across the MH care group. (DNQ review November 2026) • Recruitment plan for care support workers 2026/27 has been developed and now revised. Recruitment campaigns planned for the remainder of 26/27. (CPO review November 2026) • Bespoke recruitment campaigns are being developed to take account of specialist requirements, ie Forensics. Assessment centres being planned for October. (CPO review November 2026) • The AMD for Workforce and Development, Director of Services MH, the recruitment team and operational team work together to consider new roles in accordance with workforce plan and organisational priorities to optimise retention and recruitment into substantive consultant vacancies. (CMO review November 2026)	31 March 2027	Operational Management Group Executive Management Team Trust Board QSC PRC Safer staffing inpatient and community group Clinical Strategy Implementation Group Trustwide AHP Group	6	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality Trust clinical strategy key priority is improving the clinical offer in our services and supporting career structures	November 2026

				• Collaborative recruitment initiatives in place with West Yorkshire Mental Health and Learning Disabilities and Autism Collaborative • SWYPFT involvement in the NHSE people promise exemplar programme • Rolling programme of establishment reviews in place. • AHP Action Plan aligned with the Trust Strategy and runs from 2025-2030. • AHP Professional Leads and accountable owners meet 6 weekly to report back on delivery of their actions • Establishment reviews completed across all MH and forensic wards and approved to EMT.										
1689	Risk that the Trust does not address heath inequalities under its control in the provision of services potentially exacerbating existing health inequalities for our service users.	**DS**	**QSC**	• Equality, Diversity and Inclusion strategy and annual action plans in place • Equality Impact Assessments (EIA) including action tracker in place • SystmOne equality data provides oversight of equality data to understand our places • Annual Equality Report • Equality Involvement and Inclusion Committee and sub-committee • Equality dashboard • Making Data Count approach established • Improving access to care priority programme established • Equality Delivery System (EDS) • EDI training, development and awareness sessions in place • Work with partners in each place to address inequalities • Targeted programmes to address inequalities through linked charities • Key priority programme for 2026/27 is reducing inequalities • FIP review dashboard as part of routine monitoring (waiting times and access) • QSC receive care group case studies of actions taken to address inequalities. • Trustwide involvement in place-based health inequalities programmes • Comms plan around health inequalities in place • Accessible Information Standard review has taken place for patients and service users to ensure inclusivity • Dedicated Change Manager in place to address health inequalities	3 Moderate	3 Possible	9	1-6 Compliance risk	• New health inequalities IPR metrics have been designed and will be implemented from September 2026. (DS review November 2026) • EDI ops group to review the risk to consider the impact of any ICB changes on the EDI agenda and report back to QSC. (DS review November 2026).	30 April 2027	Recovery and reset monthly Executive Management Team QSC quarterly meeting and bi-monthly sub-committee Executive Management Team Trust Board	6	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality	November 2026

				• Priorities to address health inequalities this year approved by Trust Board.										
1159	The risk of fire at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.	**DFR**	**AC**	• Fire Safety Advisor produces monthly / quarterly Fire Reports for review / action by Senior Managers and conducts surveys. • Quarterly review undertaken by Estates Trust Action Group. • Weekly risk scans are completed by the Trust's Fire Safety Advisor • Adherence to standards for the provision, installation, testing and planned maintenance of fire safety equipment and systems. • The identification of standards for the control of combustible, flammable or explosive materials via Trust policy • Fire safety awareness training mandatory for all staff and compliance monitored. • Emergency procedures in place to ensure early recovery from unforeseen incident involving fire. • Use of sprinklers across all Trust buildings reviewed as part of the capital programme. • Reinforcement of fire safety requirements in locations where additional oxygen could be stored. • Health and Safety annual report submitted Audit Committee and Trust Board. • Quarterly Clinical Environment Safety Group AAA report presented to QSC • Vapes on acute wards available through an approved manufacturer with supplies only available through the Trust • The annual statement of fire safety compliance approved by Executive Management Team • Smoke free policy in place • Annual fire risk assessments undertaken. • Fire risk training compliance reviewed monthly and escalated appropriately as required. • Learning from incidents shared Trustwide. • Findings from the annual fire risk assessment included in the Health and Safety Annual Audit reviewed by EMT, Audit Committee and Trust Board with action plan established.	4 Major	3 Possible	12	1-6 Compliance risk	• Review of impact of Building Safety Act being undertaken on a capital scheme by scheme basis. (DFR review November 2026) • Allocation from the estate safety fund for Cheswold Park Hospital which will pick up any fire risk issues on that site. Other fire safety works would be prioritised along with the Trust Capital Plan. (DFR review November 2026).	30 April 2027	Executive Management Team Estates Trust Action Group (monthly) Safety Trust Action Group (Quarterly) Operational Management Group (monthly) AC Trust Board	6	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality	November 2026

852	Risk of information governance breach and / or non-compliance with General Data Protection Regulations (GDPR) leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.	**DFR**	**AC**	• Annual internal audit report of Data Security and Protection Toolkit. • Trust information governance mandatory training for all staff has a compliance target of 95% • Designated Caldicott guardian and Senior Information Risk Owner (SIRO) (and deputies) in post. • Qualified and experienced data protection officer in post • Policies and procedures compliant with General Data Protection Regulation (GDPR). • Improving Clinical Information and Governance (ICIG) group in place • Communications and awareness plan in place. • Data protection impact assessment process • Proactive monitoring of incidents and 'hot-spot- areas by information governance manager. • Confidentiality clause in staff contracts • Data protection included in induction checklists • Processes in place for rectifying inaccurate or incomplete data • Trust communications in place to ensure data alignment between SystmOne and the NHS Spine • Following all IG incidents, communications are circulated to all staff reminding them of their responsibilities under the UK Data Use and Access Act 2025 and Trust policy and procedures. • Overall risk assurance was low across all five objectives, with no outcomes below minimum achievement levels. • The Trust achieved the highest audit assurance level for the sixth consecutive year. • Process has been approved by ICIG to ensure lockdown of records to identified key personnel for potentially high profile cases where appropriate • DPO member of Artificial Intelligence (AI) group to ensure that IG/data protection is considered for every project. • Terms of reference for ICIG aligned with the UK Data Use and Access Act 2025	4 Major	2 Unlikely	8	Information risk (1-6)	• Process to improve how positive consent to share is captured and evidenced digitally to be rolled out. (DFR review November 2026) • Trust will look to integrate patient comms via the NHS App or Patient knows best to reduce human errors. (DFR review November 2026) • Following deep dive, clusters of breaches in service areas e.g. recent cluster in CAMHS are being supported to undertake service improvement work by change & innovation team. (DFR review November 2026)	November 2026	ICIG Operational Management Group Executive Management Team AC Trust Board	4	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality The UK GDPR has been significantly updated in 2026 under the Data (Use and Access) Act 2025, introducing new lawful bases, relaxed cookie rules, enhanced automated decision-making provisions, and stricter ICO enforcement. DSPT submitted to NHSE Digital on 29 June 2026.	November 2026
1319	Risk that there will be no bed available	**COO**	**QSC**	• Bed management process and OPEL actions aligned to the UEC planning guidance and appropriate escalations to exec Trio	3 Moderate	3 Possible	9	1-6 Clinical Safety	• Review required of data for each place to understand use of beds vs commissioned activity. (COO review November 2026)	31 March 2027	OMG QSC	4	Risk level: Risk level <15 Risks	November 2026

	in the Trust for someone requiring mental health admission to hospital therefore, they will need to be admitted to an out of area bed or undesignated bed or remain in an inappropriate environment (until a bed is available).			• Agreed governance structure including improving mental health oversight group and improvement mental health partnership group • Workstreams in place to address specific issues • Routine reviews of care whilst out of area are in place. • Barriers to discharge reports link into place-based delays in discharges. • Clinically ready for discharge escalation through multi agency discharge events in place to support patient flow. • Specific leadership at associate director level for patient flow. • Patient flow dashboard in place to ensure clear oversight • Patient safety oversight group reviews all incidents relating to patient flow • Intensive Home-Based Treatment Team pathways are in place • Daily huddle meetings dedicated to oversight on discharges to allow access to new admissions. • Inpatient improvement pathway workstream with senior input from a lead consultant psychiatrist • Daily review of all out of area placements to ensure rapid return to a Trust bed where appropriate. • Trust completed national and regional ED Improvement programme to understand delays in transfer / admission to a MH bed from ED or acute wards				and Quality risk	• Proposal to be presented to the Quality and Safety Committee in October 2026 to merge this risk with 1530, 1839 and 2063. (COO review November 2026)		EMT Trust Board		outside the risk appetite	
1585	The current NHS capital regime could result in the Trust not having sufficient allocation to complete all its capital plans adversely impacting on ability to meet	**DFR**	**FIP**	• Detailed internal capital planning and prioritisation process. • Integrated Care System (ICS) capital allocation process is transitioning from ICS to regional level. West Yorkshire ICS is maintaining local level capital oversight. • Internal cash availability. • Approved Trust digital strategy in place. • Capital allocation for 26/27 agreed • Trust Board receives 6 monthly updates on digital and estates strategy • Approved Trust Estates strategy in place. Trust Board receives 6 monthly updates • Monitoring of in-year capital spend to ensure delivery against plan • NHSE made four year allocations for capital which supports longer term planning.	3 Moderate	3 Possible	9	1-6 Financial risk	• Review of 26/27 capital programme underway. Awaiting guaranteed maximum price for older people's service programme expected October 2026. Review of Cheswold safety scheme underway. (DFR review November 2026) • In light of above, medium term capital plan phasing to be reviewed. (DFR review November 2026)	31 March 2027	Executive Management Team (monthly) FIP (monthly) Trust Board	4	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best value	November 2026

	its strategic objectives and priorities.													
1157	Risk that the Trust does not have a diverse and representative workforce at all levels which reflects all protected characteristics to enable it to deliver services which the meet the needs of the population.	**CPO**	**PRC**	• Annual Equality Report • Equality, Diversity and Inclusion strategy in place • Equality Impact Assessment. • Development and delivery of joint WRES, WDES and EDS2 action plans • Bullying and harassment policy in place • Staff networks in place eg, Disability Network, LGBT+ network, carers network. • Ongoing engagement with regional partners and regional lead from NHS England with regards to disparity in representation across nurse bandings • Microaggression resource in place via Trust intranet. • Equality dashboards for QSC to track data, progress and improvements. • A process is in place to use staff survey data to improve staff experience with a focus on feedback from all diverse groups. Local teams work on action plans and involve staff networks • The Trust ensures diverse interview panels are in place with a focus on BAME representation • Equality, Diversity and Inclusion action plan approved by Trust Board • Newly established EDI operational group in place to ensure strategic and operational alignment of EDI priorities • EDS2 actions developed	3 Moderate	3 Possible	9	1-6 Compliance risk	• Role of Equity Guardians and wider champion roles to support the Equality Strategy will be reviewed once the staff networks appointments have been made. (CPO review December 2026) • EDI ops group focussed on developing a #all of us campaign aimed at supporting staff who suffer harm at work. (CPO review November 2026) • EDI action plan – actions were received at PRC in July. A new EDI action plan based on WRES/WDES findings for 2026 has been produced and the draft plan will be submitted to Board in October. (CPO review November 2026)	31 March 2027	Executive Management Team (EMT) (quarterly) PRC Trust Board	6	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best place to work and learn	November 2026
1839	Lack of provision across the system prevents transferring people that are clinically ready for discharge	**COO**	**QSC**	• Patient flow processes establish barriers to discharge on admission • Routine multidisciplinary reviews • care plans in place • Improving Mental Health Oversight Group • Improving Mental Health Partnership Group • Care Closer to Home steering group • Barriers to discharge reports link into place-based multi-agency discharge meetings. • Clinically ready for discharge issues continue to be escalated through to MADE meetings, improvement work and the partnership group. • Where MADE meetings have not reached a solution, a gold command structure is established.	3 Moderate	4 Likely	12	Clinical Safety and Quality risk (1-6)	• Horizon assessment and treatment unit options appraisal submitted to the West Yorkshire contracting and finance workstream. Lead provider looking at options to increase direct funding for the two ATU units. (COO/DFR review November 2026) • Continue to have ICB escalation process in place to seek transfer of care. (COO review November 2026) • Proposal to be presented to the Quality and Safety Committee in October 2026 to merge this risk with 1530, 1319 and 2063. (COO review November 2026)	September 2027	Executive Management Team Operational Management Group QSC Trust Board	6	Risk level: Organisational level risks within the risk appetite BAF SA 2 – Best Quality A secondary care pathway in West Yorkshire is in place to share	November 2026

				• Specific leadership at associate director level for patient flow. • Patient flow dashboard • Bed management process and OPEL action actions aligned to the UEC planning guidance and appropriate escalations to exec Trio. • Weekly review with commissioners to progress those who are clinically ready for discharge via MADE meetings								learning of themes to barriers to discharge to inform future work streams. Similar work has commenced in South Yorkshire.	
1887	Risk that teams and individual members of staff do not feel confident that the Trust has a culture where 'Speaking Up' is encouraged; individuals are supportively heard; staff do not suffer personal detriment following reports; or receive feedback on action(s) taken which demonstrate listening and learning.	**DNQ**	**AC**	• Freedom to speak up structure in place guardian supported by two further guardians • 6 weekly oversight meetings with Lead Director DNQ, non-executive lead for FTSU supported by Deputy Director of Corporate governance • Exec Director Lead meets regularly with FTSU guardian • Trust communications (View and Headlines) in relation to speaking up and updates via Trust intranet encourage openly raising concerns • Quality walkarounds structure in place • Exec director informal visits provide opportunities for staff to raise concerns • FTSU guardian identifies and escalates detriment from any speaking up process through the use of a survey completed at closure of any concern which can be completed anonymously • Staff are signposted to other areas of the Trust for support, eg occupational health • Staffside support in place • Focused intervention from executive TRIO into areas of concern • FTSU newsletter in place • FTSU data triangulated with staff survey results • FTSU self-assessment tool and action plan in place • FTSU reports into Audit Committee and Trust Board • FTSU guardian has regular visits to services to promote freedom to speak up • FTSU promoted at welcome events • Freedom to Speak Up communications plan in place. • Freedom to Speak Up policy review completed 2026 • Review of Freedom to Speak Up strategy approved and intranet updated	3 Moderate	3 Possible	9	1 – 6 Compliance risk	• Final approval of Freedom to Speak Up Internal Operating Framework via OMG, following which intranet links will be updated. (DNQ review November 2026)	31 March 2027	FTSU steering group QSC PRC EMT Trust Board	6	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 1 – We will live our values	November 2026

				• Mandatory training speak up training available on ESR along with Listen up and follow up. • Freedom to Speak Up cases reviewed to check improvements have been embedded as part of learning. • Culture review of forensic services commissioned.										
1888	Risk that individuals do not feel safe from sexual harm whilst being cared for, working for, or visiting the Trust.	**CPO** **DNQ**	**QSC** **PRC**	• The Trust has signed the NHS England sexual safety charter • All appropriate and relevant policies in place. • Trust safeguarding team oversee all patient related sexual safety incidents via Datix. • The People Directorate oversee all staff sexual safety incidents reported through the internal reporting portal. • Incidents are reported monthly into the IPR. • The Trust reports via the Joint Safeguarding Strategic and Operational Subgroup, EMT, PRC and QSC Committee. • Quarterly sexual safety oversight group ensure findings from incidents are embedded into practice based on NHSE Sexual Safety in Healthcare Organisational Charter. • Trust intranet information page on sexual safety in healthcare in place • Sexual Safety Annual Reporting process in place • National eLearning package for sexual safety available to all staff • Bespoke face to face training package in place when required. • Senior leadership guide to sexual abuse disclosures in the NHS in place • Datix guidance in place for sexual safety incidents • Incident dashboard developed to identify themes/trends. • Sexual safety oversight group in place reporting into QSC and PRC • Further bespoke training regarding responding to disclosures of sexual harassment and sexual assault available to staff within the Trust. • Video and posters produced aligned to national workstreams. • Confidential reporting structure for staff in place. • Sexual Safety awareness campaign launched December 2025.	4 Major	2 Unlikely	8	1-6 Clinical Safety and Quality risk	• Governance processes in place to identify emerging themes/trends related to sexual safety and develop actions as appropriate through the Sexual Safety Oversight Group which feeds into Clinical Governance Group and Quality and Safety Committee. As part of this review, consider if different approaches are needed for staff and patients, and if so, if overall risk needs to be amended/reviewed. (CPO/DNQ review November 2026) • Level 1 eLearning continues to be promoted prior to becoming mandatory training, to raise awareness of zero tolerance Trust stance and understanding of what behaviours are considered inappropriate. (DNQ review November 2026) • Service user sexual safety to be considered as part of women's clinical pathway workstream. (COO review November 2026) • Undertake baseline assessment on new national staff standards, which includes "Championing Sexual Safety" which help identify any gaps areas. (CPO Review – November 2026) • A review of the steering group arrangements to be undertaken to understand how this can be linked and aligned to other arrangements for staff safety. (CPO review November 2026) • Sexual safety confirmed within the national training Framework. TNA to be undertaken following publication to inform implementation and recognition of completed national e-learning, where appropriate. (CPO review November 2026)	31 August 2027	QSC PRC Executive Management Team (EMT) Joint Safeguarding Strategic and Operational Subgroup sexual safety improvement group Quality and Safety Committee (QSC) Trust Board	4	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 2 – Best Quality	November 2026

				• Sexual misconduct policy and framework formally launched across the Trust from December 2025. Regular reports on numbers and overall compliance are reported to EMT and PRC. • Staff sexual safety reporting mechanism in place • Disciplinary outcomes monitored for fairness, transparency and alignment with national standards • Sexual safety oversight group monitor for emerging themes/trends and risk analysis • Standard reporting for PRC, QSC and EMT agreed, effective July 2026.										
2012	There is a variable and fluctuating risk relating to the capacity and sustainability of service delivery within paediatric audiology services due to resource limitation and audiologist availability which could impact on patient safety	**COO**	**QSC**	• Waiting times are closely monitored to ensure they are kept to a minimum • Two bank staff are covering the substantive vacant hours and additional bank staff sourced. • Support and advice is in place from Sheffield children's hospital. • Regular communications in place with the ICB around risk and resource implications. • Prioritisation of cases where risks may be greater. • Detailed review of the service and any incidents overseen by the general manager and director of service • New substantive audiologist in post	3 Moderate	3 Possible	9	1-6 Clinical Safety and Quality risk	• Continue to monitor access and waits for this service via performance meetings. (COO review November 2026)	February 2027	CYP&F Development and Oversight Meeting (care group meeting) OMG EMT IPR	6	BAF SA 2 – Best Quality 7 months sustainability so proposed to step down the risk to operational level.	November 2026
2084	Risk of serious harm to inpatients caused by residual ligature anchor points not fully mitigated by current	**DNQ**	**QSC**	• A programme of annual ligature reviews overseen through the Clinical Environment Risk Group. • Capital programme in place to address any identified ligature points • Policies and procedures, and reporting structure in place, for the identification and mitigation of patient safety risks. • Appropriate Operational Management Group (OMG), Clinical Governance Group and QSC escalation arrangements in place.	4 Major	2 Unlikely	8	1-6 Clinical Safety and Quality risk	• Improvement programme in relation to risk assessment and care planning lead by deputy director of nursing underway to address gaps in assurance in relation to risk assessment and safety planning. Actions from the internal audit are complete with next steps being to implement training (both face to face and e-learning). (DNQ review November 2026) • Independent review of the women's pathway of care underway which will inform learning to reduce likelihood of any further inpatient incidents. Paper to	May 2027	Performance & monitoring via EMT QSC OMG Trust Board	6	BAF SA 2 - Best Quality	November 2026

	environmental and clinical controls, resulting in potential self-harm incidents			• Patient Safety Specialist roles in place • Regular Patient safety learning events • Video of how to use and maintain the ligature cutters is available on the RRPI intranet site. • Ligature procedure updated and available to staff. • Any changes to ligature procedure demonstrated within RRPI training.					be presented to Trust Board in October. (DNQ review November 2026) • Women's pathway of care working group established, led by Chief Psychological professions Officer to take forward the findings from the independent review. (DNQ November 2026) • Improvement programme led by Chief Nurse for Elmdale and Nostell with a focus on reduction in self-harm. (DNQ review December 2026)		Patient Safety report & incident report as well as monthly reporting in the Integrated Performance Report Patient Safety Incident task and finish group Clinical Environment Risk Group.			
2085	Risk of repeat patient safety incidents and deterioration in the quality of care caused by inconsistent incident review processes, and failure to effectively embed learning across services resulting in recurring incident themes.	**DNQ**	**QSC**	• Policies and procedures, and reporting structure in place, for the identification and mitigation of patient safety risks. • Appropriate daily/weekly oversight of patient safety incidents through care group and Trust patient safety oversight groups. • Executive oversight of patient safety reviews and learning through Trust Patient Safety Oversight Group (PSOG) and Patient Safety Executive Group with escalations to EMT and QSC. . • Care group level PSOGs in place provide opportunities for learning to be identified and shared Trustwide. • Patient Safety Specialist roles in place • Regular Patient safety learning events • Clinical strategy in place. • Care group governance aligned to ensure consistency of approach across the Trust • Regular patient safety updates to QSC and Trust Board via complex clinical matters report and the quarterly patient safety and learning reports • The Trust has a Patient Safety Incident Response Framework (PSIRF) Policy and Plan. • Quality walkarounds • The Trust's PSIRF is accredited to the national Safety Incident Response Accreditation Network (SIRAN) scheme,	4 Major	2 Unlikely	8	1-6 Clinical Safety and Quality risk	• Improvement programme in relation to risk assessment and care planning lead by deputy director of nursing underway to address gaps in relation to assurance in risk assessment and safety planning. (DNQ review November 2026) • Actions from the internal audit are complete with next steps being to implement training (both face to face and e-learning). (DNQ review November 2026) • Following the launch of the national quality strategy a quality framework and plan is being developed aligned to the trust strategy. (DNQ review December 2026) • Thematic reviews of inpatient and community apparent suicides being completed to inform improvement activity. (DNQ review November 2026) • Triangulation of incidents and identification of where the Trust may be an outlier (December 2026)	May 2027	Performance & monitoring via EMT QSC OMG Trust Board Patient Safety report & incident report as well as monthly reporting in the Integrated Performance Report Patient Safety Incident task and finish group PSOG	6	BAF SA 2 - Best Quality	November 2026

				delivered by the Royal College of Psychiatrists. • Daily corporate incident huddles in place • Monthly Patient safety improvement and learning oversight group in place to strengthen the approach to identifying and sharing learning and oversight of quality improvement initiatives to address safety risks.							PSEG			
2086	Risk of unsafe or inappropriate clinical decision making caused by inconsistent completion, quality and accuracy of clinical risk assessments resulting in failure to identify, evaluate and manage individual patient risks effectively	**DNQ**	QSC	• Policies and procedures, and reporting structure in place, for the identification and mitigation of patient safety risks. • Appropriate oversight of compliance with risk assessment completion through the integrated performance report, overseen at OMG, EMT, QSC and Trust Board • Staff training • Clinical audit processes in place • Formulation of informed risk management (FIRM) assessment training in place • Risk assessment and care plan quality dip sample audits in place across community and inpatient MH • Community MH risk assessment and care planning audit dashboard in place • Care group governance groups oversight of performance in relation to risk assessments and care planning. • Monthly reporting to quality and safety committee in relation to progress of actions arising from the internal audit of risk assessments and care plans • Approach to undertaking quality assessment of risk assessments and care plans developed through the task and finish group. • Actions arising from the internal audit of risk assessments completed.	4 Major	2 Unlikely	8	1-6 Clinical Safety and Quality risk	• Improvement programme in relation to risk assessment and care planning overseen by the Task and finish group, chaired by Deputy Director of Nursing, to address the findings of the internal audit report. (DNQ review November 2026) • Actions from the internal audit are complete with next steps being to implement training (both face to face and e-learning). (DNQ review November 2026) • Review of clinical risk training underway. (DNQ review November 2026) • Final comments awaited on the draft Risk (safety assessment) training package which includes eLearning and face to face training. Recruitment processes underway for a facilitator for face to face sessions. (DNQ review November 2026).	December 2026	Performance & monitoring via Executive Management Team QSC Operational Management Group Trust Board Risk assessment and care planning task and finish group	6	BAF SA 2 - Best Quality	November 2026
2087	Risk of overuse of restrictive practices caused by inconsistent implementation of reducing restrictive practice approach	**DNQ**	QSC	• Reducing restrictive practice and intervention (RRPI) improvement plan in place • Quality walkarounds • Mandatory RRPI training in place • RRPI incidents reported via Datix and reviewed by the RRPI team who support teams with management plans and overall learning. • Alternative seclusion exits training rolled out across all Trust mental health and learning disability inpatient wards and included in four-day initial RRPI training	3 Moderate	4 Likely	12	1-6 Clinical Safety and Quality risk	• External peer review commissioned and underway to review RRPI policy, training, overall number of restrictive practices and team model. (DNQ review November 2026) • RRPI lead booked to attend professional practice programme through the Restraint Reduction Network (RRN). (DNQ review November 2026) • Review of the team establishment underway to embed trainers across clinical services. (DNQ review November 2026) • To review the ToR for RRPI TAG to ensure robust oversight of incidents across the Trust. (DNQ review November 2026)	December 2026	Performance & monitoring via Executive Management Team QSC OMG Trust Board	6	BAF SA 2 - Best Quality	November 2026

	es, resulting in potential physical or psychological harm to service users.			• The Trust has a Patient Safety Incident Response Framework (PSIRF) Policy and Plan. • RRPI incidents including the use of prone restraint monitored through IPR QSC, and Trust Board • RRPI Training is British Institute of Learning Disabilities (BILD) accredited.					• Reducing restrictive practice plan under development. (DNQ review November 2026) • Procurement of practice leader training for 16 ward leaders via the restraint reduction network. (DNQ review December 2026) • Local improvements plans developed by care groups to target reductions in seclusion use. (DNQ review November 2026)		Patient Safety report & incident report as well as monthly reporting in the Integrated Performance Report Patient Safety Incident task and finish group Patient Safety Oversight Group			

Organisational level risks within the risk appetite

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1820	The risk that a negative culture may have a detrimental impact on patient safety and quality of care.	**CPO** **CMO** **DNQ**	**QSC** **PRC**	• Weekly Trustwide patient safety oversight group receive all staffing and protected characteristic incidents • Seclusion and Segregation oversight group in place • Safer Staffing reporting into monthly Integrated Performance Report • Incident and quality monitoring in place via Care Group Quality and Governance Groups, and the Clinical Governance Group • Quality assurance system in place coordinated by Quality Governance Team, • Freedom to Speak up concerns reported to AC for oversight and monitoring around culture. • Regular informal and formal meetings with CQC in place include any culture concerns. • Review of themes from complaints • Patient experience annual report presented to Trust Board.	3 Moderate	2 Unlikely	6	1-6 Clinical Safety and Quality risk	• Work from the national Culture of Care Programme is being progressed through the Women's Pathway peer review, Elmdale and Nostell workstreams and ward 18. (CMO/DNQ review November 2026) • A Rapid Improvement Group (RIG) is in place. This is chaired by the COO. The purpose of the time limited group will be to put in actions that address the findings of the forensic cultural review and to involve staff. To be reported to PRC in November, (CPO/COO review December 2026). • Baseline assessment of the six national staff standards to be undertaken by workshops during October to establish a baseline of how the Trusts measures up to the staff standards aimed at improving staff experience. Will work through findings and report to EMT, PRC and subsequently the Board. (CPO review November 2026).	May 2027	Operational Management Group Executive Management Team Clinical Governance Group QSC PRC Trust Board Clinical Strategy Implementation Group	3	Risk level: Risk level <15 Risks outside the risk appetite BAF SA 1	November 2026

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership Teaching NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• Induction process sets out Trust values and behaviours and code of conduct • Guardian of safe working hours reported to Board annually • Medical appraisal and revalidation report submitted to Board and NHSE annually. • Complaint monitoring in place through the IPR • Supervision database in place and part of Trust performance reporting. • Quality concerns trigger tool in place. • Leadership events with managers and leaders and the CEO/DCEO to engage on current Trust challenges • Culture of Care work reported into Patient Safety Oversight Group to ensure issues are escalated • Compassionate leadership is a key priority in the Trust's Clinical Strategy • Regular deep dives are presented to PRC in relation to sickness and other indicators in the forensic care group • People Strategy approved by Trust Board. • Ward Manager Development Programme led by FoNS (Foundation of Nursing Studies) in place. • Culture of Care intranet resource available to staff • Culture of Care report presented to EMT. • A Culture of Care Sandal report developed to demonstrate work undertaken to understand and improve the approach to RRP on Sandal Ward.									
1729	Staff wellbeing may deteriorate leading to increased sickness/absence which will impact on the quality and safety of services	CPO DNQ	PRC	• Occupational health and wellbeing support centre guidance as part of the Workforce Support Hub. • Staff counselling. • Health lifestyle support on Stop Smoking and weight management. • Support and engagement from all staff networks. • Equality Impact Assessment of staff health and wellbeing offer and occupational health. • Effective supervision practices • Data analysis and hot spot reporting Trust wide	3 Moderate	2 Unlikely	6	1-6 Compliance risk	• Actions from the sickness absence reduction plan now underway. Discussions at OMG in August to discuss approach. Review on progress to be monitored at EMT and PRC in November. (CPO review November 2026). • Review of approach to sickness absence with staff side colleagues through workshop approach. Reviewing current policy to ensure it has a focus on managing attendance and supporting staff. (CPO review November 2026) • A HWB offer plan on page has been produced and is being rolled out to staff and managers during September and October. Will review as part of the sickness absence reduction plan review. (CPO review November 2026).	31 March 2027	Safer staffing reports (monthly) Moving forward group PRC	6	BAF SA 2 – Best place to work and learn	November 2026

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership Teaching NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• Sickness absence reduction plan produced in line with NHSE requirements, submitted to NHSE • Communications brief with wellbeing messages for all staff • Annual flu vaccination programme in place • Financial wellbeing information and support available to staff • Wellbeing embedded in recruitment, induction and onboarding initiatives • Wellbeing champions appointed in each of the clinical areas • FTSU processes and culture within the Trust influence staff wellbeing as does work on civility and trauma informed approach. • A focus group approach is in place to identify and support managers to deal with areas of high sickness/absence. • All actions completed following internal audit on management of sickness absence returned an outcome of limited assurance. • Care Groups and HR business partners work together to implement actions from the staff survey action plan. • PRC receives an annual report in relation to staff health and wellbeing as per the Committee Workplan • Health and Wellbeing for staff included in the People Strategy • Significant increase in the number of professional nurse advocates who provide restorative supervision for staff across the Trust. • Violence prevention and reduction group established chaired by DNQ.					• A Rapid Improvement Group (RIG) is being put in place (first meeting on 1st September). This will be chaired by the COO. The purpose of the time limited group will be to put in actions that address the findings of the forensic cultural review and to involve staff. To be reported to PRC in November, (CPO/COO review December 2026) • A peer review of restrictive practices and managing violence and aggression is underway which will potentially lead to further quality improvement work and reduction in the use of restrictive practices and incidences of violence and aggression towards staff. (DNQ review November 2026) • Violence prevention and reduction standards being refreshed. Expected completion by November 2026. (DNQ review November 2026) • Dashboards being developed to identify themes and hotspots to inform interventions. (DNQ review November 2026) • Development of violence reduction strategy to be completed by end of 2026. (DNQ review January 2027)		Operational Management Group Executive Management Team Trust Board			
695	Risk of adverse impact on clinical services if the Trust is unable to achieve the ambitions identified in its strategy	**DS**	**QSC**	• Annual priority programmes in place • Service quality metrics in place • Active engagement in West Yorkshire and South Yorkshire Integrated Care Systems • Regular review against the strategy by Trust Board. • Quality improvement process in place for all significant change. • Active stakeholder management to create opportunities for partnership and collaboration which are reflected in corporate objectives.	3 Moderate	2 Unlikely	6	1-6 Clinical Safety and Quality risk	• August Board Development Session focus on defining the Trust Board's level of ambition. Paper to be presented to TISC in October. (DS review November 2026).	August 2027	EMT (monthly) Transformation board (monthly) Operational Management Group (weekly) QSC	6	Risk level: Organisational level risks within the risk appetite BAF SA 2 – Best Quality	November 2026

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership Teaching NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• Trust-wide integrated change process in place • Internal place integration group established • Stakeholder engagement plans in place. • sustainability impact assessments in place. • Trust clinical strategy includes creative and cultural approaches in clinical services and integrated pathways. • New care includes section on individual needs to ensure disabilities are captured. • Strategy deployment plan, governance approach and measurement approved by Trust Board. • "About Me" visualisation live across all MH community and Inpatient SystmOne units • Trust's approach to digital innovation opportunities revised with strong clinical links following Digital Strategy refresh and 10 year plan • Strategy measurement governance process agreed and received by Trust Board. • A Transformation, Innovation and Sustainability Committee (TISC) oversight of progress against the Trust strategy.						Trust Board			
812	Risk that place based or collaborative commissioning arrangements adversely impact on the quality and sustainability of Trust services.	DS	QSC	• System and service transformation overseen Executive Management Team (EMT) and Board. • Quality Impact Assessment process for value for money Programmes in place. • Contracting and business development team in place • Bi-annual Executive Management Team and Trust Board investment appraisal report • Trust engagement with West Yorkshire and South Yorkshire Integrated Care System (ICS) planning process • Systemwide financial control process in place • West Yorkshire Mental Health and Learning Disability collaborative committees in common in place • Established approach to collating and reporting place-based insight from stakeholders in place.	3 Moderate	3 possible	9	Business risk (8-12)	• To consolidate our place-based expertise and capacity in order to have a role in each of our places as identified under strategic aim of best partner. Given the changing timescales for national policy decision making, this is still ongoing. We have interim arrangements in place and will keep this under review as national timelines become clear. (DS review November 2026) • Proactive engagement in each of our places to understand opportunities and risks associated with the national changes and reduction in ICB funding. (DS review November 2026) • Scoping work underway to determine resources and structure needed to continue to effectively engage in place over the medium term. (DS review November 2026).	August 2027	Bi-monthly focus by EMT on transformation. QSC Executive Management Team (monthly) Trust Board	8	Risk level: Organisational level risks within the risk appetite BAF SA 2 – Best partner	November 2026

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership Teaching NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• Horizon scanning for new business opportunities. • Trust clinical strategy in place with implementation plan • Use of workshops with external stakeholders to co-produce changes. • Executive Management Team regularly review stakeholder plan • Annual contract negotiation process established with each place • Involvement in the Overview and Scrutiny Committees (OSCs) regarding transformation proposals as required. • Trust transformation plans aligned with ICS place based plans • Ongoing relationships with GP Federations to identify opportunities for collaboration and alignment • Trust senior operational colleagues input into place-based community mental health transformation programmes. • Implementation of Trust EDI strategy includes stakeholder engagement									
1217	Risk that the Trust has insufficient capacity to meet its own strategic and system-wide objectives, potentially resulting in the Trust or system not meeting service users' needs	**DS**	**AC**	• Trust strategy in place which identifies strategic ambitions • Annual planning and annual priority setting in place with progress reports via monthly Integrated Performance Report. • Progress against priority programmes overseen via OMG and EMT. • Quality strategy approved and implementation plan established. • Improvement Network established to provide local capacity to support change. • Stakeholder map ensures resource is identified to support developments in place. • Progress against Trust strategy oversight by TISC and Trust Board • Improvement work against strategic aims reviewed at OMG regularly	3 Moderate	4 Likely	12	Business risk (8-12)	• Agree resource availability to support system-wide programmes of work in view of current financial position and how to best focus our resource and energy in view of the changing ICB function. (DS review November 2026) • Respond as required to changes in the NHS system as a result of the publication of the NHS 10-year plan. (DS review November 2026) • Following submission of annual plan further detailed work is taking place to understand key actions to be taken and risks for next year. This review will form part of the annual planning process for 2026/27. (DS review November 2026)	August 2027	Quality Strategy update to QSC AC Operational Management Group (OMG) Executive Management Team (EMT) Trust Board	9	Risk level: Organisational level risks within the risk appetite BAF SA 2 – Best value	November 2026
1432	Risk of lack of workforce planning and talent	**CPO**	**PRC**	• Leadership and management framework in place. • Coaching and mentoring offer in place	3 Moderate	3 Possible	9	Business risk (8-12)	• Undertake review of data to understand staff group shortages at each level as part of EDI action plan for 2026/27. New EDI action plan to be submitted to Board in October. (CPO review November 2026)	31 March 2027	PRC Executive Management Team	8	Risk level: Organisational level risks within	November 2026

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership Teaching NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
	management may lead to gaps in key roles and fail to promote diversity			• New appraisal process form captures information around development and future career planning • Board succession plan reviewed regularly • Comprehensive management and leadership programmes in place • Shadow Board Programme and Reciprocal mentoring programme in place • Internal transfer process established • Work with places and systems to collaborate on integrated career pathways • West Yorkshire new roles group, chaired by chief nurse and director of quality and professions. • Encouraging diversity is part of talent management processes established with support from staff network groups					• Further exercise to identify any gaps in talent and success below EMT level. (CPO review November 2026) • Plans to consider high level workforce planning needs in the organisation. To review in OMG in October 2026. (CPO review November 2026)		Trust Board		the risk appetite BAF SA 2 – Best place to work and learn	
2045	Risk that as structural changes, and changes to the role of NHSE and ICB's take place, there is less focus on mental health, learning disabilities and autism leading to contract funding impacting on the Trust's ability to deliver high quality care	**DFR**	**FIP**	• EMT and Board updated on changes to role of NHSE and ICBs in order to monitor potential impact. • Active engagement in West Yorkshire and South Yorkshire Integrated Care Systems (ICSs) and place-based arrangements. • Contracting and business development functions in place. • Contract negotiation processes in place, in order to agree arrangements for 2026/27 including Mental Health Investment Standard funding • Bi-annual Executive Management Team and Trust Board investment appraisal report. • Regular contact review process in place with commissioners. • Full engagement with ICSs in relation to system finance. • West Yorkshire Mental Health and Learning Disability collaborative committees in common in place. • Established approach to collating and reporting place-based insight from stakeholders in Trust places. • Investment priorities identified by Care Group Directors and discussed with Commissioners to be picked up as part of annual planning.	4 Major	3 Possible	12	8-12 Business risk	• Development of place based provider collaborative and delivery of functions previously delivered by ICBs. A full due diligence checklist has been developed and now needs to be completed. (DFR review November 2026) • Once ICB structural changes are implemented, a review of risk and capacity will be undertaken. (DFR review November 2026)	30 November 2026	Trust Board FIP EMT	9	BAF SA 2 ICB structural changes are in the process of being implemented.	November 2026

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership Teaching NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
2063	The risk that an increase in the use of none designated beds,136 suites and extra care beds to accommodate patients requiring inpatient care, may negatively impact on patient safety and experience and staff capacity and wellbeing, especially if the use of these areas is prolonged as a result of current levels of demand.	**COO**	**QSC**	• Daily multi-disciplinary team meetings for discharge planning • Daily (x 3) patient flow meetings for bed management process and 24 hr bed management • Weekly MADE (Multi agency discharge event) meetings • Weekly ICB escalation meetings • Barriers to discharge meeting with system wide partners • Internal governance flow process with escalations • National improvement programme for patient flow completed. Joint improvement QI project in place with NHSE • Oversight of non-designated beds reviewed weekly at PSOG • Communication that. • Internal oversight from general managers and patient flow managers to ensure the Trust is continually progressing towards compliance with non-designated beds not being used due to bed pressures and only used once clinically indicated	2 Minor	3 Possible	6	Clinical Safety and Quality Risk (1-6)	• Joint ownership within the ICB to look at barriers to discharge such as housing etc (COO review November 2026) • Proposal to be presented to the Quality and Safety Committee in October 2026 to merge this risk with 1839 and 1319. (COO review November 2026)	September 2027	EMT QSC Trust Board	2	Target score is Likelihood of 1 Rare and Consequence 2 Minor	November 2026

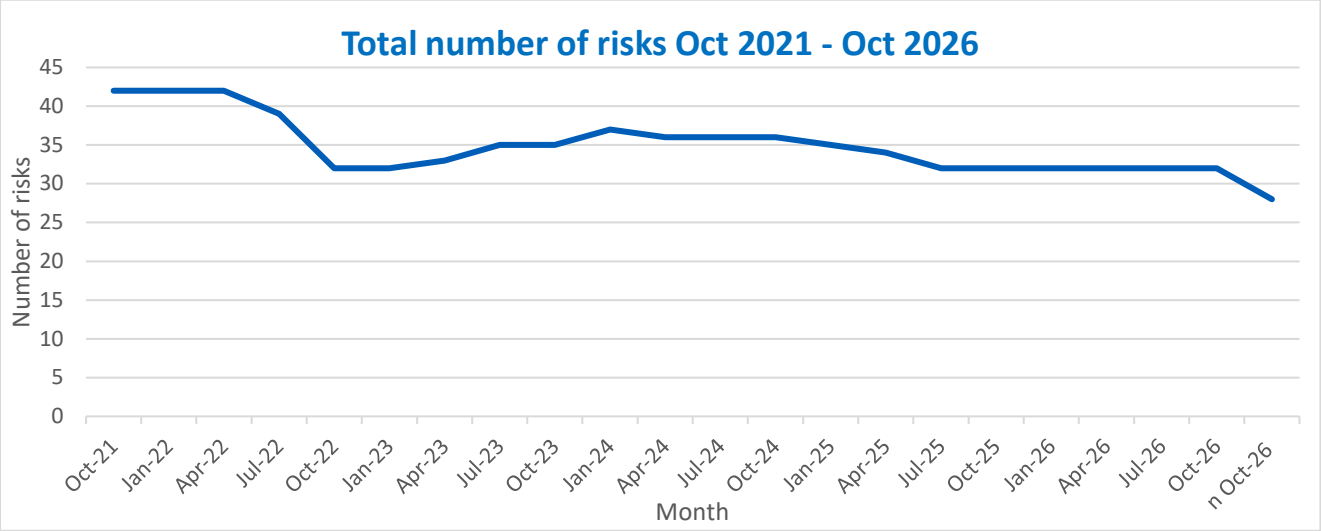
South West Yorkshire Partnership Teaching NHS Foundation Trust

Appendix 1

Trust Board
27 October 2026
Organisational Risk Register (ORR)
Quarter 2 analysis, October 2021 – October 2026

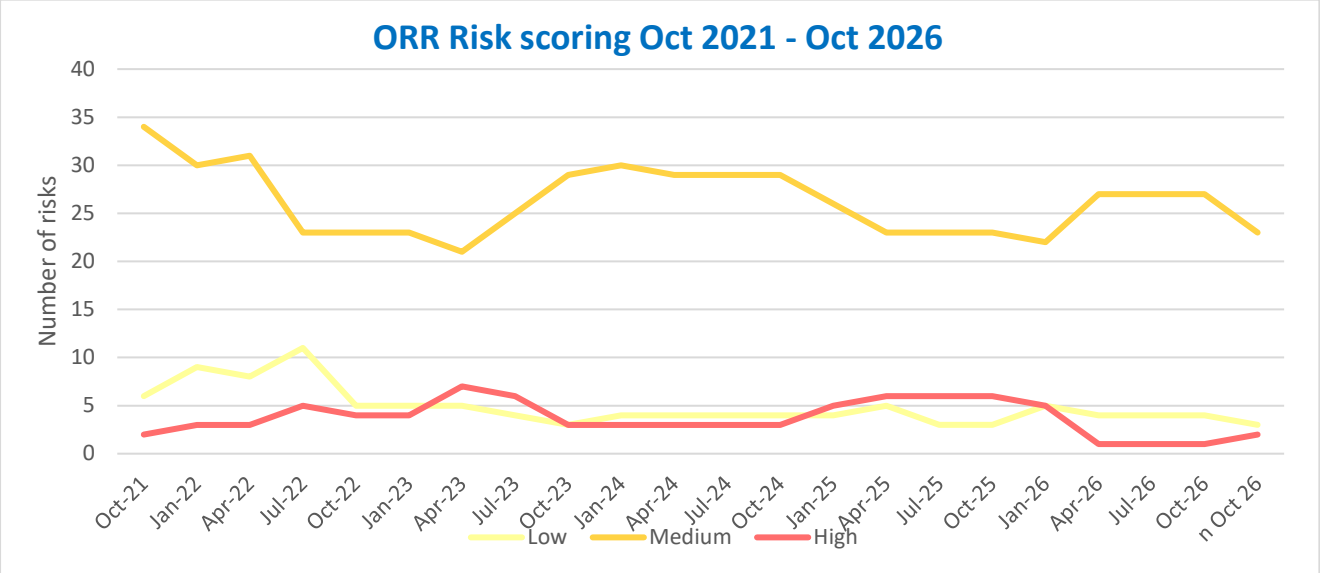
This heat map includes figures from the current Organisational Risk Register from October 2021 to October 2026 to show a longer-term trend. The charts show the current position as well as the projection if the proposals are accepted by Trust Board.

Total number of risks from October 2021 to October 2026



Proposed changes = n October 2026, the total number of risks will reduce to 28 risks.

Total risk by grading from October 2021 – October 2026



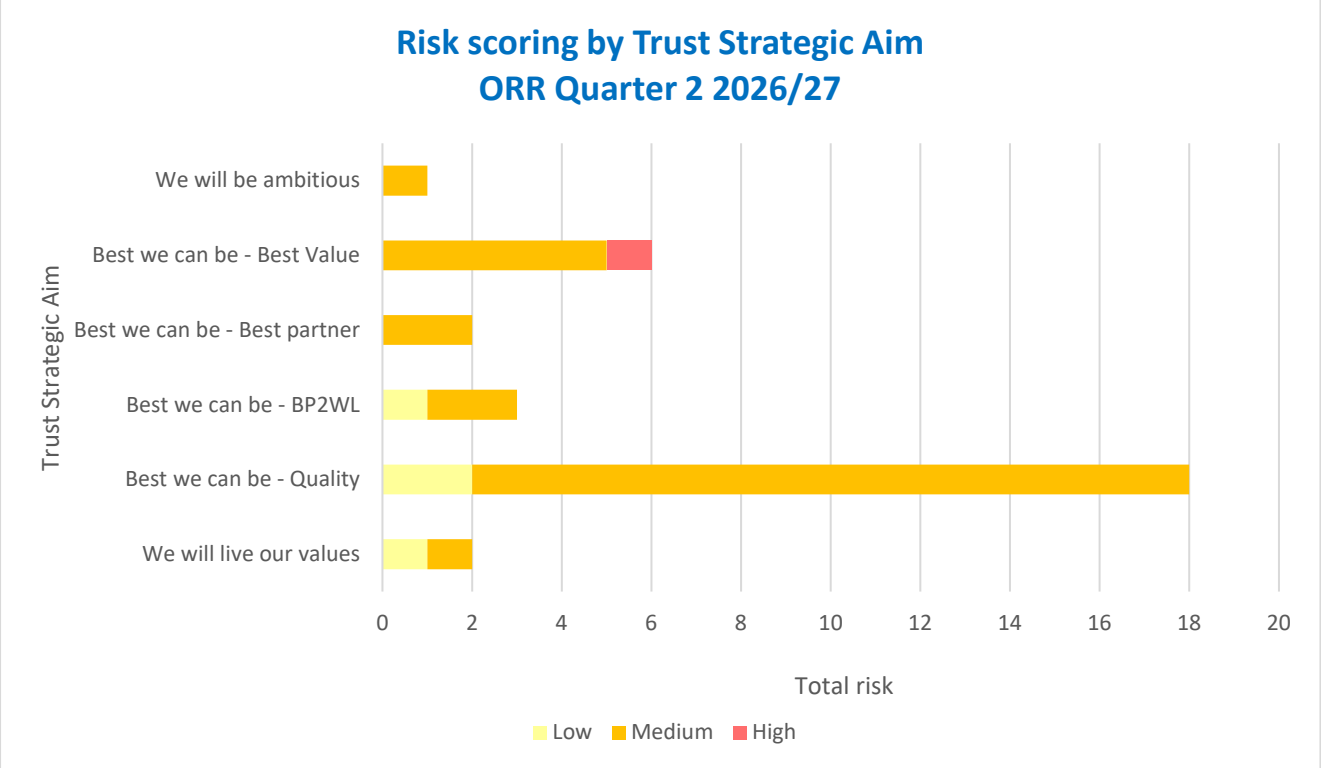
With **all of us** in mind.

Proposed changes = n Oct 2026.

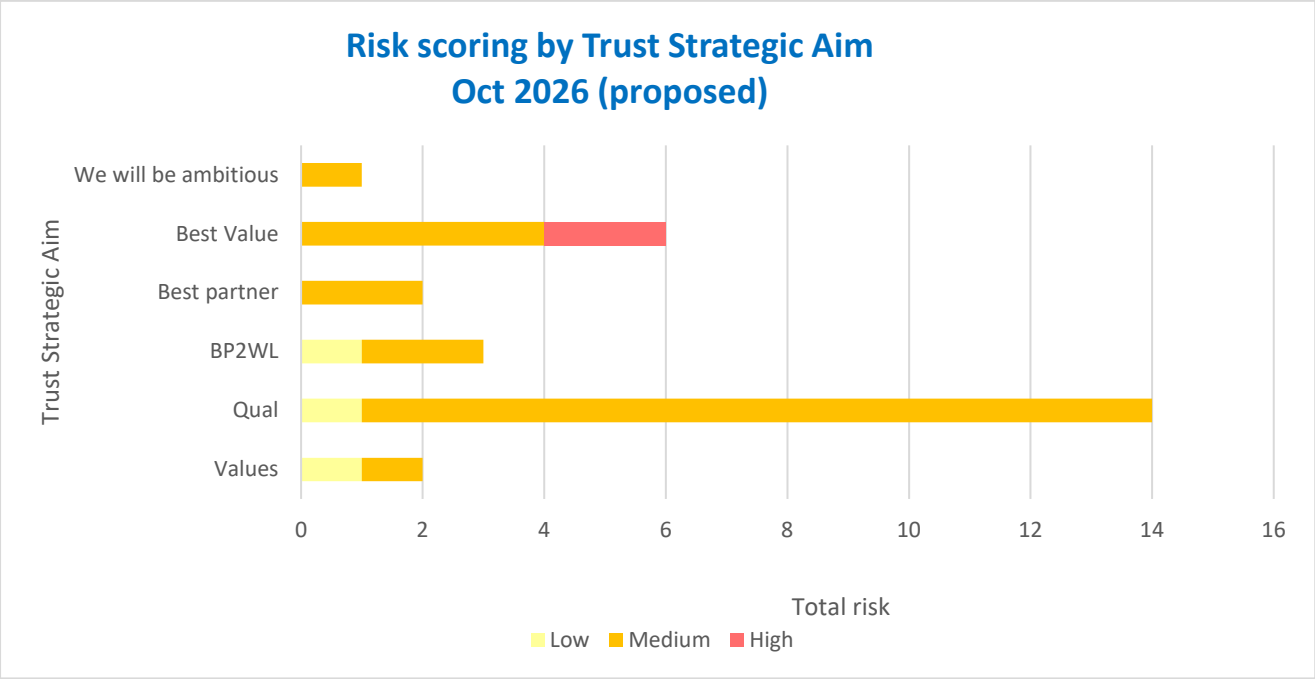
The current accumulative risk score is 309 and this will reduce to 280 if the proposals are accepted.



A current breakdown of Trust strategic aims ORR Quarter 2 2026/27

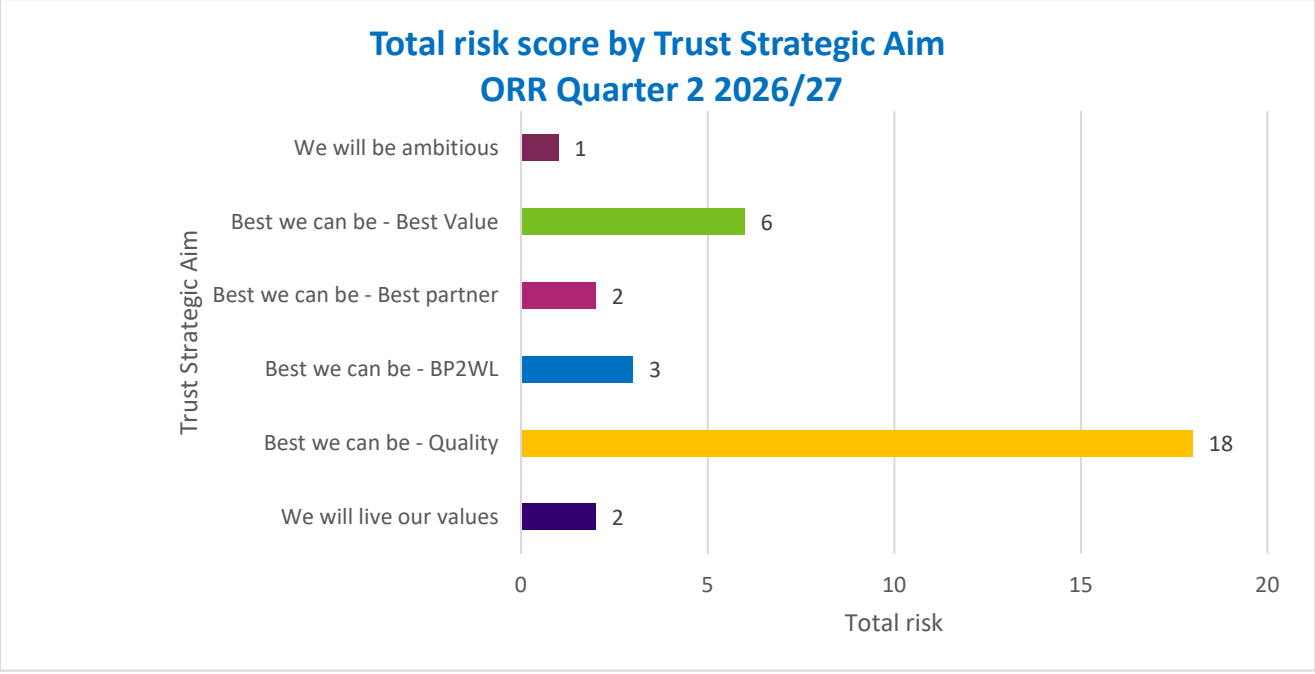


If the proposed changes are accepted:

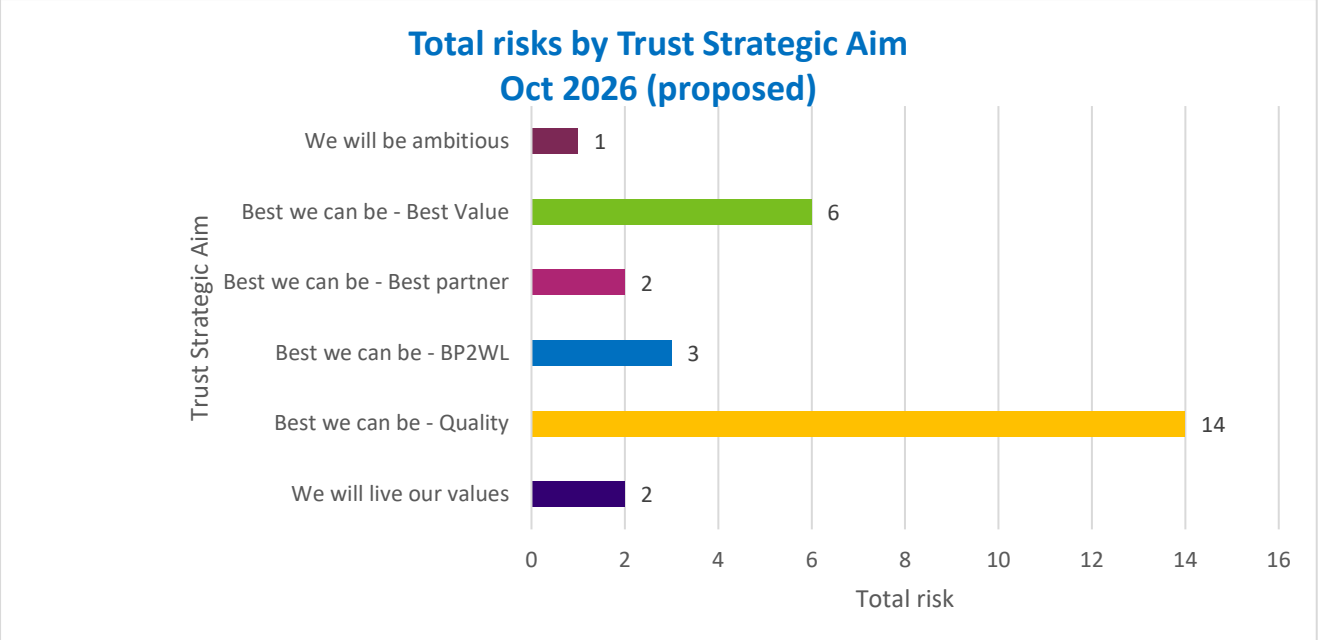


If the proposals are accepted by Trust Board, low (yellow) risks reduce to 3. Medium (amber) risks reduce to 23 risks and high (red) risks increase to 2 risks.

Total number of risks by Trust objectives ORR Quarter 2 2026/27 (current):



Total number of risks by Trust objectives ORR Quarter 2 2026/27 (proposed)



If the proposed changes are accepted by Trust Board, risk alignment to the Trust strategic of Best Quality will reduce by 4 for this quarter.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 10.3

Private/Public paper:	**Public**		
Title:	**Women's Pathway External Review**		
Lead Director:	**Adele Fox, Chief Operating Officer**		
Mission/values:	The draft Women's Pathway supports the Trust's purpose by placing women at the centre of safe, compassionate and personalised care, involving families and carers where appropriate, and using external review and learning to improve quality and outcomes.		
Purpose:	To provide Board members with an overview of the findings set out in the report of the external review of the Women's Pathway.		
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):	The following BAF risks align with this presentation: **2.1** – Services are not accessible to, nor effective for, all communities, especially those most disadvantaged, leading to inequality in health outcomes or life expectancy. **2.3** – Failure to create a learning environment leads to a lack of innovation and repeat incidents. **4.3** – Lack of, or ineffective, co-production, involvement and engagement with communities, service users and carers could result in services that do not meet the needs of the populations we serve.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships.	The review supports system and place-based objectives to improve mental health outcomes, reduce inequalities and deliver safe, personalised and trauma-informed care. Its recommendations emphasise stronger collaboration with commissioners and partners, improved continuity across services, and co-production with women, families and carers.		
Any background papers / previously considered by:	Board members are aware the review.		
Executive summary:	The external review was commissioned following three inpatient deaths, a significant near miss and wider feedback that care for women with complex emotional and relational needs was not as cohesive or effective as it could be therefore risks associated with the pathway. The reviewers visited four female inpatient wards and community services, met with staff, service users, carers		

	and families, and reviewed relevant policies, records, audits and incident investigations. The review identified committed staff, strong engagement and pockets of good practice. Community services generally demonstrated a clear, psychologically informed model, supported by evidence-based interventions, supervision and Trust guidance. Service users valued therapeutic approaches, and examples of effective practice included specialist community in-reach to wards, Multi Service Support Plans and a focus on timely discharge. However, there is currently no clearly defined Trust-wide Women's Pathway, minimum service standard or shared clinical model across inpatient and community services. Key concerns include variation arising from locality and commissioning arrangements; inconsistent language, care planning and access to essential information; limited involvement of service users and carers; differences in risk ownership and approaches to admission and discharge; limited psychologically informed inpatient provision; and gaps in data, training, pathway oversight and assurance that learning from incidents is embedded. Ward environments and extended admissions may also increase risk for some women with complex needs. The review concludes that the Trust has a strong foundation for improvement but requires clearer executive and clinical leadership, co-production and a consistent, trauma-informed and psychologically led pathway. The recommendations include establishing executive leadership and a clinical network; benchmarking against national guidance; developing a standardised pathway, workforce and training plan, and outcome measures; strengthening psychological capacity and transitions between services; standardising Multi Service Support Plans and clinical language; improving data and record quality; and considering a specialist hub and Assessment, Coordination and Engagement function. These actions should support safer, more equitable and coherent care across the Trust.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** the outcomes of the findings of the review of the Women's Pathway of Care conducted by an external review team.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Women's Pathway Review

Board briefing and proposed response

October 2026

Purpose: receive the independent findings, agree the immediate response and confirm governance for delivery.

With all of us in mind.

Purpose and Board ask

South West Yorkshire Partnership Teaching NHS Foundation Trust

Independent review of care for women with complex emotional and relational needs

Receive assurance

- The review used visits, staff and service-user discussions, document review and incident learning.
- It identifies strengths, material pathway gaps and 22 recommendations.

Confirm direction

- Support a Trust-wide, psychologically informed pathway.
- Prioritise safer transitions, standardised practice and meaningful involvement of women and families.

Approve next steps

- Confirm executive sponsorship and delivery leadership.
- Require a costed implementation plan, measurable outcomes and regular Board reporting.

With **all of us** in mind.

Why the review was commissioned

A focused external review following serious patient safety events

South West Yorkshire Partnership Teaching NHS Foundation Trust

Context

- Commissioned following internal reviews of three female inpatient fatalities and one serious near miss.
- Scope narrowed to women with complex emotional and relational needs because of complexity and acuity.

Method

- Four-day programme of ward and community visits in April 2026.
- Discussions with staff, leaders, service users and families, plus review of policies, audits, records and incidents.

Important caveat

- The reviewers describe the work as a snapshot based on a sample . The report therefore provides some assurance but not full assurance , while still identifying consistent themes requiring action.

With **all of us** in mind.

What is working well

A strong foundation exists, particularly in community services

South West Yorkshire Partnership Teaching NHS Foundation Trust

People and culture

- Staff were open, constructive and motivated to improve.
- Service users described structured therapeutic approaches and skills as helpful.

Clinical practice

- Community teams described Structured Clinical Management and DBT-informed approaches.
- Accessible supervision, Trust guidance and specialist in-reach provide useful support.

Learning and governance

- Incident reviews were described as comprehensive and compassionate, with family views included.
- Risk assessment, care planning and therapeutic risk guidance provide a sound policy base.

Estates and local initiatives

- Ward cleanliness and maintenance were commended.
- Examples include specialist in-reach, discharge-focused questioning and short-term post-discharge support.

With **all of us** in mind.

Principal gaps and risks

The central issue is fragmentation across pathway interfaces

South West Yorkshire Partnership Teaching NHS Foundation Trust

Strategy and equity
• No defined women's pathway; commissioning differences contribute to variation in offer.

Clinical model
• Community practice is more psychologically informed; inpatient care was described as more medically focused.

Transitions and risk
• Different views about admission, discharge and ownership can delay flow and weaken continuity.

Workforce and data
• Insufficient demand, caseload, skills and training analysis to support workforce planning.

Care planning
• Inconsistent naming, storage, ownership, review and use of Multi Service Support Plans.

Environment
• Different ward layouts and size create challenges for therapeutic care, observation and engagement.

Safety, experience and pathway implications

The review highlights avoidable variation and weak interfaces

Safety

- Purpose of admission and expected discharge date were not always clear.
- The report identifies inconsistent use of lanauage to describe care plans and support plans.
- Assurance that incident actions are embedded was less robust in relation to neurodiversity.

Experience

- Women and families reported gaps in women-specific, trauma-informed and neurodiversity-informed care.
- Family involvement in care and safety planning was not consistent.
- Availability of female staff was raised by service users.

Flow

- Lack of a shared model contributes to tension between inpatient and community teams.
- Longer stays may increase risk for some people with complex emotional needs.
- Alternatives, rapid review and trusted assessment require development.

The 22 recommendations

Delivery spans immediate stabilisation, pathway development and longer-term redesign

South West Yorkshire Partnership Teaching NHS Foundation Trust

0–3 months | 7

- Name executive and delivery leads.
- Map the current pathway.
- Standardise good practice and language.
- Introduce rapid review arrangements.

3–6 months | 8

- Benchmark guidance and capacity.
- Establish the clinical network.
- Strengthen involvement in support plans.
- Introduce solution-focused pathway meetings

6+ months | 7

- Develop the clinical model, workforce plan and outcome measures.
- Report outcomes to Board.

Note: the recommendation list totals 7 short, 8 medium and 7 long-term actions. This corrects the numerical summary in the report.

With **all of us** in mind.

Proposed first 90-day response

South West Yorkshire Partnership Teaching NHS Foundation Trust

Convert the review into a controlled, measurable improvement programme

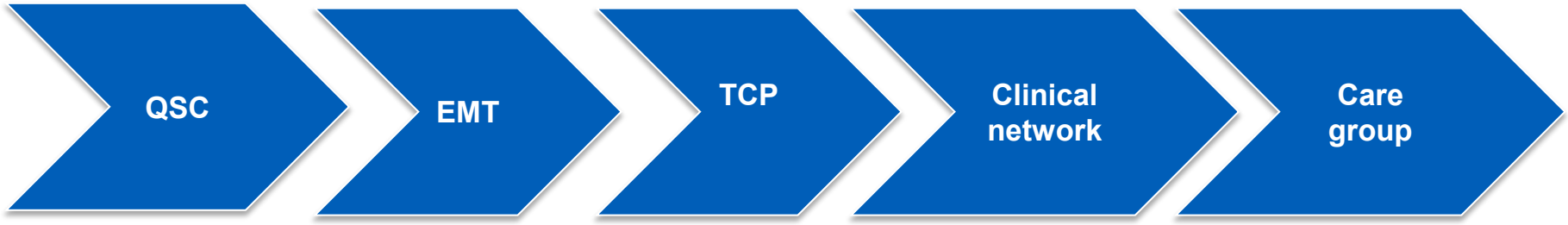
1	**Leadership**	Confirm Executive Lead; appoint Director, Clinical and Involvement leads.
2	**Safety controls**	Standardise support plan terminology, location, ownership and review expectations.
3	**Rapid review**	Introduce an urgent cross-pathway review mechanism for material change or variance.
4	**Pathway map**	Map entry, crisis, admission, inpatient care, discharge and community follow-up.
5	**Baseline**	Establish demand, caseload, incidents, length of stay, readmission, training and psychology capacity.
6	**Governance**	Create a clinical network and programme board with milestones, risks and benefits.

With **all of us** in mind.

Proposed governance and assurance

Clear ownership, staged decisions and outcome-based reporting

South West Yorkshire Partnership Teaching NHS Foundation Trust



QSC	EMT	TCP	Clinical network	Care group
Strategic direction, resources and assurance	Executive oversight and barrier removal	Delivery, risk, dependencies and benefits	Clinical model, standards and co-production	Implementation, local assurance and escalation

Board assurance measures

- Safety: self-harm incidents, serious incidents and evidence that learning is embedded. Flow: admissions, length of stay, readmissions and discharge delays.
- Quality and experience: care-plan compliance, involvement, access to psychological interventions, workforce capability and outcome measures.

With **all of us** in mind.

Decisions requested of the Board

South West Yorkshire Partnership Teaching NHS Foundation Trust

Support a proportionate response that strengthens safety now and builds the future pathway

The Board is asked to:

- Receive the findings and note the report's some assurance caveat.
- Endorse the proposed direction of travel toward a Trust-wide, women-centred and psychologically informed pathway.
- Confirm the Executive Lead and require a named delivery leadership trio.
- Approve development of a costed implementation plan with quality impact, equality impact and workforce implications.
- Request an initial progress report within 6 months via QSC, followed by agreed routine reporting on delivery, risks and outcomes.

Recommended position: endorse the immediate actions, while reserving decisions on major service or estate redesign until options, evidence, costs and impacts are fully appraised.

With **all of us** in mind.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 10.4

Private/Public paper:	**Public**		
Title:	**CQC Inspection of Community CAMHS: Summary of Initial Feedback and Trust Response**		
Lead Director:	**Chief Nurse / Director of Quality and Professions**		
Mission/values:	The paper reflects our commitment to be honest, open and transparent, respectful, person first and in the centre, and to improve and be outstanding through compassionate care, responsive action and continuous learning.		
Purpose:	To provide Trust Board with the preliminary feedback from the CQC inspection of Community CAMHS services in Barnsley, Wakefield and Kirklees, and assurance on the Trust's initial response and next steps.		
Strategic aims:	Live Our Values	✓	The paper supports the Trust's strategic focus on high-quality, compassionate and collaborative care, effective partnership working, and being a supportive place to work and learn.
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	The following BAF risks align with this paper **2.2** The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives. **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. **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. **5.2** Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships.	The paper supports system and place-based objectives for accessible, safe and joined-up children and young people's mental health services. The feedback provides positive assurance on partnership working with third-sector organisations and jointly commissioned single points of access.		

Any background papers / previously considered by:	CQC preliminary feedback following inspection visits to Community CAMHS services in Barnsley on 29 September 2026, Wakefield on 30 September 2026 and Kirklees on 1 October 2026; Care Group initial action plan at Appendix 1.
Executive summary:	The CQC undertook short-notice inspection visits to Community CAMHS services in Barnsley, Wakefield and Kirklees between 29 September and 1 October 2026. The feedback received to date is preliminary and should not be interpreted as the CQC's final findings or regulatory judgement. A draft inspection report will be issued for factual-accuracy review. Initial feedback was positive about staff engagement and local leadership, the quality and currency of care plans, integrated working across CAMHS teams, partnership working with third-sector services, and the warm, compassionate and collaborative approach observed in care delivery. The CQC identified matters requiring action or clarification relating to the recording of parental responsibility and Gillick competence in SystmOne, security of a clinic room in Barnsley, availability of clinical rooms in Wakefield and Kirklees, and consultant psychiatrist provision for the Calderdale and Kirklees Crisis Team. The Barnsley environmental risk has been addressed through installation of a fully operational fob-access system. The Care Group is seeking clarification of the consent-recording finding before making any system change. Room availability and booking arrangements remain under review, and the Crisis Team will review its clinical operating model and requirements for consultant psychiatrist support. The Care Group action plan will be monitored through established governance arrangements and reviewed when the draft inspection report is received. The final CQC report and completed or revised action plan will be reported through the Trust's quality governance route.
Recommendation:	**Trust Board members are asked to:** • **NOTE** the preliminary CQC feedback and take **ASSURANCE** that the feedback has been immediately acted upon where required.

CQC Inspection of Community CAMHS

Summary of initial feedback and Trust response

1. Introduction

The Care Quality Commission undertook inspection visits with 1 day notice to Community CAMHS services in Barnsley on 29 September 2026, Wakefield on 30 September 2026 and Kirklees on 1 October 2026. Following the inspection they provided preliminary feedback via email however, this should not be interpreted as the CQC's final findings or regulatory judgement. A draft inspection report will be issued in due course, at which point the Trust will have the opportunity to check its factual accuracy.

2. Feeback Received

The initial feedback was positive about the quality of staff engagement, care planning and collaborative working across the services visited. Inspectors described staff as warm and compassionate in their interactions with young people and families. Staff also spoke positively about working for the Trust and reported feeling valued and supported by local management.

Inspectors identified a small number of areas requiring clarification or further action. These related to the recording of parental responsibility and Gillick competence within SystmOne, security of a clinic room in Barnsley, availability of clinical rooms in Wakefield and Kirklees, and consultant psychiatrist provision for the Calderdale and Kirklees Crisis Team.

The Care Group has developed an initial action plan in response (appendix 1). Immediate action has been taken where a clear environmental risk was identified, with further review and clarification under way for the remaining matters.

2.1 Positive feedback

The key areas of positive feedback were:

- **Staff experience and local leadership:** Staff spoke positively about working within SWYT CAMHS and described feeling valued and supported by local management.
- **Care planning:** Care plans reviewed across the locations were up to date and contained the relevant information required by the teams involved in the young person's care.
- **Integrated working:** Inspectors found evidence of effective working between core, crisis and specialist CAMHS teams.
- **Partnership working:** Positive links were identified with third-sector services, including organisations involved in jointly commissioned single points of access.

- **Compassionate and collaborative care:** During observations, staff demonstrated a warm and compassionate approach and worked collaboratively with young people and families to understand their needs and identify appropriate support.

2.2 Areas identified for action or clarification

Recording of parental responsibility and Gillick competence

Across the sites visited, inspectors raised concerns about how parental responsibility and Gillick competence are recorded within SystmOne. Although young people's consent was evidenced within the care record, this was not immediately clear during the initial review. The Care Group has requested further discussion with the CQC inspector to understand this finding fully and intends to address any factual issues through the formal factual-accuracy process.

The Trust's current Consent to Care, Treatment and Discharge Tool was developed through a dedicated task and finish group, with legal and clinical safety input, and is supported by training and e-learning. Following the feedback, the Head of Quality for CYPMHS has reviewed the matter with the Clinical Legislation Manager and Health Intelligence Analyst. The current position is that no system change will be made until the finding has been clarified and the draft report received.

Security of the Barnsley clinic room

At the Barnsley site, inspectors identified that a clinic room was not restricted by fob access. This created the potential for visitors to enter the room and access its contents, including sharps, without staff knowledge.

A fob-access system has subsequently been installed and is fully operational. This action is complete.

Availability of clinical rooms

At the Wakefield and Kirklees sites, staff described difficulties securing rooms for regular clinical sessions. Management advised that community venues are also used to support service delivery.

The Care Group's initial response includes continued use of appropriate community settings and reinforcement of room-booking and cancellation processes.

Consultant psychiatrist provision

Concerns were raised in relation to the absence of dedicated consultant psychiatrist provision for the Calderdale and Kirklees Crisis Team. Inspectors were advised that, when consultant input was required, prescribing clinics could need to be rearranged.

The Crisis Team will undertake a review of clinical operational practice to establish the team's support requirements in relation to consultant psychiatrist input.

3. Assurance and next steps

The initial feedback provides positive assurance regarding staff culture, compassionate practice, care planning and multidisciplinary and partnership working. The environmental issue identified at the Barnsley site has been addressed promptly.

Further assurance is required in relation to:

- the clarity and accessibility of consent information within SystmOne;
- the sustainable availability of suitable clinical accommodation in Wakefield and Kirklees; and
- whether current consultant psychiatrist arrangements provide sufficient and timely support to the Calderdale and Kirklees Crisis Team.

The Care Group action plan will be monitored through the appropriate governance arrangements. It should be reviewed and updated once the draft inspection report is received, including any changes arising from the factual-accuracy process. The final CQC report and the completed or revised action plan will be reported through the Trust's established quality governance route.

4. Recommendation.

The Board is asked to note the initial CQC feedback, including the positive findings relating to staff, care planning and collaborative practice; receive assurance that immediate action has been taken to secure the Barnsley clinic room; and note that further review and clarification are under way in response to the remaining matters. The Board should also note that these are preliminary findings and that a further update will be provided following receipt and factual-accuracy review of the draft CQC report.

Appendix 1

CQC inspection of South West Yorkshire Partnership Teaching NHS Foundation Trust – Community CAMHS response to initial inspection feedback

Item	Subject	CQC Initial Feedback	Trust Response
1.	Barnsley site clinic room	The clinic room was open access and was not fob access only. This meant that visitors could access this room and its contents such as sharps without staff knowledge.	The FOB access system has been installed and is now fully operational.
2.	Use of Parental Responsibility (PR) and Gillick Competency.	We found that if PR was chosen on SystmOne Gillick competency could then not also be chosen.	The Care Group has requested to meet with the CQC inspector to understand this finding. This matter will be addressed once the report has been received via factual accuracy. The 'Consent to Care, Treatment and Discharge Tool' was developed by a dedicated Task and Finish group with the support of the Trust legal department and launched in 2022. The tool was approved via the Trust Clinical Safety Design Group. Training was delivered with the support of the Clinical Legislation Manager. There has subsequently been the development of an E learning package. The Head of Quality (CYPMHS) met with the Clinical Legislation Manager and Health Intelligence analysist since the CQC feedback and it was agreed no further action is to be taken at this time as the tool is consistent with Trust policy and in law, health professionals only need the consent of one appropriate person before providing treatment.
3.	Room availability	At the Wakefield and Kirklees sites concerns were raised around room	Community settings are also utilised to manage this, and staff are reminded about booking and cancellation processes.

Item	Subject	CQC Initial Feedback	Trust Response
		availability and finding it difficult to book rooms for regular sessions.	
4.	Consultant provision	Across the Calderdale and Kirklees Crisis team concerns were raised about the lack of a dedicated consultant for the team meaning when a consultant was required prescribing clinics were rearranged.	The Calderdale and Kirklees Crisis team are to undertake a review of clinical operational practice to understand what the support requirements of the team are in respect of the Consultant Psychiatrist.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
29 September 2026
Agenda item 10.5

Private/Public paper:	**Public**		
Title:	**Learning from Healthcare Deaths Report for 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 report is to provide assurance and oversight of patient safety activity in South West Yorkshire Partnership Teaching NHS Foundation Trust in line with the Patient Safety Incident Response Framework (PSIRF). The report also provides assurance regarding safety incidents overview, emerging themes/trends and learning and improvement and updates on wider patient safety activity. It also provides assurance that learning from healthcare deaths arrangements are in place. This report will be published on the Trust website once approved by Trust Board.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	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:	Quality and Safety Committee and Trust Board have previously received quarterly and annual patient safety oversight reports, learning from healthcare deaths reports and patient safety updates. The Quality and Safety Committee reviewed this report in September 2026.		

With **all of us** in mind.

Executive summary:	**Key Issues and Assurance** • Between 1 April and 30 June 2026, 513 deaths were identified on Trust clinical systems where there had been contact within 180 days of death. Of these, 110 deaths were reported and reviewed, with 69 meeting the Trust's criteria for inclusion within the mortality review process. • Statistical Process Control analysis demonstrates common-cause variation in both overall reported deaths and deaths within scope for review, providing assurance regarding the stability of reporting processes. • All in-scope deaths have received a proportionate review in line with Trust policy, with escalation to Structured Judgement Review (SJR), LeDeR or other learning responses where indicated. • Five inpatient-category deaths required Structured Judgement Reviews and these remain in progress. Findings and learning will be reported in the Quarter 2 report. • Learning Disability mortality arrangements remain established, with 11 deaths notified through the LeDeR programme and ongoing work to improve access to external review findings across the region. • Mortality governance arrangements have been strengthened through the re-establishment of monthly mortality review meetings, thematic learning forums and revised PSIRF processes. **Risks and Mitigations** The report identifies several areas requiring continued monitoring: • Delays in receiving confirmed causes of death may affect the timeliness of final conclusions and thematic learning. Cases remain open to review should further information emerge. • comparison and interpretation of trends. Assurance is therefore triangulated through review quality, timeliness, learning and action implementation. • Limited access to completed LeDeR reviews from West Yorkshire ICB restricts the Trust's ability to fully triangulate external learning, and work is underway to establish an agreed information-sharing process. **Equality and Quality Impact** The report highlights the significant health inequalities experienced by people with severe mental illness and learning disabilities and confirms the Trust's commitment to using mortality reviews to identify inequalities, improve physical healthcare outcomes and strengthen preventative care. Further work is planned to introduce cumulative inequalities monitoring within mortality reporting from Quarter 2 2026/27
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** and to **NOTE** the next steps identified.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Learning from Healthcare Deaths Report

Cumulative data covering the period 1/4/2026 – 30/6/2026

Prepared by Patient safety support team

1. Introduction

Learning from deaths remains a national priority. The Trust has maintained a Learning from Healthcare Deaths policy since 2017. The policy reflects the National Quality Board's framework for identifying, reporting, reviewing, investigating and learning from deaths in care, including transparent reporting to the Board and meaningful engagement with bereaved families and carers.

While many people receive high-quality care in the weeks, months and years before death, there remain important opportunities to learn where care may not have met expected standards or where system factors contributed to outcomes. National evidence highlights marked inequalities in premature mortality. People living with severe mental illness have a life expectancy 15–20 years shorter than the general population, largely because of preventable physical illness. Adults with a learning disability die nearly 20 years younger than the general population, and many deaths occur from conditions that could have been treated or prevented. These inequalities reinforce the need for mortality review arrangements to examine physical healthcare, access to preventive interventions, reasonable adjustments, transitions between services and wider system factors, and to translate identified learning into measurable improvement (NHS England, 2024; NHS England, 2025; LeDeR, 2023).

More broadly, national mortality data continues to demonstrate significant variation and inequality in outcomes, reinforcing the importance of robust review processes and system learning (ONS, 2025).

In response, the Trust adopts a broad and inclusive approach to reviewing deaths, ensuring that opportunities for learning are maximised, particularly in relation to health inequalities, physical health, and the quality of care provided across systems.

The Trust continues to work collaboratively with partners across the North of England to develop and strengthen its approach. All reportable deaths are reviewed in line with Trust policy, with a strong emphasis on engagement with families and carers, recognising the valuable insights they provide in understanding care and identifying learning. A representative from the Patient Safety Support Team attends quarterly regional mortality meetings to support the sharing of learning and best practice across organisations.

This Learning from Deaths report alongside the Patient Safety Oversight Report which the Board reviewed in September 2026 forms part of the Trust's wider arrangements for patient safety oversight and assurance to the Trust Board.

2. Scope

The Trust has systems in place to identify and capture the known deaths of its service users on its electronic clinical information system. The Learning from Deaths policy sets out which deaths are reportable, how deaths are responded to and reviewed, and how the Trust engages with bereaved families and carers.

For core reporting purposes, the Trust is deemed the main provider of care if, at the time of death, the patient met one or more of the following criteria:

1. An episode of inpatient care within our service.
2. Patient discharged from SWYPFT inpatient bed in the 30 days prior to death.
3. An episode of community treatment due to identified mental health, learning disability or substance misuse needs.
4. A Community Treatment Order.
5. A conditional discharge.
6. An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
7. Guardianship
8. Deprivation of Liberties legislation (DOLS)

It should be noted that there will be some overlap in reporting with other providers due to complexities in healthcare provision.

Each reported death that meets the scope criteria is reviewed in line with the three levels of scrutiny adopted by the Trust, consistent with National Quality Board guidance.

All in-scope deaths are considered using one of the following levels of review:

1. Death Certification

- Review of the cause of death as certified by the attending doctor.
- In some cases, the Trust may only be notified that the death was certified or referred to the Coroner, without detailed information regarding the cause.

2. Case Record Review

Proportionate review of the clinical record to identify learning, including:

- Manager's Service Learning Review
- Structured Judgement Review (SJR) where a more in-depth assessment of care is required

3. Learning Response

Where a patient safety incident is identified and further understanding is required, the Trust may commission a proportionate, system-based learning response in accordance with its Patient Safety Incident Response Policy and Plan. Selection of the response should be informed by the potential for learning and improvement rather than by a fixed severity threshold and should include compassionate engagement with those affected. Methods may include:

- After Action Review (AAR)
- Patient Safety Incident Investigation (PSII)
- Learning from Lives and Deaths Reviews (LeDeR) (for people with learning disabilities and/or autism)
- Other external reviews, such as safeguarding reviews

Reported deaths predominantly relate to people who died while receiving community care or within six months of their last contact. Each reported death is screened against the Trust's scope and escalation criteria. Where concerns, family questions, potential problems in care or recurring themes are identified, the Trust selects a proportionate review or learning response and considers whether immediate safety action is required. Findings are aggregated through mortality governance to support thematic analysis, improvement and Board assurance.

Annual Cumulative Dashboard[1] Report 2026/27 covering the period 01/04/2026 – 30/06/2026

A summary of deaths reported in the year 2026/27 to the end of Quarter 1 is presented in table 1. A total of 513 deaths were identified on the Trust's clinical systems where there had been contact within 180 days prior to death, which is broadly consistent with the previous quarters (at the date of extract 31/7/26).

Of these, 110 deaths were reported on Datix and reviewed in line with Trust policy. Sixty-nine met the Trust's criteria for inclusion in the mortality review dataset and 41 were reviewed but were outside scope. This reconciles to the 110 deaths shown in Table 1.

Table 1 Summary of 2026/27 Annual Death reporting by financial quarter to 30/06/2026

Reporting criteria		2025/26 Total	26/27 Q1	26/27 Q2	26/27 Q3	26/27 Q4	2026/27 Total
1	Total deaths identified on SWYPFT clinical systems where there had been system activity within 180 days before death	2125	513				
2	Deaths reported on Datix by staff, by reported date, and reviewed	390	110				
3	Deaths within the Trust's scope	277	69				
4	Deaths reported on Datix but outside the Trust's scope	113	41				

Figure 2 presents two Statistical Process Control (SPC) charts for the 24-month period to 30 June 2026, showing:

- All deaths reported (by reported date)
- Deaths identified as being in scope for further review

The chart for all reported deaths shows common-cause variation over time. Although reporting increased in January 2025, the chart did not identify a special-cause signal. This supports continued routine monitoring; it does not, by itself, determine whether individual deaths require review or exclude the possibility of themes within the underlying cases.

The chart for deaths in scope also shows common-cause variation within the displayed limits. This provides assurance about the stability of reporting volumes, but should be considered alongside review quality, timeliness, family involvement, thematic findings and evidence that learning has led to sustained improvement.

[1] Dashboard format and content as agreed by Northern Alliance group.

Figure 2 Statistical Process Control charts for all deaths reported in the 24-month period up to the end of the financial quarter by date reported and all deaths which were in scope for further review

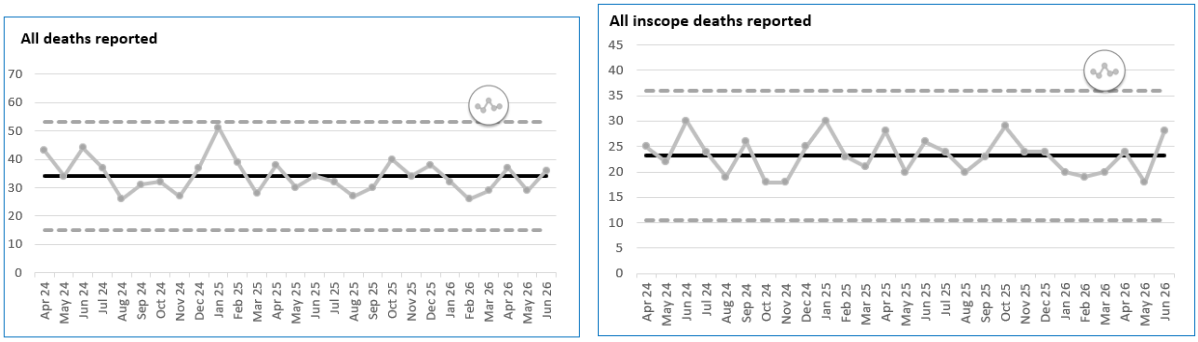


Table 2 shows the distribution of 69 deaths in scope for review during Quarter 1 2026/27 across Care Groups. The majority of in-scope deaths relate to Mental Health Community services (51; 74%) , reflecting the nature of the Trust's service provision, where most patients receive care in community settings. Smaller numbers are seen across Mental Health Inpatient services (6); Learning Disability services (10); Barnsley physical health and wellbeing (1) and Children and Young People's Mental Health (1); Forensic Services including Cheswold Park Hospital had no deaths reported.

Quarter 1 reporting volumes are broadly consistent with the distribution expected from the Trust's service model. However, the small numbers in several care groups limit meaningful comparison. Assurance should therefore be drawn from triangulation with completeness of reporting, review timeliness, identified themes and evidence of completed improvement actions rather than from volume alone.

Table 2 Breakdown of the total number of deaths in scope for review in 2026/27 by Care Group by financial quarter

Financial quarter - date reported	Barnsley Physical Health & Wellbeing Care Group	Mental Health Care Group (Inpatient)	Mental Health Care Group (Community)	Forensic Services Care Group	Cheswold Park Hospital	Learning Disability and ASD/ADHD Care Group	Children & Young People Mental Health Care Group	Total
2026/27 Q1	1	6	51	0	0	10	1	69
2026/27 Q2								
2026/27 Q3								
2026/27 Q4								
Total	1	6	51	0	0	10	1	69

Table 3 records the learning response for each of the 69 in-scope deaths. All deaths first receive a Service-Learning Review; the categories are therefore not cumulative and should not be added as separate review activities. Where a subsequent response is selected, this is

shown as the principal outcome. LeDeR is an external review process that runs alongside, and does not replace, the Trust's own mortality review or patient safety incident response.

The data is refreshed throughout the year to ensure it reflects the most up-to-date position, including any changes following confirmation of cause of death or progression of review processes.

Table 3 Summary of total number of all in scope deaths in 2026/27 by the respective level of mortality review process

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review		Level 3: Learning Response				
	Certification of death	Service Learning Review (1st stage case note review)	Structured Judgment Review (SJR)	After Action Review	Patient Safety Incident Investigation (PSII)	Learning Disability Death process (LeDeR)	Other reviews	Total
2026/27 Q1	12	41	5	0	0	11	0	69
2026/27 Q2								
2026/27 Q3								
2026/27 Q4								
Total	12	41	5	0	0	11	0	69

Learning Disability deaths

The Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR) programme supports local service improvement and reduction of health inequalities. Integrated care systems complete standardised reviews for people with a learning disability and autistic people whose deaths are notified at age 18 or over. LeDeR is not a substitute for the Trust's own mortality review or patient safety incident response; relevant processes should be coordinated and learning shared. Further information is set out in NHS England's Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR) Policy 2021.

It should be noted that the figures in the sections below may not tally with the numbers reported by care group (in table 2 above). This is because we identify Learning Disability and Autism diagnosis by a field on Datix to determine if any patient who died had a learning disability and/or autism diagnosis, irrespective of where they were cared for at the time of death.

Table 4 shows 12 deaths in Quarter 1 involving people recorded as having a learning disability and/or autism diagnosis and who had current Trust contact or contact within the previous six months. Eleven adult deaths were notified to LeDeR: ten by the Trust and one by another organisation. One death involved a person under 18 and was therefore outside the adult LeDeR review pathway; relevant child death review requirements continue to apply.

The Trust routinely consults with the LeDeR system to ensure any death that we are aware of is reported to the national LeDeR team. Where a death has not already been reported to LeDeR, we will ensure this occurs irrespective of the level of contact with the Trust. Table 4 shows that there was one occasion when a death had already been reported by another provider.

Table 4 Summary of total number of in scope deaths in 2026/27 by the Review process (including people with Learning Disability and/or Autism diagnoses)

	Reported to Learning Disability Death process (LeDeR)	Reported on LEDER by another organisation	Not reportable to LEDER as under 18 years of age	Total
2026/27 Q1	10	1	1	12
2026/27 Q2				
2026/27 Q3				
2026/27 Q4				
Total	10	1	1	12

The 11 deaths reported to LeDeR are broken down as follows:

- Ten people were under the care of learning disability teams, or had been within the previous six months, and had a learning disability and/or autism diagnosis.
- One person was under the care of an Enhanced Team
- Nine of the 11 people who died had a learning disability diagnosis
- One person had an autism diagnosis
- One person had both a learning disability and autism diagnosis

LeDeR reviews are led by colleagues outside of the Trust services, predominantly led by an Integrated Care Board (ICB). This gives the reviews objectivity and the ability to have oversight of the whole care provision of the person who has died. As these reviews can take some time to conclude, we ask managers to complete the Service Learning Review to ensure any internal learning and reflection can take place at a much earlier stage.

Across the regions of West and South Yorkshire, a process is established for the reviewing of all deaths under the LeDeR framework. South Yorkshire ICB routinely share outcomes of completed reviews with the Patient Safety Support Team.

South Yorkshire ICB have recently provided their latest report which covers LeDeR reviews concluded in Quarter 1. Findings from reviews in the Barnsley area (which will include Acute care provision) found a predominantly positive picture of care, with evidence of effective multidisciplinary working, ongoing primary care involvement and implementation of reasonable adjustments to support access to healthcare. LeDeR reviews demonstrated good engagement with specialist services, routine monitoring of long-term conditions and coordinated transition arrangements where required. Positive examples included individualised approaches to communication and clinical procedures, regular health monitoring and collaborative working between health, social care and education services.

There was positive practice in a case demonstrating appropriate use of reasonable adjustments to support blood tests, whilst another case identified positive engagement with multiple agencies, including mental health and criminal justice services.

The principal learning theme across Barnsley reviews related to preventative healthcare. There were some cases which identified limited evidence regarding uptake of influenza and COVID-19 vaccinations and reinforced the importance of proactive follow-up, recording of invitations, refusals and reasonable adjustments to support access. A further theme related to family engagement within the review process, where invitations were issued but family contributions were not obtained, reducing opportunities to gain additional insight and learning from lived experience. Overall, there was no evidence of significant care concerns, with learning largely focused on strengthening preventative healthcare arrangements and family engagement.

West Yorkshire ICB does not currently routinely share completed LeDeR review reports with the Trust. This limits the Trust's ability to triangulate external learning with its own mortality data. The Patient Safety Support Team will seek an agreed information-sharing and escalation route through the relaunched monthly mortality meeting and relevant ICB governance arrangements. Progress, outstanding reviews and any associated risks will be reported through mortality governance and the Quality and Safety Committee.

Other deaths

Table 5 below shows 57 deaths where the patient is recorded as not having a learning disability or autism diagnosis, along with the level of review which was completed. As noted above, all reported deaths have a Service Learning Review completed to ensure the care and treatment leading up to a death was considered, although if there is another review process followed or the death was certified, this will be what is included in this report. For example, if a death is reported in the table below as Certified, or has a Structured Judgement Review, it will also have had a Service Learning Review completed as standard process.

Table 5. Summary of total number of in scope deaths in 2026/27 by the Review process (excluding Learning Disability deaths)

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review			Level 3: Learning Response		
	Certification of death	Service Learning Review (1st stage case note review)	Case note review	Structured Judgment Review (SJR)	After Action Review	Patient Safety Incident Investigation (PSII)	Total
2026/27 Q1	12	40	0	5	0	0	57
2026/27 Q2							
2026/27 Q3							
2026/27 Q4							
Total	12	40	0	5	0	0	57

Of the 57 deaths reported in table 5, 50 of the deaths were under the care of Community mental health services at the time of death or had been in the months prior to death. Analysis of these deaths is as follows:

- Four apparent suicides were scrutinised through Care Group and Trust Patient Safety Oversight Group arrangements. On the evidence available at the time, the Service-Learning Reviews were accepted, and no additional learning response was selected. The cases remain open to reconsideration if further information becomes available.
- Three deaths had an unconfirmed cause of death, with apparent suicide considered possible. These were scrutinised through Care Group and Trust Patient Safety Oversight Group arrangements. On the evidence available at the time, the Service-Learning Reviews were accepted, and no additional learning response was selected. The cases will be reconsidered when further information is received.
- In 27 of the 50 deaths, the confirmed cause was physical illness. This included 13 people receiving end-of-life care, four deaths associated with long-term conditions, four following deteriorations in physical health and six sudden deaths, including cardiac arrest or stroke. The principal reporting outcome was certification or an accepted Service-Learning Review.
- At the time of reporting, 15 deaths were awaiting confirmation of the cause of death. Available information indicated a likely physical cause, but the specific cause was not yet available to the Trust. The Service-Learning Reviews were accepted on the evidence available, and each case will be revisited when further information is received.
- One death was associated with substance misuse. Following review, no additional learning response was considered proportionate on the evidence available at the time. The case will contribute to the Trust's thematic work on substance misuse-related deaths.
- Further analysis found that teams continued to report deaths consistently. Half of the reviewed individuals were not actively receiving services at the time of death, and current or historical substance misuse was recorded in approximately half of the cases. One review identified learning about inter-organisational information sharing, family involvement and consideration of access to means. No additional Trust learning was identified in the remaining reviews on the evidence available at the time; cases will be reconsidered if further information emerges.

In all cases, when further information comes to light, the case is revisited to see if any change is needed to the response method selected.

Of the 57 deaths shown in Table 5, seven met the Trust's inpatient reporting definition. Six were attributed to the Mental Health Inpatient Care Group and one to Barnsley Physical Health and Wellbeing. These are detailed in the next section.

Inpatient deaths

Table 6 shows seven deaths within the Trust's inpatient reporting category in Quarter 1 2026/27: six attributed to the Mental Health Inpatient Care Group and one to Barnsley Physical Health and Wellbeing. This category includes deaths during an inpatient admission and deaths in the community within 30 days of discharge from a Trust inpatient facility. All seven people were recorded within the White English, Welsh, Scottish, Northern Irish or British ethnic group. Given the small number, no inference about disparity can be drawn. The Trust will monitor cumulative mortality data and review findings by ethnicity, age, sex,

deprivation, disability, learning disability and autism, severe mental illness and other relevant protected characteristics to identify emerging inequalities while maintaining confidentiality for small groups.

As with all deaths, every inpatient death is reviewed to determine whether a further response is needed and if so, deciding the most appropriate response. All deaths underwent a manager-led Service Learning Review, and additional information completed on Datix in the 'Death of a Service User' sections. All initial Service Learning Reviews were subsequently reviewed by the Patient Safety Support Team and the Trust's Patient Safety Oversight Group to determine the need for, and level of, any further review, and external reporting to LeDeR where necessary.

In Quarter 1, one inpatient-category death was associated with Barnsley Physical Health and Wellbeing services and occurred at the Neurorehabilitation Unit. The person was receiving end-of-life care and the death was certified.

The remaining six deaths were attributed to the Mental Health Inpatient Care Group and included people who died during an admission or within 30 days of discharge, as shown below.

Table 6 Trust wide Inpatient deaths in 2026/27 by date reported

Care Group	Service	Ward	Financial quarter – date reported				Total
			2026/27 Q1	2026/27 Q2	2026/27 Q3	2026/27 Q4	
Mental Health Care Group (Inpatient)	Older People Inpatient	Poplars	2				**2**
		Ward 19	1				**1**
	Adult Acute Inpatient	Ashdale	1				1
		Elmdale	1				1
		Stanley	1				1
Barnsley Physical Health and Wellbeing	General Community Inpatient	Neuro Rehab Unit	1				1
Total			**7**				**7**

Five of the six mental health inpatient-category deaths in Quarter 1 resulted in Structured Judgement Reviews being commissioned. At the reporting cut-off, these reviews were in progress. Completion dates, review quality, engagement with families and carers, identified learning and resulting actions will be monitored through the monthly mortality meeting and Patient Safety Oversight Group, with the outcome reported in the next quarterly report.

The five cases for SJR in Quarter 1 included two potential apparent suicides (unconfirmed) and three deaths of patients who were under (or recently under) the Mental Health Act at the time of death. These were associated with physical health deterioration.

Of the two apparent suicides, one case involved a patient who died following discharge from an acute inpatient ward. The scope of the SJR includes documentation of Multi-disciplinary meetings and discharge medication needs. The second case is a death following discharge

from an acute inpatient ward. The scope will include close review of the discharge process and medication.

The other two inpatient-category deaths were associated with physical health deterioration. On the evidence available at the time, certification or the Service-Learning Review was accepted as the proportionate outcome and no additional Trust concerns were identified. These cases will be reconsidered if further information becomes available.
Families and carers are offered compassionate engagement in accordance with the Trust's Learning from Deaths and PSIRF arrangements. For these seven deaths, the completion and outcome of engagement is being checked as part of review quality assurance and will be included in the next quarterly report.

At each stage of the reporting process, opportunities for learning are identified and acted upon. Care group leaders are actively encouraged to implement immediate improvements where this can be achieved at a local level, ensuring teams are empowered to lead on safety and quality. This approach supports timely intervention and reduces reliance on the completion of formal reporting processes before action is taken. It also mitigates the risk of recurrence by avoiding unnecessary delays in implementing changes while reviews are ongoing.

There can be delays in confirming cause of death. Where information is unavailable or unclear, this is sought through the Trust's Legal Team and the relevant coroner's office. Cases remain open to reconsideration and the selected response may be revised if new information identifies concerns or additional learning.

3. Wider Patient Safety and Learning System Updates

The following section provides an overview of broader patient safety developments and system improvements.

- The review of the Patient Safety Incident Response Framework (PSIRF) plan and associated procedures has concluded in Quarter 1 2026/27. The final version of the PSIRF Plan was approved at QSC in July 2026
- The revised plan shifts from reviewing individual incident types to a focus on a smaller number of themes which are identified within incident reviews. Our internal review processes for all deaths would seek to identify where themes are present and then consider the most appropriate method of responding in line with the Learning from Deaths policy and also the Patient Safety Incident Response plan.
- Revised procedures and flowcharts have been published on the Trust's patient safety intranet, alongside clarified governance and sign-off arrangements, to ensure that learning is consistently captured, reviewed and shared. The review has also introduced practical flowcharts to support the selection of the most appropriate PSIRF response. These include alignment with Learning from Deaths requirements, supporting decision-making where there is a need to determine whether a death may have resulted from problems in care.
- All reported deaths continue to receive an initial proportionate review. Cases meeting the Trust's escalation criteria are considered through the Patient Safety Oversight Group and mortality governance arrangements. Oversight will remain supportive and improvement-focused, with evidence of the decision rationale, engagement with those affected, response quality, timeliness, actions and impact.

- Separate reports on the Suicide Prevention Strategy and the thematic review of apparent suicides have been presented to the Quality and Safety Committee, providing focused assurance and oversight in these priority areas.
- The Trust has commissioned an independent review of the women's care pathway, due to conclude in July 2026. The findings from this review, alongside the ongoing investigations, will further inform targeted improvement activity.
- A review of the last three years inpatient apparent suicides has been completed and is out for consultation with care group leads. The report will be extended to include a review of learning over time, barriers and challenges and will form the foundation for additional years reporting on inpatient apparent suicides and the incidence of self-harm on the inpatient units.
- The Structured Judgement Review (SJR) template has been reviewed to ensure full alignment with the updated national template requirements.
- The Datix 'Death of a Service User' section has been enhanced to align with regional reporting requirements, supporting near real-time suicide surveillance and improved system-wide intelligence.
- The allocation process for assigning Structured Judgement Reviews has been reviewed and during Quarter 1, the allocation process for SJRs has been improved and also the Trust's dedicated medical investigators (who are all consultant psychiatrists) are now undertaking or supporting Structured Judgement Reviews to enhance clinical input and consistency.
- Mortality governance arrangements have been re-established in Quarter 1. This included a monthly mortality review meeting and a quarterly forum focused on thematic learning. These forums include Care Group representation and provide oversight of both local and national learning.

4. Next Steps

The following section outlines the key actions and developments planned to further strengthen the Trust's approach to mortality review, learning, and patient safety.

Priority action	Lead	Target	Evidence of completion
Complete and quality-assure the five Quarter 1 Structured Judgement Reviews, including family and carer involvement and resulting actions.	Patient Safety Support Team with relevant Care Group leads	Report in Quarter 2 2026/27	Completed reviews, PSOG oversight and action-impact record
Agree a route with West Yorkshire ICB for receipt or formal feedback from completed LeDeR reviews.	Patient Safety Support Team	Update in Quarter 3 2026/27	Documented information-sharing or escalation route and review log
Introduce cumulative inequalities monitoring across mortality data and review findings.	Patient Safety Support Team with Equality and Analytics colleagues	From Quarter 2 2026/27	Quarterly dashboard showing relevant characteristics, themes and actions

Priority action	Lead	Target	Evidence of completion
Complete thematic analysis of deaths involving substance misuse and Early Intervention Teams.	Relevant Care Groups with Patient Safety Support Team	Report in Quarter 3 2026/27	Thematic report, agreed actions and measures of impact

- Work continues to strengthen the organisation's understanding of the needs and care pathways for individuals with co-existing drug and alcohol use disorders who have died, to inform targeted improvement actions.
- The revised resource model will support a coordinated mortality process. Team managers and Patient Safety Specialists will continue to review deaths as they are reported. Service-Learning Reviews will be considered through the Patient Safety Oversight Group where relevant, with immediate safety actions initiated without waiting for a formal review to conclude. The monthly mortality meeting will monitor completeness, timeliness, emerging themes, family involvement, proportionality of response and delivery of improvement actions.
- Work continues to review the Structured Judgement Review training we provide internally considering changes in allocation processes.
- The 2025/2026 apparent suicide report is underway, a highlight report has been requested to include data on those individuals recently discharged from hospital.
- The revised mortality governance processes which were re-established in Quarter 1 will continue to develop as we move forward. It is envisaged that thematic learning from our quarterly mortality governance forum will provide opportunities to share and learn together and identify any new areas for improvement. As this develops, thematic learning will be included in future reports.
- In conjunction with point above, mechanisms for sharing learning will also be reinforced through the Learning and Improvement Oversight Group (LIOG), supporting thematic analysis of deaths and enabling the organisation to better use mortality data to identify trends and inform improvement priorities.
- The above processes have identified a small number of deaths of individuals who had been under the care of Early Intervention Teams, these will be explored through thematic analysis to understand these further. This will commence in September.

5. Recommendations

The Trust Board asked to receive the Quarter 1 mortality data and note the limitations arising from small numbers and incomplete cause-of-death information. The Board can take assurance that deaths are being identified, screened and reviewed through the Trust's Learning from Deaths and PSIRF arrangements.

South West Yorkshire Partnership Teaching
NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 10.6

Private/Public paper:	**Public**		
Title:	**Thirlwall Inquiry Board Assurance Report**		
Lead Director:	**Caroline Johnson, Chief Nurse / Director of Quality & Professions**		
Mission/values:	The report supports the Trust's values by reinforcing openness, compassion, professional curiosity, speaking up, accountability and a learning culture in which patient safety concerns are heard, acted upon and used to improve care.		
Purpose:	To provide Trust Board with assurance on the Trust's response to the findings and 17 recommendations of the Thirlwall Inquiry; set out their direct, partial or transferable relevance to the Trust; identify current controls, evidence of effectiveness, gaps and risks; and agree the actions and oversight routes required to strengthen assurance before the report is presented to the Board.		
Strategic aims:	Live Our Values	✓	Supports the Trust's strategic aims by strengthening patient safety, compassionate and accountable leadership, organisational learning, speaking-up arrangements, evidence-based governance, partnership working and the consistent translation of national inquiry learning into practice.
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	The following BAF risks align most directly with this report: **1.2** Compassionate and diverse leadership and a values-based inclusive culture is not delivered, resulting in a poor workforce and service user experience. **2.2** The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives. **2.3** Failure to create a learning environment leads to lack of innovation and to repeat incidents. **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 response supports national, regional and system objectives for safe, open and accountable care. It strengthens interfaces with integrated care boards, Medical Examiners, Coroners, police, safeguarding partnerships, LeDeR and child death review processes, and provides routes to escalate cross-provider risks, information-sharing gaps and learning that require partnership action.
Any background papers / previously considered by:	This report has been reviewed by the EMT on 8 October and 13 October by QSC with subsequent amends made based on feedback through the reviews.
Executive summary:	The Thirlwall Inquiry identified profound failures in recognising, escalating and responding to serious patient safety concerns. Although several recommendations are specific to neonatal services or directed at national bodies, the wider learning is relevant to all NHS providers, particularly where suspected deliberate harm, early or emerging indicators of risk, mortality patterns or professional concerns require timely recognition, protective action, escalation and Board oversight. The Trust has assessed all 17 recommendations for direct applicability, partial applicability, transferable learning or no direct application. Established controls are in place across safeguarding, incident management, PSIRF, medicines governance, mortality review, Freedom to Speak Up, recruitment and Fit and Proper Person processes, quality assurance and Board reporting. The assessment provides reasonable assurance in several areas and partial assurance where further evidence, clarification, testing or strengthening is required. Priority actions are to clarify, through a cross-policy flowchart, how safeguarding, incident and workforce processes operate together where deliberate harm is suspected; seek national clarification on related training and contractual requirements; strengthen mortality, child and baby death, bereavement and family-engagement reporting; introduce concise monthly mortality reporting to EMT; improve triangulation of patient safety and speaking-up intelligence; confirm access to independent expert advice where required; test key controls in practice; and monitor national developments in manager accountability. The central assurance challenge is not the absence of governance structures, but demonstrating consistently that controls are understood, applied, triangulated and effective in improving safety. The proposed actions therefore focus on strengthening evidence of operation and impact through existing governance routes. Delivery will be monitored through the identified committees, with updates to EMT every two months and material gaps or delays escalated to QSC and the Board.
Recommendation:	**Trust Board members are asked to**: • **RECEIVE** assurance that that the Trust has assessed the relevance of all 17 Thirlwall Inquiry recommendations and has established controls in place across the principal areas of transferable learning. • **NOTE** the action being taken to address areas of partial assurance.

Thirlwall Inquiry

Board Assurance Report

1. Introduction

This report provides the Board with assurance on South West Yorkshire Partnership NHS Foundation Trust's response to the findings and recommendations of the Thirlwall Inquiry, published on 15 September 2026. It sets out the principal areas of learning, identifies the recommendations that are directly or indirectly relevant to the Trust, and describes the assurance approach being used to assess current controls, evidence of effectiveness, gaps, risks and required actions.

The Thirlwall Inquiry was established to examine events at the Countess of Chester Hospital following the convictions of Lucy Letby for the murder and attempted murder of babies in neonatal care. The Inquiry considered how concerns were raised, escalated and responded to, and examined wider issues relating to patient safety, safeguarding, leadership, governance, professional challenge and organisational accountability. While several recommendations are specific to neonatal services and national bodies, the findings contain wider learning for all NHS providers where concerns about possible harm, weak signals, staff conduct, mortality patterns or organisational response require timely recognition, escalation and assurance.

The purpose of this report is to support Board oversight of the Trust's response to the Thirlwall Inquiry by setting out the key learning, mapping the recommendations to existing Trust arrangements, and identifying where further assurance or strengthening is required. The report distinguishes between the controls in place, evidence that those controls are operating in practice, evidence of impact, known limitations and the actions required to close any gaps.

2. Summary of Inquiry findings

The Thirlwall Inquiry identified profound failures in the recognition, escalation and response to serious patient safety concerns at the Countess of Chester Hospital. Although the events related to neonatal services, the findings are of wider relevance to all NHS providers because they expose weaknesses in safeguarding practice, leadership culture, governance oversight, speaking up arrangements, professional challenge and organisational accountability.

A central finding of the Inquiry was that concerns raised by clinicians were not acted upon with sufficient urgency or seriousness. Safeguarding processes were not triggered effectively, and the organisational response became overly focused on employment, grievance and reputational issues rather than the immediate protection of patients. The Inquiry reinforces that, where deliberate harm or serious risk to patients is suspected, the threshold for action must be precautionary and protective.

The Inquiry also found significant weaknesses in leadership and governance. There was a disconnect between frontline clinical concern and executive decision-making, and insufficient Board-level grip on the nature, seriousness and pattern of emerging risks. For the Trust, this underlines the importance of timely, triangulated and unfiltered intelligence from incidents, mortality reviews, safeguarding concerns, Freedom to Speak Up, complaints, workforce information and direct engagement with clinical teams.

A further theme from the Inquiry was the need for organisations to identify and act on early signs that may indicate emerging risk. Individual incidents, deaths, episodes of deterioration or professional concerns may not appear significant when considered in isolation; however, when reviewed together they may indicate a pattern, outlier or repeated concern that requires escalation. For the Board, the key assurance question is whether relevant intelligence is not only reported, but actively reviewed, triangulated and escalated where emerging concerns may indicate potential risk.

The Inquiry placed significant emphasis on speaking up and professional challenge. It found that staff concerns were not consistently heard, believed or acted upon. The Board should therefore seek assurance that staff have multiple routes to raise concerns, that leaders respond with curiosity and urgency, that staff are protected from detriment, and that speaking up themes are triangulated with wider quality, safety, safeguarding and workforce intelligence.

The Inquiry also highlighted the importance of accountability, candour and putting patients first. Its recommendations seek stronger accountability for NHS managers, including strengthened controls over senior manager movement, a potential barring system, an individual duty of candour and clearer standards requiring managers to prioritise patient safety. This has implications for Fit and Proper Person processes, recruitment, references, appraisal, conduct, leadership development, duty of candour and Board oversight of leadership behaviours.

A consistent message throughout the Inquiry is that assurance cannot rely solely on the existence of policies, procedures or committee structures. The Board must be assured that controls operate effectively in practice and that they make care safer. The Trust's response should therefore distinguish clearly between documented arrangements, evidence of operation, evidence of impact, known limitations and any further action required.

Overall, the Inquiry provides a significant source of learning for SWYPFT. The Board is asked to consider the findings not as neonatal-specific learning alone, but as a wider test of the Trust's systems for safeguarding, escalation, speaking up, mortality oversight, leadership accountability, governance effectiveness and implementation of national inquiry recommendations.

3. Inquiry recommendations

The Thirlwall Inquiry made 17 recommendations. These have been summarised in the table below to support Board oversight of the Trust's assessment, current assurance, gaps and actions.

Each recommendation has been reviewed for direct applicability, partial applicability, transferable learning or no direct application to SWYPFT. Where assurance is partial or limited, the table identifies the action required and the proposed oversight route.

The main report focuses on the assurance judgement, key gaps and actions. Supporting evidence will be retained separately and made available as required.

Rec.	Recommendation theme	Applicability to SWYPFT	Assurance level	Current assurance	Gaps / action to strengthen assurance	Oversight route
1	Introduce in-cot cameras with livestreaming for parents in neonatal units	Not applicable. The recommendation requires in-cot cameras with livestreaming for parents in neonatal units; the Trust does not provide neonatal care.	Not applicable	No direct Trust assurance requirement identified.	Not applicable	None
2	Restrict, record and assure access to insulin storage	Partially applicable. Neonatal focus, but insulin is administered in Trust inpatient and community settings.	Partial assurance	Medicines governance arrangements are in place, including pharmacy oversight, storage requirements, incident reporting and Trust guidance relating to insulin medicines, used predominantly in general community services.	By 31 March 2027, the Medicines Safety Group will complete and report a documented audit of insulin storage and access controls, including whether access is restricted to authorised staff and appropriately recorded; insulin-related incident recording and oversight; staff uptake of the Trust's insulin medicines guidance; and alignment with the agreed competency framework. Any gaps will have named owners and completion dates, with progress reported through Clinical Governance and QSC.	Medicines Safety Group / Clinical Governance Group / QSC.
3	Implement relevant standards from the National Bereavement Care Pathway	Transferable relevance. The Trust does not provide neonatal care but supports bereaved families and friends following patient deaths.	Partial assurance	The Trust has a Family Liaison Officer, bereavement standards, bereavement champions across a number of services and a monthly bereavement forum. Signposting to postvention support is provided where appropriate.	By 31 March 2027, the Learning from Deaths lead will assess the National Bereavement Care Pathway for neonatal death and document which standards are relevant to Trust services. Quarterly reporting will show families offered contact,	PSEG / EMT / QSC.

Rec.	Recommendation theme	Applicability to SWYPFT	Assurance level	Current assurance	Gaps / action to strengthen assurance	Oversight route
					contacted, engaged, declining or unable to be contacted, concerns raised and feedback received. Bereavement champion coverage will be reviewed and actions agreed for any gaps. Family or carer concerns requiring senior oversight will be escalated through the monthly EMT mortality report.	
4	Train all staff and Board members to respond to suspected deliberate harm and reflect safeguarding duties in contracts	Directly applicable.	Reasonable assurance	Safeguarding training is mandatory for relevant staff, including bank staff, and Board members. Level 1 and Level 2 safeguarding training are nationally developed e-learning packages aligned to the Core Skills Training Framework; Level 3 is delivered through classroom or virtual learning. Compliance is monitored through the IPR and People Remuneration Committee. Initial review indicates that the existing Level 3 provision does not fully address the recommendation's specific focus on recognising and responding to concerns or suspicions of deliberate harm by a member of staff. As the Level 1 and Level 2 content is nationally determined, further clarification is required from NHS England on the	By 31 March 2027, the Safeguarding Team and People Directorate will seek clarification from NHS England on the intended training and contractual requirements arising from this recommendation, including whether changes to the nationally developed Level 1 and Level 2 safeguarding packages are planned. Informed by that clarification, the Trust will assess whether additional local content is required within Level 3 training or through supplementary guidance or briefing for staff and Board members. The People Directorate will also clarify the application of the recommendation to employment contracts, bank arrangements and agency supply terms. For the purpose of this review, "contractual	People Remuneration Committee / Strategic Safeguarding Governance.

Rec.	Recommendation theme	Applicability to SWYPFT	Assurance level	Current assurance	Gaps / action to strengthen assurance	Oversight route
				intended training requirements and whether national packages will be updated.	arrangements" will be understood as the provisions requiring staff and temporary workers to comply with safeguarding policies, complete required training, and report and escalate concerns about suspected deliberate harm. Any identified gaps and proportionate remedial actions will be reported to the People Remuneration Committee and Strategic Safeguarding Governance.	
5	Ensure systems share and triangulate safety information	Nationally led, with local relevance to information flow, data quality and triangulation.	Partial assurance	The IPR enables triangulation of safety data.	By 31 March 2027, the Assistant Director of Nursing (Patient Safety) will further strengthen the triangulation of incidents, complaints, Freedom to Speak Up, claims and coronial learning within the quarterly Patient Safety Oversight report.	Clinical Governance Group / EMT / QSC / Board.
6	Ensure the Board can identify all child and baby deaths, mortality trends and exceptions	Directly applicable.	Reasonable assurance	The Board receives the Learning from Healthcare Deaths report quarterly. QSC receives monthly notable incident updates. The IPR reports child deaths. Apparent suicides, Learning from Deaths and Patient Safety Incident Oversight reports address themes and trends. Focused reviews are	By 31 March 2027, the quarterly Learning from Healthcare Deaths report will be further strengthened to clearly state the number of deaths judged more likely than not to have resulted from problems in care and to ensure that all deaths of children and babies within the Trust's scope are clearly identifiable in Board reporting. By 31 January 2027, a concise	EMT / QSC / Board / Patient Safety Oversight Group.

Rec.	Recommendation theme	Applicability to SWYPFT	Assurance level	Current assurance	Gaps / action to strengthen assurance	Oversight route
				commissioned where potential themes emerge.	monthly mortality report will be introduced for EMT, highlighting deaths, emerging themes and matters requiring executive attention. EMT will also be asked to consider additional mortality metrics within the IPR. Significant exceptions will continue to be escalated to QSC, and a proposal for a thematic review of green-rated deaths will be presented to the Patient Safety Oversight Group by 31 March 2027.	
7	Assign named oversight of real-time mortality data and escalation	Neonatal-specific mechanism, with transferable relevance.	Reasonable assurance	The Trust has a suicide prevention lead, safety specialists and a lead Consultant for mortality governance. The Chief Nurse is accountable for mortality oversight. The executive trio attend the weekly Patient Safety Oversight Group where all deaths are discussed. The Trust Medical Patient Safety Specialist, Kiran Rele, also attends relevant external forums, providing a route for applicable national or system intelligence to inform Trust oversight.	No further action required.	Patient Safety Oversight Group / QSC.
8	Ensure effective review and escalation	Partially applicable through safeguarding interfaces. The Trust does not provide	Partial assurance	The Trust participates in Child Death Overview Panel and Sudden Unexpected Death in Infancy and	Child deaths will be included within the strengthened mortality reporting	Safeguarding Governance /

Rec.	Recommendation theme	Applicability to SWYPFT	Assurance level	Current assurance	Gaps / action to strengthen assurance	Oversight route
	of unexpected child deaths	neonatal or children's inpatient wards.		Childhood safeguarding processes where deaths relate to Trust service users, including CAMHS service users or children of adult service users. Safeguarding themes are reported to Board quarterly, with exceptions escalated through monthly notable incident reporting to QSC.	arrangements set out under recommendation 6.	QSC / EMT / Board.
9	Act immediately and protect patients where deliberate harm is suspected	Directly applicable and priority area.	Partial assurance	Safeguarding policies, incident reporting routes, daily incident huddle, thematic analysis of incidents and PSIRF processes are in place. These are supported by Patient Safety, People, professional standards, police liaison and executive escalation routes where concerns require immediate protective action or senior oversight.	By 31 December 2026, the Chief Nurse, Chief People Officer and Safeguarding Lead will review how the Trust's existing Safeguarding Adults, Safeguarding Children, incident reporting and disciplinary/conduct policies operate together where deliberate harm or an allegation against a member of staff is suspected. Rather than establishing a separate procedure, this review will identify any gaps, ambiguity or duplication and produce a concise flowchart setting out how concerns should be raised and managed. The flowchart will clarify immediate protective action; referral and escalation thresholds; responsibilities across Safeguarding, Patient Safety, the People Directorate and professional leads; police	Safeguarding Strategic Governance / EMT / QSC.

Rec.	Recommendation theme	Applicability to SWYPFT	Assurance level	Current assurance	Gaps / action to strengthen assurance	Oversight route
					liaison; support for patients and staff; and review requirements. It will be communicated to relevant staff, with implementation tested through audit or a desktop exercise by 30 June 2027. The arrangements will be reviewed again when the national procedure is published and amended where required.	
10	Obtain timely, impartial expert review of complex or high-risk cases	Nationally led, with local relevance.	Reasonable assurance	The Trust can access internal and external specialist advice and independent review where required. There is recent evidence of this through two externally commissioned incident reviews and the independent review of the women's pathway of care.	By 31 January 2027, the Chief Nurse and Medical Director will develop an internal protocol, for approval by EMT, for obtaining timely independent expert advice in complex or high-risk cases. The protocol will define decision criteria, approval routes, expected timescales, conflict-of-interest controls and documentation requirements. Compliance will be tested through the next eligible case or, if no case arises, through a desktop exercise by 31 March 2027, with the outcome reported to EMT.	Patient Safety Oversight Group / EMT.
11	Link death reviews with Medical Examiner and safeguarding processes	Partially applicable through mortality review and safeguarding interfaces.	Partial assurance	Mortality review and safeguarding processes are in place, with external medical examiner interfaces where relevant.	By 31 March 2027, the mortality governance lead will revise quarterly and monthly mortality reporting to record safeguarding, possible harm and professional concerns; show linkage with Medical	Mortality Governance / Strategic Safeguarding Governance / EMT.

Rec.	Recommendation theme	Applicability to SWYPFT	Assurance level	Current assurance	Gaps / action to strengthen assurance	Oversight route
					Examiner, Coroner, police, LeDeR, child death review and PSIRF processes; and report the status and age of outstanding external reviews. Delayed feedback, cross-provider issues or information-sharing gaps affecting learning or assurance will be escalated through the next monthly EMT exception report.	
12	Ensure access to paediatric and perinatal pathology expertise	National workforce recommendation; not directly applicable, subject to confirmation of any Trust dependency.	Not applicable / confirmation required	No direct Trust assurance gap has been identified; confirmation of any dependency on paediatric or perinatal pathology advice is required.	By 31 December 2026, the Medical Director will confirm whether any Trust service depends on paediatric or perinatal pathology advice, document the assessment and rationale, and identify an appropriate access and escalation route for any dependency. The outcome will be recorded through Clinical Governance; if no dependency is identified, the action will close with documented evidence.	Clinical Governance Group / EMT / QSC.
13	Strengthen NHS manager accountability through national barring and regulation requirements	Nationally led in relation to the proposed manager barring scheme and any subsequent statutory regulation, with direct local relevance to pre-employment checks	Reasonable assurance	Robust pre-employment checks are undertaken in accordance with NHS Employers employment check standards. Fit and Proper Person requirements are applied to roles within their current scope.	The People Directorate will continue to undertake robust pre-employment checks for all appointments in accordance with NHS Employers employment check standards and will apply the Fit and Proper Person requirements to the roles within their current scope. The Trust will monitor national developments relating	People Remuneration Committee / EMT / Board.

Rec.	Recommendation theme	Applicability to SWYPFT	Assurance level	Current assurance	Gaps / action to strengthen assurance	Oversight route
		and Fit and Proper Person requirements.			to the proposed manager barring scheme and any subsequent statutory regulation. If a national scheme is introduced, recruitment processes will be updated to include the required check, in line with the national implementation timetable and any revised NHS Employers standards. No extension of the Fit and Proper Person requirements to additional management roles is proposed at this stage; this position will be reviewed if national requirements change or further assurance indicates that this is necessary.	
14	Test evidence in practice and respond openly to regulatory scrutiny	Directly relevant to internal assurance and regulatory readiness.	Reasonable assurance	Quality assurance systems, regulatory engagement and improvement monitoring arrangements are in place. The Trust's approach is intended to test evidence in practice rather than rely solely on policy, process or self-reported assurance.	By 31 March 2027, the Quality Assurance lead will complete the next planned development phase of the Quality Assurance System, including measures that test whether key controls operate consistently across services, defined escalation thresholds and an evidence-based reporting cycle. Findings from internal testing and regulatory scrutiny will be reported openly to QSC, with identified gaps, challenge and dated remedial actions clearly recorded.	Clinical Governance Group / EMT / QSC / Board.

Rec.	Recommendation theme	Applicability to SWYPFT	Assurance level	Current assurance	Gaps / action to strengthen assurance	Oversight route
15	Strengthen national oversight of CQC performance and regulatory concerns	External recommendation; limited direct applicability.	Not applicable	The recommendation is directed to national oversight arrangements and does not create a specific additional Trust requirement.	No further action required.	None.
16	Ensure speaking-up concerns are heard, acted on and free from detriment	Nationally led, with direct local relevance.	Partial assurance	Freedom to Speak Up arrangements, multiple routes for staff to raise concerns, Guardian reporting and Board oversight are in place. The Trust promotes openness and learning, supports leaders to respond constructively, and monitors themes, actions, outcomes and potential detriment.	The Freedom to Speak Up Guardian and People Directorate will continue to promote multiple routes for staff to raise concerns; monitor and report themes, actions and outcomes to the Board; strengthen triangulation with Patient Safety, Safeguarding, Governance and workforce information; support leaders to respond constructively and compassionately; monitor potential detriment and ensure appropriate support; and demonstrate the learning, improvement and impact arising from concerns raised.	Board / EMT / Audit Committee.
17	Track, evidence and complete applicable inquiry recommendations	Directly applicable.	Partial assurance	The Trust has established governance processes for reviewing national reports and tracking actions.	The Chief Nurse will provide updates to EMT every two months on delivery of the actions arising from the applicable Thirlwall Inquiry recommendations.	EMT.

4. Key assurances and areas for strengthening

The assessment identifies that many of the key controls relevant to the Thirlwall Inquiry recommendations are already in place across the Trust. These include safeguarding policies and training, incident reporting, daily incident review arrangements, PSIRF processes, medicines governance, mortality oversight, Freedom to Speak Up arrangements, duty of candour, Fit and Proper Person processes, Board reporting and established governance routes through EMT, QSC and Board.

The report provides assurance that the Trust has established routes for recognising, reporting, reviewing and escalating patient safety concerns, deaths, safeguarding matters, speaking up concerns and wider quality and safety intelligence. There is also evidence that the Trust commissions focused reviews where potential themes are emerging and uses a range of governance routes to provide routine and exception-based assurance.

The main areas for strengthening are not the absence of controls, but the need to evidence consistently that controls are understood, operating effectively and triangulated across services. The priority areas are: clarifying, through a cross-policy flowchart, how existing safeguarding, incident and workforce processes operate together where deliberate harm is suspected; seeking national clarification on whether safeguarding training and contractual arrangements require further strengthening in relation to deliberate harm by staff; strengthening the quarterly Learning from Healthcare Deaths report, including clear visibility of child and baby deaths, and introducing monthly mortality reporting to EMT; considering additional mortality metrics for the IPR; improving visibility of family engagement and mortality learning; assessing relevant National Bereavement Care Pathway standards; strengthening speaking-up response, triangulation, feedback and protection from detriment; maintaining robust pre-employment checks and monitoring national manager accountability requirements; testing quality and safety evidence in practice; and maintaining regular EMT oversight of delivery against applicable Thirlwall recommendations.

5. Conclusion

The Thirlwall Inquiry provides important learning for all NHS providers, including organisations that do not provide neonatal care. The Trust has reviewed the recommendations through the lens of direct applicability, transferable learning and Board assurance. The assessment indicates that a number of relevant controls are already in place, supported by established governance, reporting and escalation routes.

The key assurance challenge is to demonstrate that these controls are consistently understood, applied, tested and triangulated across services. The proposed actions are therefore focused on strengthening evidence of operation and impact, rather than creating new governance structures. Progress against these actions will be monitored through the agreed governance routes and escalated to Board where required.

6. Recommendations and next steps

The Board is asked to receive assurance on the Trust’s current response to the Thirlwall Inquiry recommendations and to maintain oversight of the actions required to strengthen assurance where gaps or limitations have been identified.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 10.7

Private/Public paper:	**Public**		
Title:	**Annual Safeguarding Report 25/26**		
Lead Director:	**Dr Caroline Johnson Chief Nurse and Director of Quality and Professions**		
Mission/values:	This report supports the Trust's mission and values by promoting safe, compassionate, inclusive and person-centred safeguarding practice, effective partnership working, accountability and continuous learning.		
Purpose:	To present the 2025/26 Annual Safeguarding Report, provide assurance on safeguarding governance and performance, highlight key activity and gaps, and seek support for the 2026/27 priorities.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	**2.**1 Services are not accessible to, nor effective for, all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy. 2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents. 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. 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.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships.	The report demonstrates the Trust's contribution to system and place-based safeguarding objectives through active participation in statutory partnerships, reviews, audits and multi-agency risk management across Barnsley, Calderdale, Kirklees and Wakefield. This supports coordinated practice, shared learning and the requirements of the NHS Code of Governance. The 2026/27 priorities will strengthen this contribution, although specialist-team capacity remains a risk requiring review.		

With **all of us** in mind.

Any background papers / previously considered by:	This report is received annually through EMT and the Quality and safety Committee in September 2026.
Executive summary:	This paper presents the Trust's Annual Safeguarding Report for 1 April 2025 to 31 March 2026 and provides reasonable assurance regarding adult and children's safeguarding governance, performance, specialist support, workforce development and partnership activity. Key achievements included improved compliance across all safeguarding training levels, substantial advice and supervision activity, active multi-agency participation and the translation of learning from reviews and audits into policies, training and practice resources. Headline activity included: • **555 adult safeguarding incidents** were recorded. Year-on-year comparison should be treated with caution because Cheswold Park commenced reporting through the Trust's Datix system in April 2025. • **216 children's safeguarding incidents** were recorded, representing a **15.5% increase** compared with 2024/25. • The Safeguarding Advice Service recorded **1,165 adult safeguarding contacts** and **709 children's safeguarding contacts**. • Safeguarding supervision and professional-support activity comprised **846 children's safeguarding attendances** and **103 adult safeguarding attendances**. These figures may include repeat attendance by individual staff members. Prominent themes included neglect, self-neglect, domestic abuse, information sharing, mental capacity, cumulative risk and Think Family practice. Further improvement is required in safeguarding documentation, incident categorisation, information triangulation, person-led outcome measurement, Mental Capacity Act assurance, routine domestic abuse enquiry and external-review action tracking. Increasing complexity, partnership commitments and operational demand continue to place pressure on specialist-team capacity. Priorities for 2026/27 will therefore include reviewing the Safeguarding Advice Service, completing a demand-and-capacity review, strengthening care group accountability, improving data and recording, developing supervision arrangements and demonstrating the impact of safeguarding interventions and learning. Progress will be monitored through the Strategic Safeguarding Meeting and Quality and Safety Committee, with significant safeguarding, capacity or delivery risks escalated to the Executive Management Team.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** the report and note the reasonable assurance provided on the Trust's safeguarding arrangements during 2025/26. • **NOTE** the principal risks and gaps in assurance relating to data quality and triangulation, domestic abuse enquiry, safeguarding supervision, Mental Capacity Act practice and oversight of review actions. • **ENDORSE** the safeguarding priorities for 2026/27 and require progress, impact and any material risks to be reported through established governance arrangements.

Safeguarding Annual Report

April 2025– March 2026

Safeguarding Team

CONTENTS

ITEM	Page Number
Foreword	3
Executive summary	4
Introduction	4
Purpose	5
Scope	5
Safeguarding Approach	6
Making Safeguarding Personal	6
Think Family	6
Governance and accountability arrangement	6
Safeguarding Assurance and Performance	7
Training	7
Safeguarding Adults Incidents	8
Safeguarding Children Incidents	13
Safeguarding Adults Advice	16
Safeguarding Children Advice	17
Supervision	17
Quality, Audit and Improvement	18
Internal Audit	19
Multi agency audit	20
Policies and procedures	21
Annual Safeguarding Confrence	21
Joint Academic Psychiatric Seminar	21
Safeguarding Situation, Background, Analysis, Recommendations (SBARs)	22
Partnership working	22
Learning from Reviews	24
Horizon Scanning	26
Priorities for 2026/27	27
Conclusion and recommendations	28
Appendix A Safeguarding advice calls 2024/25.	29

1. Foreword

Safeguarding is everyone’s responsibility and is central to the Trust’s commitment to delivering safe, compassionate, inclusive and person-centred care.

During 2025/26, the Trust continued to support staff to recognise, prevent and respond to abuse, neglect, exploitation and other forms of harm affecting children, young people, adults at risk, families and carers. The Safeguarding Team provided specialist leadership, advice, supervision, training, assurance and partnership representation across a broad and increasingly complex safeguarding agenda.

The year has demonstrated the expertise, commitment and responsiveness of the Safeguarding Team and the wider workforce. It has also highlighted the importance of strengthening data quality, care group ownership, external review oversight, Mental Capacity Act assurance and evidence that safeguarding activity leads to improved outcomes.

This report recognises the progress made during 2025/26 and sets out clear priorities for 2026/27. These priorities will support stronger governance, improved organisational learning and a more consistent, trauma-informed and outcome-focused approach to safeguarding.

Dr Caroline Johnson
Chief Nurse and Director of Quality and Professions

2. Executive Summary

This report describes safeguarding activity, assurance, learning and improvement across the Trust during the period 1 April 2025 to 31 March 2026.

The Trust maintained established safeguarding governance, specialist advice, training, supervision and multi-agency partnership arrangements. Mandatory safeguarding training improved across all six training levels between Quarter 1 and Quarter 4. The Safeguarding Team also provided substantial advice, consultation and supervision to staff managing complex concerns.

During the year:

- 555 adult safeguarding incidents were reported, an increase of 12.6% from 2024/25.
- 216 children's safeguarding incidents were reported, an increase of 15.5%.
- The Adult Safeguarding Advice Service recorded 1,165 contacts.
- The Children's Safeguarding Advice Service recorded 709 contacts.
- Children's safeguarding supervision recorded 846 staff attendances.
- Adult safeguarding supervision recorded 103 staff attendances.
- Training compliance improved across all adult and children's safeguarding levels.

The most significant adult safeguarding themes were neglect, self-neglect, financial harm, psychological harm, physical harm and domestic abuse. The main children's safeguarding themes included concerns recorded as "child protection: other," requests for service, neglect, physical harm and other significant safeguarding concerns.

An increase in incident reporting does not necessarily demonstrate an equivalent increase in abuse or neglect. Increased awareness, improved reporting behaviour, service pressures, data categorisation and changing levels of complexity may all influence the figures. Further triangulation with clinical records, advice activity, local authority decisions and outcomes is required.

Learning from audits and external reviews highlighted recurring themes of:

- Professional curiosity
- Cumulative risk
- Self-neglect
- Mental capacity and executive functioning
- Think Family practice
- Domestic abuse
- Information sharing
- Communication adjustments
- Carer identification
- Clear ownership of multi-agency risk
- Escalation where engagement or service response is limited

During 2025/26, the Safeguarding Team maintained a comprehensive programme of specialist advice, supervision, training, assurance and partnership activity. Key achievements included improved mandatory training compliance, sustained specialist advice and supervision, active

participation across four local safeguarding systems, and the translation of review and audit learning into training, policies and practice resources.

Principal challenges included increasing demand and complexity, pressure on specialist capacity, variation in safeguarding recording and categorisation, and limited evidence of the impact of some interventions. The overall opinion is one of reasonable assurance, with further improvement required in information triangulation, routine domestic abuse enquiry, review-action tracking, and safeguarding supervision

3. Introduction

3.1 Purpose

The purpose of this Annual Safeguarding Report is to provide the Trust Board, through the Quality and Safety Committee, with assurance regarding the effectiveness of the Trust's safeguarding arrangements during the period 1 April 2025 to 31 March 2026.

The report:

- Summarises the Trust's delivery of its statutory, regulatory and partnership safeguarding responsibilities.
- Describes the governance arrangements supporting accountability, oversight and escalation.
- Presents key performance information relating to safeguarding incidents, specialist advice, supervision and mandatory training.
- Evaluates safeguarding quality, learning and improvement activity.
- Summarises the Trust's contribution to local safeguarding partnerships and statutory reviews.
- Identifies significant themes, risks and gaps in assurance.
- Sets out the safeguarding priorities and improvement actions for 2026/27.

The report is intended to support the Board in determining whether safeguarding arrangements are appropriately led, implemented and monitored, and whether further action or assurance is required.

3.2 Scope

The report covers safeguarding activity across all Trust care groups, clinical services and corporate functions. It includes:

- Safeguarding adults at risk of abuse or neglect.
- Safeguarding children and young people.
- Think Family practice.
- Making Safeguarding Personal.
- Domestic abuse.
- Mental Capacity Act and deprivation-of-liberty practice where relevant to safeguarding.
- Prevent and relevant public-protection arrangements.
- People in Positions of Trust and allegations involving staff.
- Safeguarding advice, consultation and supervision.
- Mandatory safeguarding training.
- Safeguarding incidents and emerging themes.

- Internal and multi-agency audits.
- Learning from statutory and independent reviews.
- Partnership working across Barnsley, Calderdale, Kirklees and Wakefield.
- Relevant national developments and horizon scanning.

3.3 Sources of Assurance

The report draws on information from:

- The Trust's patient safety incident reporting system.
- Adult and children's safeguarding advice records.
- Mandatory training information.
- Safeguarding supervision records.
- Clinical-record and safeguarding-documentation audits.
- Care group and Trust governance reports.
- Safeguarding Adults Boards and Safeguarding Children Partnerships.
- Statutory and independent reviews.
- Internal and multi-agency audits.
- Policy, training and workforce-development activity.
- Feedback from staff, people who use services, families, carers and partner agencies where available.

3.4 Trust Safeguarding Approach

Safeguarding is a fundamental component of safe, effective and person-centred care and is recognised as everyone's responsibility across South West Yorkshire Partnership Teaching NHS Foundation Trust. The Trust seeks to prevent abuse, neglect and exploitation, respond promptly when concerns arise, and work collaboratively with people, families, carers and partner agencies to promote safety, wellbeing and human rights.

The Trust's safeguarding approach is underpinned by the statutory principles of empowerment, prevention, proportionality, protection, partnership and accountability. Practice is expected to be person-led, trauma-informed, culturally responsive and based on the least restrictive intervention appropriate to the circumstances.

3.5 Making Safeguarding Personal

The Trust promotes Making Safeguarding Personal, ensuring that safeguarding activity is informed by the person's views, wishes and desired outcomes. Staff should support people to participate meaningfully in decisions, make appropriate communication adjustments and consider advocacy where required. Safety is considered alongside the person's rights, autonomy, relationships, independence and wider wellbeing.

3.6 Think Family Approach

A Think Family approach is embedded across adult and children's services. Staff are expected to consider the needs and safety of children, adults at risk, parents, carers and other family members, recognising that concerns affecting one person may have implications for the wider family or household. This includes consideration of parenting and caring responsibilities,

domestic abuse, parental mental ill health, substance use, young carers and transitions between services.

4. Governance and Accountability

The Trust maintains established safeguarding governance arrangements to support effective leadership, oversight and accountability. The Chief Executive holds overall accountability for safeguarding, with executive leadership provided by the Chief Nurse and Director of Quality and Professions. Strategic coordination is led by the Assistant Director of Nursing, Quality and Professions, supported by named professionals and the specialist Safeguarding Team.

The Safeguarding Team provides professional leadership, advice, supervision, training and assurance across adult and children's safeguarding, Think Family practice, domestic abuse, Prevent, external reviews and related improvement activity. Clinical teams and care groups retain responsibility for immediate safety, risk management, care planning, record keeping, safeguarding referrals and completion of agreed actions.

Internal oversight is provided through:

- The **Strategic Safeguarding Meeting**, which provides quarterly scrutiny of safeguarding performance, risks, learning and improvement.
- The **Operational Safeguarding Meeting**, which provides monthly oversight of activity, emerging concerns, performance and action delivery.
- **Care group governance arrangements**, which monitor local safeguarding risks, training, incidents, audits and review actions.
- The **Quality and Safety Committee**, which scrutinises safeguarding assurance and escalated risks on behalf of the Trust Board.
- The **Executive Management Team and Trust Board**, which receive significant risks, annual assurance and matters requiring executive action.

The Trust is represented on Safeguarding Adults Boards, Safeguarding Children Partnerships and relevant domestic abuse, Prevent, public-protection, statutory-review and quality-assurance arrangements across Barnsley, Calderdale, Kirklees and Wakefield. Trust representatives are responsible for bringing partnership risks, actions and learning into internal governance and ensuring that relevant improvements are implemented and monitored.

These arrangements provide a clear route for scrutiny and escalation from clinical services and care groups through to executive and Board oversight. During 2026/27, the Trust will strengthen care group assurance, partnership feedback arrangements and evidence that safeguarding actions result in sustained improvements in practice and outcomes

5. Safeguarding Assurance and Performance

5.1 Mandatory Training

The Safeguarding Team continues to deliver training across the Trust, in line with the intercollegiate documents. In April 2025 the team re- introduced face to face training for both adult and children level three staff as part of the induction programme. This has provided an opportunity for greater discussion, reflection and group work, whilst helping to foster those links with practitioners from the earliest opportunity. In addition to mandatory training, the team has facilitated multiple sessions for partner organisations across Calderdale, Kirklees, and Wakefield. These have included training on parental mental health and co-delivery of neglect

training, both of which received positive evaluations. Safeguarding training compliance improved across the Trust during 2025/26. All six adult and children's safeguarding training levels recorded a higher compliance rate in Quarter 4 than in Quarter 1, demonstrating positive progress during the year.

The table below shows the mandatory training figures for mandatory safeguarding training compliance figures April 2025 to March 2026:

Quarter	Adults Level 1	Adults Level 2	Adults Level 3	Children Level 1	Children Level 2	Children Level 3
April to Jun-2025	91.06%	89.14%	82.23%	93.29%	87.25%	85.16%
July to Sept-2025	92.31%	90.87%	81.68%	93.72%	89.49%	84.6%
Oct to Dec-2025	92.87%	92.30%	82.60%	93.6%	92.73%	86.67%
Jan to Mar-2026	93.73%	94.87%	88.17%	94%	94.5%	90.90%
Year End	**92.49%**	**91.79%**	**83.67%**	**93.65%**	**90.99%**	**86.83%**

Table 1: Trust wide mandatory safeguarding training compliance figures April 2025 to March 2026

The Safeguarding Team provide training compliance data on the levels of compliance at the Joint Safeguarding Strategic meeting and the Safeguarding Operational meetings. The team drill down into the data and escalate concerns where the levels of compliance have been noted to be below the 80% compliance rate to the Ward/Team Managers, Quality and Governance Leads and Matrons.

5.2 Adult Safeguarding Incidents reported via Datix

During 2025/26, 555 adult safeguarding incidents were recorded, an increase of 62 incidents, or 12.6%, compared with 2024/25. This increase should be interpreted cautiously because Cheswold Park began reporting incidents through the Trust's Datix system from April 2025. The 2025/26 figure therefore includes activity that was not captured in the previous year's dataset and is not directly comparable on a like-for-like basis.

Increased reporting may also reflect greater staff awareness and reporting confidence, alongside rising complexity and wider pressures affecting people who use services. Incident numbers alone do not demonstrate an equivalent increase in the prevalence or severity of abuse and neglect.

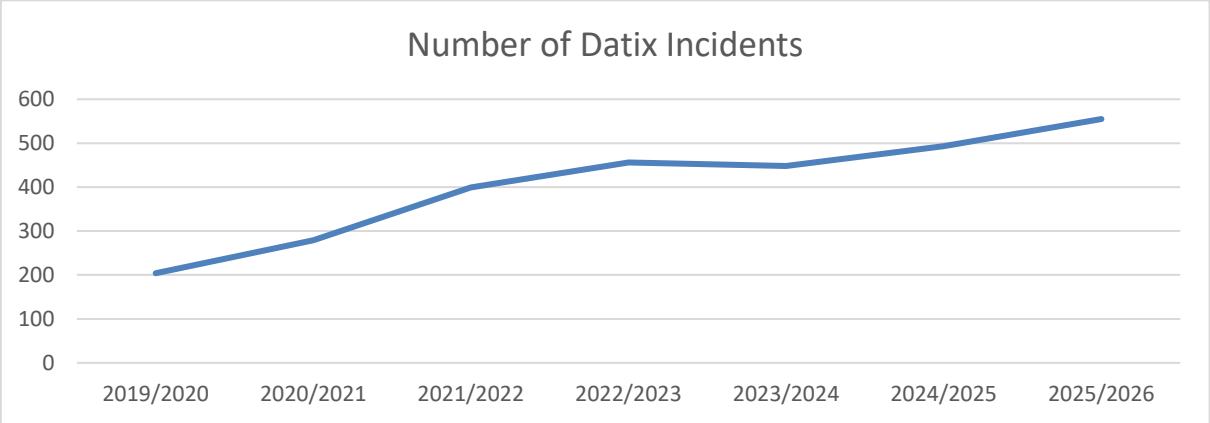
Neglect was the most frequently recorded category, accounting for 156 incidents, or 28.1%, followed by self-neglect at 76 incidents, or 13.7%. Together, these categories represented 41.8% of all adult safeguarding reports. Financial, psychological, physical and domestic abuse also remained prominent themes. The marked increase in neglect and self-neglect requires further examination, including the effect of the expanded reporting arrangements and whether these categories are being applied consistently.

Most incidents were graded green or yellow, with 30 amber incidents and no red incidents. Severity grading should be interpreted cautiously because it does not necessarily reflect

ongoing safeguarding risk, alleged criminality, the person's experience or whether the local authority initiated a statutory enquiry.

Table 2: Adult Safeguarding Datix Incidents 2025/26

Reporting year	Number of incidents	Annual change
2019/20	204	
2020/21	279	+36.8%
2021/22	399	+43.0%
2022/23	456	+14.3%
2023/24	448	-1.8%
2024/25	493	+10.0%
2025/26	**555**	**+12.6%**



5.3 Safeguarding Adults Data by category

Neglect remained the most frequently recorded safeguarding adults category in 2025/26, accounting for 156 incidents (28.1% of all safeguarding adults concerns). This was followed by self-neglect (76 incidents; 13.7%), financial abuse (67; 12.1%), psychological or emotional abuse (63; 11.4%), physical abuse (61; 11.0%), domestic abuse (54; 9.7%), and sexual abuse (31; 5.6%).

Combined, neglect and self-neglect accounted for 232 incidents, representing 41.8% of all safeguarding adults concerns reported during the year. This highlights the continuing importance of identifying and responding to concerns where individuals may be at risk due to unmet care needs, inadequate support, or an inability to care for themselves safely.

The number of recorded neglect incidents increased significantly from 93 in 2024/25 to 156 in 2025/26, a rise of 67.7%. Self-neglect concerns also increased substantially, doubling from 38 to 76 incidents. These increases warrant further review, as there may be variation in how staff differentiate between neglect by another person or organisation and self-neglect. The Safeguarding Team will continue to work with care groups to strengthen understanding of definitions and promote consistent coding and recording practices.

Physical abuse concerns increased from 52 to 61 incidents during the year, while psychological or emotional abuse remained stable at 63 incidents. Financial abuse reduced from 78 to 67 incidents, and domestic abuse concerns fell from 88 to 54 incidents. These reductions should be interpreted with caution, as domestic abuse may present through, and therefore be recorded under, a range of other safeguarding categories including psychological, physical, sexual, financial abuse, or neglect.

Seven incidents of cuckooing were recorded during 2025/26, reinforcing the need for continued awareness of criminal exploitation. Such cases often involve another person exerting control over an adult's home, finances, relationships, or daily living arrangements.

In addition, seven concerns relating to radicalisation were recorded, compared with three in 2024/25. While overall numbers remain low, each concern requires appropriate safeguarding assessment and Prevent oversight to ensure risks are recognised and managed effectively.

Table 3: 2025/26 Adult Safeguarding Referrals by Category

Type of Abuse	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Sexual Abuse	34	52	77	43	48	34	31
Physical Abuse	20	41	49	58	50	52	61
Neglect	**32**	**29**	**60**	**77**	**84**	**93**	**156**
Self-Neglect	8	11	17	23	33	38	76
Hate Crime	2	3	9	17	23	10	5
Discriminatory (included within hate crime from 2023/24)	1	0	0	0	N/A	N/A	N/A
Organisational	3	10	11	11	7	15	13
Domestic Abuse	**12**	**28**	**38**	**57**	**39**	**88**	**54**
Radicalisation	1	2	5	5	2	3	7
Psychological	**21**	**49**	**73**	**72**	**81**	**63**	**63**
Financial	**31**	**32**	**47**	**71**	**70**	**78**	**67**
Human Trafficking	0	1	1	1	0	0	0
Forced Marriage	0	0	0	3	0	1	2
Nutrition	5	1	0	0	0	0	0
Failure in the Safeguarding process	1	4	7	10	9	13	12
Other	**34**	**15**	**5**	**8**	**1**	**0**	**1**
Cuckooing[1]	**0**	**0**	**0**	**0**	**1**	**5**	**7**
Total	**204**	**279**	**399**	**456**	**448**	**493**	**555**

5.4 Severity of Safeguarding Adults Incidents

Of the 555 safeguarding adults incidents recorded during 2025/26, over half were assessed as low risk. A total of 301 incidents (54.2%) were graded green (low risk), 224 incidents (40.4%)

[1] *Cuckooing: where offenders exploit someone by taking over their home and use the property for their own purposes, often the storage of drugs or weapons but not exclusively. Victims are often targeted because of a vulnerability, and offenders can be violent and threatening. Cuckooing is not a criminal offence, however there may be changes to legislation going forward that will rectify this position.

were graded yellow (moderate risk), and 30 incidents (5.4%) were graded amber (high risk). No incidents were graded red.

While the majority of concerns were assessed as low or moderate risk, the proportion of incidents graded yellow and amber highlights the ongoing need for robust safeguarding oversight, timely intervention, and appropriate escalation to protect adults at risk and mitigate harm.

The absence of red-graded incidents should not be viewed in isolation as evidence that no serious safeguarding concerns occurred during the year. Incident severity grading reflects the level of harm or impact assessed under the Trust's patient safety framework and should not be regarded as a direct measure of safeguarding complexity or seriousness. It is distinct from:

- A local authority decision regarding whether Section 42 enquiry criteria are met
- The seriousness of any alleged criminal offence
- The level of ongoing safeguarding risk to the individual
- Whether a statutory safeguarding review is required
- The individual's own experience and impact of the incident

A review of safeguarding adults incidents identified opportunities to improve the consistency, quality and accessibility of safeguarding information recorded across incident-reporting systems and clinical records.

The review found that safeguarding information was not always documented consistently or linked effectively across systems. In some cases, it was difficult to establish a clear chronology of events, identify all individuals involved, understand the actions taken to mitigate risk, locate associated local authority referrals, or confirm the outcome and closure of safeguarding activity. Where concerns involved multiple individuals, safeguarding information was not always recorded within each relevant clinical record, limiting visibility of risk and decision-making.

Further improvement is also required in relation to the quality and completeness of safeguarding referrals submitted to local authorities. Referrals containing incomplete, inaccurate or insufficient information may be returned for clarification or declined, creating additional administrative burden for staff and potentially delaying assessment, intervention and support for adults at risk. Staff also reported challenges in obtaining timely updates regarding the progress and outcomes of safeguarding concerns once referrals had been submitted.

Improving the quality of safeguarding documentation, strengthening record linkage across systems, and enhancing the standard of referral information will remain key priorities for 2026/27. This work will support more effective safeguarding practice, improve assurance regarding decision-making and outcomes, and strengthen partnership working with local authority safeguarding teams.

The table below shows the safeguarding adults incidents as categorised by severity:

	Green Low risk - minor or no injury, impact or intervention	Yellow Moderate risk - Moderate injury, impact or intervention	Amber high risk – major injury, impact or intervention	Total
Cuckooing	2	1	4	7
Domestic Abuse	22	31	1	54

	Green Low risk - minor or no injury, impact or intervention	Yellow Moderate risk - Moderate injury, impact or intervention	Amber high risk – major injury, impact or intervention	Total
Emotional/psychological abuse	37	23	3	63
Financial abuse	46	19	2	67
Forced marriage	2	0	0	2
Hate Crime & Discriminatory abuse	3	2	0	5
Neglect concerns	80	69	7	156
Organisational abuse	8	5	0	13
Physical abuse	35	22	4	61
Radicalisation or Terrorist Activities Affecting an Adult	3	3	1	7
Self-Neglect	39	34	3	76
Sexual abuse	15	12	4	31
Failure in Safeguarding Process	8	3	3	12
Safeguarding external review (for safeguarding team use only)				
Total	301	224	30	555

Table 4: Adult Safeguarding by Severity 2025/26

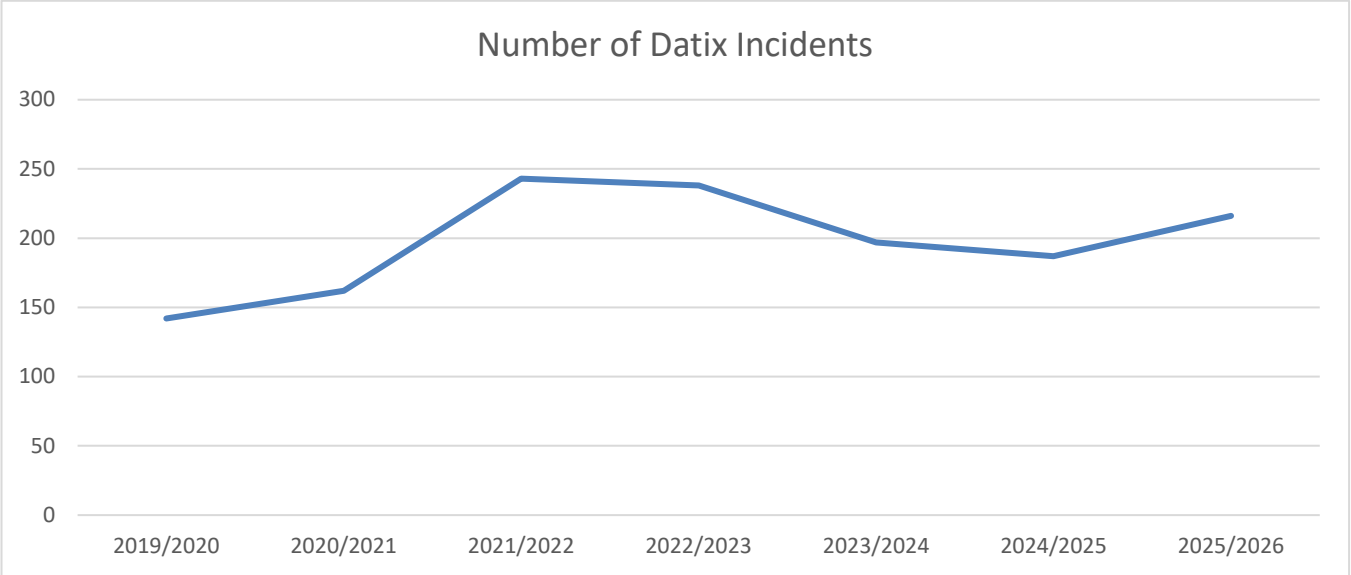
5.5 Safeguarding children Datix figures

The number of DATIX completed for children safeguarding has increased this year. The safeguarding team continues to undertake the triangulation audit on a monthly basis , reviewing how many practitioners had sought advice from the safeguarding team, whether the safeguarding node had been updated appropriately and were copies of the referral attached to the DATIX and uploaded on to the patient record. Alongside the triangulation audit an additional audit of the samples of the written referrals is also undertaken and feedback is provided directly to the practitioner and their line manager. Triangulation findings are feedback to the care group via the governance updates on a monthly basis. There continues to be gaps in documenting in the safeguarding node that the team continue to promote through training and supervision

Year	Number of Datix Incidents
2019/2020	142
2020/2021	162
2021/2022	243
2022/2023	238
2023/2024	197
2024/2025	187
2025/2026	**216**

Table 6: Child Safeguarding Datix Reports

SPC 2: Chart to represent the number of Datix incidents for safeguarding children from 2019-2026:



Analysis of Datix safeguarding reports by category shows that 'Child Protection - Other' remained the most frequently recorded category during 2025/26, with 55 incidents reported. This category is often selected when practitioners are uncertain about the most appropriate abuse or safeguarding category to apply. Use of this category increased during the year, highlighting the importance of continued support and guidance to strengthen categorisation and recording practices. Where incidents are recorded as 'Child Protection - Other', the Safeguarding Team reviews the information provided to ensure the category has been used appropriately and reclassifies incidents where a more specific safeguarding category is identified.

Sexual abuse was the second most frequently reported category during 2025/26. This increase may reflect greater awareness and recognition of child sexual abuse across the Trust, supported by learning from the Child Safeguarding Practice Review (CSPR) annual review, *"I Wanted Them All to Notice."* During the year, the Safeguarding Team enhanced resources available to staff through the safeguarding intranet pages, including guidance on communicating effectively with children and young people, recognising the signs and indicators of child sexual abuse, and access to resources from the Centre of Expertise on Child Sexual Abuse. These developments are intended to support practitioners in identifying, recording and responding appropriately to concerns.

Neglect was the third most commonly reported category, with 32 incidents recorded. Review of these incidents identified recurring themes relating to parental or carer capacity being adversely affected by substance misuse, impacting their ability to meet the needs of children and young people. These cases often required a coordinated multi-agency response to assess risk, provide support and promote the child's welfare.

During 2025/26, three incidents were reported involving the admission of children to adult inpatient wards where no age-appropriate inpatient provision was available. These incidents involved two individual children. In each case, the Safeguarding Team was notified and worked alongside clinical teams to provide advice and support. There was evidence of effective multi-

agency working, appropriate safeguarding arrangements, and Child and Adolescent Mental Health Services (CAMHS) in-reach support to inpatient ward staff to help ensure the children's needs were met safely and appropriately.

Across all child safeguarding incidents reported during the year, there was clear evidence of referrals being made to local authority children's services where appropriate and of effective multi-agency collaboration. The Trust's commitment to the Think Family approach was evident throughout communications with partner agencies, ensuring that the wider needs and circumstances of children, parents and carers were considered as part of safeguarding assessment and intervention.

The table below summarises child safeguarding referrals by category

Type of Abuse	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**2025/2026**
Child neglect	30	34	41	42	38	38	32
Child protection - other	30	30	61	53	46	41	55
Physical abuse	21	28	36	43	35	33	24
Request for service	17	16	25	22	25	26	40
Sexual abuse	19	29	52	34	27	21	34
Emotional abuse	9	7	15	20	13	8	12
Admission to adult wards	12	13	1	7	4	5	3
Death	2	0	0	2	1	2	1
Radicalisation	1	2	1	2	1	1	1
Honour Based Violence	0	0	0	0	0	1	0
Safeguarding external review	0	2	0	0	1	1	1
Child visiting	1	1	0	0	0	2	3
Hate crime	0	0	1	1	0	0	0
Failure in the Safeguarding process	0	0	10	12	6	8	10
Total	142	162	243	**238**	**197**	**187**	**216**

Table 7: 2025/26 Child Safeguarding Referrals by Category

	Green Low Risk – minor or no injury, impact, or intervention	Yellow Moderate Risk – moderate injury, impact, or intervention	Amber High Risk – major injury, impact, or intervention	Red Extreme Risk – catastrophic impact, life threatening injury or patient safety death	**Total**
Honour based abuse against a child	0	0	0	0	**0**
Request for Service	26	14	0	0	**40**

	Green Low Risk – minor or no injury, impact, or intervention	Yellow Moderate Risk – moderate injury, impact, or intervention	Amber High Risk – major injury, impact, or intervention	Red Extreme Risk – catastrophic impact, life threatening injury or patient safety death	**Total**
Child (under 18yrs) admitted to adult mental health unit	3	0	0	0	**3**
Child neglect/parenting concern (allegation or concern)	17	14	1	0	**32**
Physical abuse/violence to child (allegation or concern)	8	15	1	0	**24**
Emotional abuse of child	7	5	0	0	**12**
Sexual abuse of child (allegation or concern)	15	16	3	0	**34**
Death of a child	1	0	0	0	**1**
Radicalisation or Terrorist Activities affecting a child	1	0	0	0	**1**
Child Protection – other	22	30	3	0	**55**
Failure in safeguarding process	5	3	2	0	**10**
Total	**108**	**97**	**11**	**0**	**216**

Table 8: Child Safeguarding Incidents by Severity 2025/26

5.6 Safeguarding adult advice

The Safeguarding Team operated a Monday-to-Friday advice service throughout 2025/26, providing specialist support to practitioners managing complex safeguarding concerns.

The service recorded 1,165 contacts. Domestic abuse and information sharing were the most frequent themes, accounting for 238 and 236 contacts respectively. Other significant areas included physical abuse, financial or material abuse, neglect, mental capacity and self-neglect. Although lower in volume, enquiries concerning People in Positions of Trust, organisational abuse and inter-agency concerns often required detailed consultation and multi-agency coordination.

Mental Health Services accounted for approximately 85% of all contacts, followed by Learning Disability and Adult Autism/ADHD Services, Barnsley Health and Wellbeing Services and Forensic Services.

The volume and complexity of contacts demonstrate the continuing value of accessible specialist safeguarding advice. The high number of information-sharing enquiries also indicates that practitioners require ongoing support to balance confidentiality, consent and safeguarding responsibilities. During 2026/27, the Trust will review the accessibility, responsiveness and capacity of the advice service, strengthen information-sharing guidance and improve how advice, professional consultation and supervision are defined, recorded and evaluated. Detailed activity is provided in Appendix A.

5.7 Children's Safeguarding Advice Service

During 2025/26, the Children's Safeguarding Advice Service recorded 709 contacts, supporting practitioners with risk assessment, decision-making and multi-agency working.

Information sharing was the most frequent theme, generating 170 contacts. Other significant areas included concerns relating to sexual abuse at 70, neglect and omission at 69, emotional abuse at 52, physical abuse at 51, domestic abuse at 47, early help at 44 and parental mental health at 33. Think Family contacts increased to 16, reflecting continued consideration of the needs of children within the wider family context.

CAMHS accounted for approximately 69% of contacts, while Mental Health Services accounted for approximately 28%. The remaining contacts came from other care groups, Trust-wide services and external agencies.

Feedback received during 2025/26 highlighted concerns regarding the accessibility of safeguarding advice and the timeliness of responses. As a result, a review of the Safeguarding Advice Service is planned for 2026/27. The review will explore service accessibility, responsiveness, and practitioner experience, identifying opportunities to strengthen the service and ensure safeguarding advice remains timely, effective, and responsive to the needs of staff and partner agencies.

5.8 Safeguarding Supervision 2025/26

Safeguarding supervision supports staff to reflect on complex cases, analyse risk, apply professional curiosity and consider information sharing, escalation and multi-agency working. It also provides an important source of professional and reflective support.

5.9 Children's safeguarding supervision

During 2025/26, the Safeguarding Children Team recorded 846 staff attendances, representing 4,211 recorded minutes of supervision and professional-support activity. Supervision was provided across Children, Young People and Families, Mental Health, Barnsley and Trust-wide services, with the offer extending to Forensic Services during the second half of the year.

This demonstrates a sustained supervision offer and supports staff across the Trust to maintain a Think Family approach and consider the safety and wellbeing of children and young people within clinical practice.

5.10 Adult safeguarding supervision

The Safeguarding Adults Team recorded 103 staff attendances, representing 545 recorded minutes of supervision. Support was provided across Mental Health, Barnsley, Learning Disability and Forensic Services, with broader service participation during the second half of the year.

Safeguarding advice calls also provided case-based reflection and supervisory support. As this activity was not always recorded separately as formal supervision, the reported figures may underrepresent the full level of support delivered.

Future development

During 2026/27, the review of the Safeguarding Advice Service will clarify how advice, consultation and supervision are defined and recorded. This will strengthen assurance regarding demand, service reach and the impact of supervision on professional decision-making and safeguarding practice.

5.11 Sexual safety

In line with national work to strengthen safety, dignity and respectful care within mental health services, the Trust has continued a focused programme of improvement, particularly across inpatient settings. Staff awareness of personal safety, professional boundaries and the importance of responding promptly to inappropriate or harmful behaviour has increased, supported by specialist advice and guidance from the Trust Safeguarding Team.

Reported incidents may involve people using services, staff or other individuals. The Trust reviews these reports to identify recurring themes, affected groups, environmental factors and opportunities for prevention. Responses include immediate safety planning, appropriate safeguarding and patient-safety action, trauma-informed support for those affected, review of clinical formulations and care plans, and escalation to external agencies where required

The table below shows the number of sexual safety incidents over the year 2025/26 :

Table 5: Sexual Safety Incidents 2025/26

	2025									**2026**			**Total**
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Inappropriate sexual behaviour	7	16	18	15	17	28	15	12	21	9	10	7	**175**
Alleged sexual assault or harassment	2	3	0	2	0	8	4	1	1	0	3	0	**24**
Sexual harassment	1	2	1	1	0	0	2	3	2	3	1	0	**16**
Sexual assault	1	1	4	2	2	4	3	0	0	1	2	2	**22**
Other sexual incident	0	0	3	0	0	1	1	1	1	0	1	0	**8**
Total	11	22	26	20	19	41	25	17	25	13	17	9	**245**

The table above shows a significant increase in incidents in September 2025, this was investigated further and it was attributed to a couple of individual service users who were unwell and displaying sexualised behaviours.

Sexual Safety for Service Users

A working group, which focused on the sexual safety of service users began in April 2025. This is chaired by the Associate Director of Nursing, Quality and Professions and attended and support by colleagues from across Mental Health, Forensics and Learning Disability services. Children and Families services are joining in 2026. This working group aligns with the Sexual Safety Collaborative Standards and uses this to help guide the work.

Throughout the 2025/26, the group has:

- Developed a sexual safety dashboard, using Datix information, to monitor and track sexual safety incident within services, enabling targeted work to take place.
- Refreshed the “Sexual Safety and Relationships Guidance”.
- Developed “Guidance on the use of Sexual Aids in Inpatient services”, following a request from the Mental Health Care Group.
- Released a SBAR (Situation, Background, Assessment, Recommendations) report to support staff following a sexual safety incident involving a service user.
- Develop guidance to support staff with completing a Datix following a sexual safety incident, to ensure all relevant information is available for review and analysis and to aid with learning and improvement.
- Held bi-monthly meetings of the group, identifying any new trends, information or developments.
- Updated the Sexual Safety Standards poster for service users, gaining lived experience feedback to help make this relevant and meaningful for service users.
- Reviewed the previous audit from Ward 18, identified actions from this and ensured completion of these actions. A repeat audit is planned for Q3/Q4 2026/27.
- Piloted the use of sexual safety cards on select wards, to gather feedback from service users on how safe they feel. This feedback is being shared with the working group and is supporting actions and developments

5.12 Person in a Position of Trust (PiPoT)/LADO[2]

The Trust’s lead for Person in Position of Trust (PiPoT) is the Associate Director of Nursing, Quality and Professions. A PiPoT concern arises when an employee or volunteer behaves in a way, either inside or outside of work, that breaches professional boundaries or conflicts with the organisation’s values, such as forming inappropriate relationships or financial exchanges with service users. If such behaviour may impact their role, it could lead to an internal investigation and possible disciplinary action.

Where vulnerable adults or children are involved, concerns must be reported to the relevant local authority: the LADO for children, or the PiPoT lead for adults. The Trust investigates concerns involving its own staff, volunteers, or bank staff, while keeping the local authority informed.

To raise awareness, the Trust has finalised PiPoT guidance, now available via the intranet. Two tiers of training support its implementation:

- Tier 1: For non-patient-facing staff, delivered via e-learning.
- Tier 2: For patient-facing staff, available through webinars or face-to-face workshops led by the Safeguarding Team.

The training covers:

- the importance of values-based and therapeutic relationships.
- understanding the PiPoT role and boundaries.
- responding to potential breaches.
- what happens after a breach is reported.

Workshops offer interactive learning and are especially suited to clinical leads, though all staff grades are encouraged to attend.

6. Quality, audit and improvement

6.1 Internal Audit

[2] A LADO is a Local Authority Designated Officer, a key safeguarding role in the UK responsible for managing and overseeing allegations made against adults who work with children.

A Trust-wide Prevent audit was completed in April 2025 to assess staff understanding of the Prevent duty, radicalisation risks, referral pathways and information-sharing responsibilities.

The audit provided positive assurance regarding general staff awareness. Of those responding, 88.78% had completed mandatory Prevent training, 67.91% understood the national Prevent agenda and objectives, and 81.32% reported awareness of the safeguarding process for concerns relating to radicalisation. The Trust Safeguarding Team was the most frequently identified route for advice and escalation.

The audit also identified gaps in understanding of the Channel process, referral arrangements and consent requirements. Of the respondents, 35.64% reported that they did not understand the Channel process and 72.41% were unsure whether consent was required for a Channel referral.

During 2026/27, the Trust will refresh its Prevent resources, clarify Channel and referral pathways, and continue to promote learning through mandatory training, safeguarding communications and link practitioners.

The wider 2026/27 safeguarding internal audit programme will be informed by previous findings, statutory-review learning, safeguarding advice themes and identified gaps in assurance. Planned activity includes follow-up work relating to domestic abuse, children visiting inpatient services and personal safety, alongside audits of Making Safeguarding Personal, external-review action closure, information sharing and risk to others.

6.2 Multiagency Audit

The Safeguarding Team has undertaken several planned audits following external safeguarding reviews. These include:

- The Safeguarding Team continue to actively participate in several multi agency audits across the Trusts geographical footprint. With strong links and representation at both the children and adult safeguarding partnerships and boards the learning from the multiagency audits helps to ensure that the Trust remains up to date and supports the culture of continual improving and learning.

- The Safeguarding Team contributed to several multi-agency audits across Kirklees, Calderdale, Barnsley and Wakefield.

- In May 2025 The safeguarding team contributed to the Sexual Abuse multiagency audit in Kirklees. That involved reviewing health records of several children and young people to seek assurance around actions taken when a disclosure of sexual abuse had been made Following on from the findings further mapping work was undertaken across the footprint to clarify and strengthen the response from agencies , The safeguarding team updated and expanded the Trust Intranet pages on childhood sexual abuse, providing links to the centre of excellence of childhood sexual abuse including support for staff In July 2025 the safeguarding team contributed to the multiagency Neglect audit in Barnsley which looked at the use of the Neglect tool kit across agencies, reviewing 41 children and families .The findings identified barriers for practitioners in using the toolkit as it was perceived as too time-consuming, this led to a review of the existing tool and a more streamlined version was developed .

- In July 2025 the safeguarding team contributed to the multiagency Sexual abuse audit led by Barnsley safeguarding children partnership. The audit helped to inform the Partnership sexual abuse strategy and delivery plan.

- In January 2026 the safeguarding team contributed to the multiagency audit in Kirklees looking at the step-down process from Child In Need. This allowed for themes around consistency in decision making and threshold of needs to be considered.

6.3 Policies and Procedures

The Child in-patient visiting policy underwent a review in 2025 and was approved by the EMT in November 2025 . The policy is there to support staff to assess the suitability of facilitating a child visit to a mental health inpatient ward and also considers what to consider when planning home leave for service users where they may be children. The policy includes appendices for Newton Lodge who also have an additional procedure. To support this policy the safeguarding team has continued to support the delivery of the child contact training in Newton Lodge.

6.4 Annual safeguarding conference

The Trust's annual safeguarding conference was held on 10 October 2025 and focused on sexual abuse and intrafamilial harm. The event brought together speakers from a range of specialist organisations, including RASAC, GASPED, Andy's Man Club, Papyrus, Deflect and Protect, IDAS, SPACE and Turning Point.

Presentations highlighted the prevalence and impact of sexual violence, the importance of trauma-informed practice, and ensuring individuals feel believed, heard and empowered when disclosing abuse. Sessions also explored support available for male survivors, suicide prevention, domestic abuse, digital exploitation and radicalisation risks, and the increasing harms associated with substance misuse among young people.

Key themes throughout the conference included vulnerability, safeguarding in the digital environment, the importance of early intervention, and the value of partnership working to support individuals affected by abuse, exploitation and emotional distress.

The conference was well attended by Trust staff and partner agencies, and feedback was overwhelmingly positive, with delegates reporting increased awareness and understanding of contemporary safeguarding issues and available support services.

6.5 Joint Academic Psychiatric Seminar

The Joint Academic Psychiatric Seminar was held in October 2025 via Teams. The Safeguarding Team delivered a joint children and adult training session, and the following topics were covered: Think Family and professional curiosity. This topic was chosen as it is a recurring feature in many safeguarding child practice reviews and is particularly pertinent in times where services are often stretched and contacts may be reduced or moved to online that practitioners are reminded of the need to Think Family. The Adult safeguarding training focused on learning from adult safeguarding reviews, audits completed by the Safeguarding team, annual report key highlights and work of the safeguarding team update. The key areas of learning were around, professional curiosity, self-neglect and hoarding, communication, especially where there are communication needs / sensory needs and se of accessible information. Over 100 delegates attended the seminar, and the presentations were shared with all the participants. The feedback from the delegates was very positive. With over 30 responses to the questionnaire, with all either rating the raining as exceeded expectations or met expectations.

6.6 Safeguarding Situation, Background, Analysis, Recommendations (SBARs)

The Safeguarding Team continue to provide information to colleagues across the Trust to support learning and promote robust safeguarding practice within the care provided. One of the ways that the team support this is through the dissemination of the safeguarding newsletter. Learning has been formulated into a briefing paper using the SBAR format, in which is then shared in the weekly newsletter. Below are examples of briefing papers shared during the timeframe of this report. These can also be accessed by staff through the Trust's learning library. The table below shows a summary of briefing papers Situation, Background, Analysis, Recommendations (SBARs) during 2025/26

Date	Title of SBAR
February 2025	Learning for neglect strategy toolkits
November 2025	The Child protection information sharing system
September 2025	Safeguarding advice line

These can be accessed on the learning library: Learning library (sharepoint.com)

7.0 Partnership Working

South West Yorkshire Partnership Teaching NHS Foundation Trust is an active member of the Safeguarding Adults Boards and relevant subgroups across Barnsley, Calderdale, Kirklees and Wakefield. The Trust contributes to quality assurance, statutory reviews, domestic abuse arrangements, learning and development, complex-risk management, public protection and policy development.

Participation provides external challenge and assurance, enables the Trust to influence local priorities and supports the transfer of multi-agency learning into Trust governance, training and clinical practice.

Place-based activity and learning

Place	Key activity and learning during 2025/26	Focus for 2026/27
Barnsley	Learning from the Safeguarding Adults Reviews reinforced the importance of professional curiosity, persistence, accessible communication, decision-specific mental capacity assessment, trusted relationships and coordinated responses to self-neglect and non-engagement.	Embed review learning, strengthen Making Safeguarding Personal and self-neglect practice, and evidence the impact of completed actions.
Calderdale	Partnership activity focused on domestic abuse, self-neglect, complex risk, communication needs, information sharing and multi-agency escalation. Learning highlighted	Strengthen routine domestic abuse enquiry, support MARAC and DRAMM arrangements, and align Trust

Place	Key activity and learning during 2025/26	Focus for 2026/27
	the importance of clear risk ownership and appropriate professional challenge.	activity with Calderdale's 2026–2029 priorities.
Kirklees	The Trust contributed to statutory reviews, multi-agency audits and the Board's Challenge Event. Key themes included self-neglect, domestic abuse, homelessness, crisis response, workforce capacity and the need to demonstrate the impact of review learning.	Improve safeguarding supervision, workforce resilience, multi-agency risk ownership, domestic abuse recording and evidence of learning impact.
Wakefield	The Board strengthened quality and performance assurance, policy accessibility and learning relating to mental capacity, homelessness, substance use, self-neglect and complex lives.	Support the Board's assurance and improvement priorities and ensure relevant actions are reflected within Trust governance and safeguarding workplans.

The Trust's participation in the four Safeguarding Adults Boards provides important external assurance and access to local and regional learning. During 2026/27, the Trust will strengthen the recording of Board commitments, confirm lead and deputy representation, improve the transfer of partnership learning into care group governance and provide clearer evidence that multi-agency actions have changed practice and improved outcomes for adults at risk.

7.1 Joint Targeted Area inspection (JTAI) Calderdale

In January 2026 the Safeguarding Team participated in a multi-agency audit In Calderdale, looking at referrals made to the front door where no further action was taken through a lens of cultural competency. This was following the findings from a key learning point identified in the Sara Sharif Child Safeguarding Practice Review with the importance of cultural competence. The audit looked at the use of interpreters across agencies and understanding and responding to the needs of racially minoritised children and families. The audit identified gaps across the partnership around access to Romany services which was addressed through the safeguarding partnership.

7.2 Equality and inclusion

Audit and review learning during 2025/26 reinforced the importance of cultural competence, accessible communication, professional interpreters and reasonable adjustments. The Trust recognises that poverty, homelessness, disability, neurodivergence, language barriers and digital exclusion may affect safeguarding risk and access to support. During 2026/27, the Trust will improve analysis of protected-characteristic data and strengthen involvement of people from seldom-heard communities.

7.2 Learning Circle Wakefield

In December 2025, the Trust contributed to a multi-agency learning circle following the death of a young person with a history of trauma and significant mental health needs. Learning focused on responding to cumulative trauma, multi-agency risk management, the quality of clinical documentation and the challenge of maintaining safety where risk is persistent and complex. The relevant care group completed a documentation audit and implemented improvements, with wider learning shared through safeguarding resources and governance.

7.3 West Yorkshire Organisational Safeguarding Assessment (Formerly Section 11)

It is a legal duty of key organisations who work with children and young people to have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children. The West Yorkshire Safeguarding Children Partnerships and Adult Safeguarding Boards have worked together to introduce a shared online version of the organisational safeguarding assessment. The Safeguarding Team submitted this assessment to provide assurance to the multi-agency partners. Providers who deliver services in multiple areas across West Yorkshire are only required to submit one online Section 11 entry, which negates the need for duplicate submissions. In response to the submissions in each area, e.g., Kirklees, Calderdale and Wakefield facilitate various challenge events where providers are required to demonstrate actions and provide assurance. The next submission for Wakefield is due in October 2026.

In Barnsley, they too are moving towards a single online assessment as part of the South Yorkshire safeguarding assurance. No request has been received from Barnsley at the time of writing the annual report.

8. Learning and action plans from Domestic Homicide Reviews (DHRs), Child Safeguarding Practice Reviews (CSPRs) and Safeguarding Adult Reviews (SARs).

A Safeguarding Adult Review (SAR) takes place when:

- an adult in the area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult
- an adult in the area has not died, but the Safeguarding Adult Board (SAB) knows or suspects that the adult has experienced significant abuse or neglect

A Domestic Abuse Related Death Review (DARDR) formerly known as a Domestic Homicide Review (DHR) is a locally conducted multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have resulted from violence, abuse or neglect by:

- a person to whom he or she was related, or with whom he or she was or had been in an intimate personal relationship; or,
- a member of the same household as himself or herself
- where a victim has died by suicide in the context of domestic abuse

A Child Safeguarding Practice Review (CSPR), formerly known as a Serious Case Review (SCR), should be carried out for every case where abuse or neglect is known or suspected and either a child dies, or a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

From April 2025 to March 2026, the Trust has been involved in:

- Twenty scoping requests that did not progress
- Eight Safeguarding Adult Reviews,
- Seven Domestic Homicide Reviews/DARDRs,
- One Safeguarding Children Practice Review

8.1 Learning from Reviews

One SAR have been published within this timeframe. Barnsley Safeguarding Adults Board commissioned a statutory review following the death of Brian, aged 84. The review considered

how agencies responded to increasing self-neglect, declining physical health and repeated refusal of support. Concerns included significant weight loss, food insecurity, reduced mobility, fire risk and an unsafe home environment.

The review identified good practice through persistent engagement, professional curiosity and joint working between health, social care, housing and emergency services. However, opportunities were missed to assess the cumulative risks and consider whether Brian could act on decisions about his safety and wellbeing.

Key learning

The review reinforced the need to:

- Maintain persistent, relationship-based engagement when support is declined.
- Explore discrepancies between a person's account and observed circumstances.
- Assess cumulative risk and coordinate information across agencies.
- Distinguish the presumption of capacity from a decision-specific capacity assessment.
- Consider executive functioning where a person can express a decision but may be unable to implement it.
- Recognise and support family members, friends, neighbours and informal carers.
- Escalate concerns through multi-agency arrangements where risks continue to increase.

Seven-point briefing Œ Safeguarding Adults Review - fiBrianfl

8.3 Learning from Domestic Abuse Related Death Reviews

A joint Domestic Abuse Related Death Review and Independent Mental Health Homicide Investigation concerning Pat was published in August 2025. The Trust contributed to the multi-agency review, which examined how services worked with Pat and Mr G and identified learning for individual organisations and the wider Kirklees partnership.

Key learning included the importance of:

- Recognising domestic abuse where mental illness, cognitive impairment, caring responsibilities or other complex needs are present.
- Maintaining a Think Family approach and identifying the support needs of carers and family members.
- Sharing relevant information across organisational boundaries.
- Strengthening multi-agency risk assessment, safety planning and professional accountability.
- Translating review recommendations into sustained changes in frontline practice.

Kirklees partners strengthened domestic abuse governance, quality assurance, safety planning, workforce training and coordination of learning across the Communities Board and safeguarding partnerships. During 2026/27, the Trust will continue to monitor agreed actions and seek evidence that learning has been embedded and resulted in improved practice and safer outcomes.

Domestic Homicide Review 'Pat' Assurance Statement

8.4 A Child Safeguarding Practice Review (CSPR)

During 2025/26, the Trust contributed to two Child Safeguarding Practice Reviews that were not published.
Learning from the review concerning Baby G informed an action plan developed with the Perinatal Mental Health Service. Improvement activity has focused on strengthening the visibility of the child's voice within the parent's clinical record and improving safeguarding supervision through smaller, more focused groups.
The review concerning Child U reinforced the importance of Think Family practice, including consideration of risks to children and other family members where parents are receiving mental health services. In response, the Safeguarding Team developed a practitioner toolkit addressing family risk, parenting capacity and the wider impact of parental mental ill health.

Learning from both reviews continues to be embedded through Level 3 safeguarding training, supervision, clinical guidance and Trust intranet resources. Progress against the associated actions is monitored through safeguarding and care group governance arrangements.

11.0 Horizon Scanning

11.1 AGNI Judgement

On 2 June 2026, after the 2025/26 reporting period, the UK Supreme Court handed down its judgment in *A Reference by the Attorney General for Northern Ireland* [2026] UKSC 16, commonly referred to as the AGNI ruling. The judgment applies across the UK and changes the legal approach to determining whether a person is deprived of liberty. It replaced sole reliance on the Cheshire West "acid test" with an individualised, multi-factorial assessment that considers the nature, duration and impact of restrictions, alongside the person's wishes and feelings. As a post-year-end development, the Trust will review relevant policies, provide staff briefings and strengthen recording, legal advice and audit arrangements during 2026/27

11.2 Children's Safeguarding Policy and Legislative Developments (2026)

Revised **Working Together to Safeguard Children** guidance was published in March 2026, shortly before the end of the reporting period. The guidance strengthens expectations for child-centred and whole-family practice, multi-agency accountability, information sharing, cultural competence and responses to hidden and extra-familial harm. It also places greater emphasis on demonstrating the impact of safeguarding arrangements on children and families.

The **Children's Wellbeing and Schools Act 2026**, which received Royal Assent after the reporting period, introduces further reforms intended to strengthen information sharing, oversight of children outside mainstream education and safeguarding responsibilities across partner agencies. As individual provisions will be implemented at different times, the Trust will monitor commencement arrangements and assess their implications for clinical services and partnership working.

During 2026/27, the Safeguarding Team will update Level 3 training and practice resources, support implementation of revised multi-agency arrangements and provide additional guidance where required. Particular attention will be given to lawful and proportionate information sharing, Think Family practice, the child's lived experience, anti-discriminatory practice and clear professional accountability.

11.3 Southport Enquiry

Following publication of Phase 1 of the Southport Inquiry on 13 April 2026, the Safeguarding Team developed an SBAR briefing to support clinical practice, safeguarding and public protection. As publication occurred after the 2025/26 reporting period, this is presented as a post-year-end development.

The Inquiry identified significant multi-agency failings in the ownership and coordination of cumulative risk, information recording and sharing, consideration of risk to others, oversight of harmful online activity and interpretation of behaviours associated with autism. The findings were clear that autism should neither be associated generally with violence nor used to minimise concerning behaviour.

Key learning for the Trust includes:

- Assessing risk to others alongside risk to self.
- Establishing clear professional ownership of complex-risk plans.
- Escalating concerns where responsibility or accountability is unclear.
- Sharing relevant information lawfully and proportionately.
- Applying professional curiosity to cumulative risk, online activity and family dynamics.
- Seeking specialist safeguarding, Prevent, forensic and neurodevelopmental advice where appropriate.
- Using safeguarding supervision to support complex decision-making.

During 2026/27, the Trust will embed this learning through clinical briefings, training and safeguarding supervision. Audit and case-review activity will be used to assess the quality of information sharing, professional curiosity, risk assessment, escalation and multi-agency ownership.

11.4 Domestic Abuse: National Developments and Trust response

During 2025/26, national policy continued to strengthen the role of health services in identifying and responding to domestic abuse. The NHS Standard Contract requires providers to maintain effective safeguarding arrangements, while wider national policy emphasises early identification, trauma-informed support, effective referral pathways and collaboration with specialist domestic abuse services.

The Trust progressed its domestic abuse improvement programme through audit and action planning, routine enquiry, updated Level 3 safeguarding training. The Trust also commissioned Behind Closed Doors training, providing staff with further opportunities to strengthen awareness, professional curiosity and confidence in recognising and responding to domestic abuse. Audit findings indicated that routine enquiry and recording were not yet consistently embedded, and further workshops, guidance and re-audit are planned for 2026/27.

Bespoke training was also developed with Admiral Nursing colleagues following learning from a review involving domestic abuse and dementia. The initial session reached more than 90 Admiral Nurses working across a range of health and care settings. Evaluation responses indicated that the training was relevant to practice and increased participants' confidence in recognising and responding to domestic abuse where dementia is present. The session has subsequently been delivered within the Trust and to external partners.

During 2026/27, the Trust will continue to strengthen routine enquiry and recording, promote Behind Closed Doors and other role-appropriate training, improve access to specialist support and evaluate the impact of learning through follow-up audit and safeguarding assurance arrangements.

12. Proposed priorities for 2026/27

Priority 1: Strengthen governance, accountability and specialist capacity

Ensure that safeguarding responsibilities are clearly owned across care groups and that the specialist Safeguarding Team has sufficient capacity and resilience to deliver operational support, assurance and improvement activity.

Priority 2: Review and Improve the Safeguarding Advice Service

The Trust will undertake a comprehensive review of the Safeguarding Advice Service to ensure that it remains accessible, responsive and sustainable. The review will consider increasing demand, response times, staffing capacity, service-user experience, practitioner feedback and any unmet need.

Priority 3: Improve safeguarding data, documentation and information sharing

Strengthen the quality, accuracy and consistency of safeguarding records, incident categorisation, local authority referrals and information sharing across Datix, clinical records and partner-agency systems.

Priority 4: Strengthen domestic abuse and public-protection arrangements

Embed routine domestic abuse enquiry, improve recording and referral pathways, and strengthen Trust assurance regarding MARAC, MAPPA, Prevent, online harm and risk to others.

Priority 5: Demonstrate the impact of learning and quality improvement

Ensure that learning from Safeguarding Adults Reviews, Domestic Abuse Related Death Reviews, Child Safeguarding Practice Reviews, audits and incidents leads to measurable and sustained improvements in frontline practice.

Priority 6: Develop the safeguarding workforce

Improve Level 3 training compliance, strengthen access to safeguarding supervision and establish clearer definitions and standards for advice, consultation and reflective supervision.

Concluding statement:

The Trust maintained established leadership, governance, specialist advice, supervision, training and multi-agency partnership arrangements, enabling staff to identify and respond to increasingly complex safeguarding concerns across adult, children’s and family services.

The year demonstrated tangible progress. Mandatory training compliance improved across all safeguarding levels, frontline teams continued to access substantial specialist advice and

supervision, and the Trust contributed actively to statutory reviews, multi-agency audits and safeguarding partnerships across Barnsley, Calderdale, Kirklees and Wakefield. Learning from incidents, audits and external reviews informed changes to policy, training, clinical guidance and practice resources.

The report provides reasonable assurance that effective safeguarding arrangements are in place. It also identifies areas where stronger and more consistent evidence is required, including safeguarding documentation, care group accountability, Mental Capacity Act assurance, routine domestic abuse enquiry, external-review action tracking and the measurement of person-led outcomes.

The breadth of the Trust's geographical footprint, rising safeguarding demand, increased case complexity and extensive partnership responsibilities continue to place significant pressure on the capacity and resilience of the specialist Safeguarding Team. These pressures may limit the team's ability to balance responsive operational support with planned audit, training, supervision, policy development and evaluation of impact. Maintaining safe and sustainable specialist capacity is therefore a key organisational priority.

During 2026/27, the Trust will undertake a review of safeguarding demand, capacity and delivery arrangements. The findings will inform workforce planning, prioritisation and the future operating model for specialist safeguarding support. The wider improvement programme will also focus on data quality and information triangulation, advice and supervision arrangements, learning from reviews, multi-agency ownership of risk and evidence of improved outcomes.

Progress will be monitored through care group and Trust governance, with significant capacity or safeguarding risks escalated to the Quality and Safety Committee and Executive Management Team. The Trust's priority is to move beyond assurance based primarily on activity and demonstrate clearly that safeguarding interventions result in timely action, safer care, meaningful involvement and improved outcomes for adults, children, families and carers.

Appendix A: Safeguarding Advice Calls 2025/26.

Safeguarding Adult advice call totals April 2025 – March 2026.

	Barnsley Health & Wellbeing Services (incl. Children's Services)	CAMHS	External Agencies	Forensic Services	LD and Adult ASD & ADHD Services	Mental Health Services	Support Services	Total
Child Exploitation	0	1	0	0	0	0	0	1
Concerns around mental capacity/ best interests	5	0	0	1	6	47	0	59
Discriminatory	0	0	0	1	1	1	0	3
Domestic Abuse	2	1	0	2	8	225	0	238
Early Help-EHA	0	1	0	0	0	2	0	3
Escalation	0	0	0	0	0	1	0	1
Finance and Material	2	0	0	4	2	88	0	96
Hoarding	0	0	0	0	0	1	0	1
Homelessness	0	0	0	0	0	4	0	4
Info Sharing	15	3	5	10	17	185	1	236
Interagency issues	0	0	0	0	0	4	0	4
Modern Slavery	1	0	0	0	0	5	0	6
Neglect and Omission	10	1	0	1	20	55	0	87
Non-recent Sexual Abuse	0	0	0	2	0	16	0	18
Organisational	0	0	0	1	1	4	0	6
Other – see below*	0	0	0	2	6	50	0	58
Parental MH	0	0	0	0	0	5	0	5
Parental Sub Misuse	0	1	0	0	0	1	0	2
Person in Position of Trust.	0	0	0	2	0	14	0	16
Physical Abuse	4	1	0	4	9	90	0	108
Psychological	0	0	0	1	1	43	0	45
Radicalisation	0	0	0	0	0	14	0	14
Self-Harm	0	0	0	0	0	8	0	8
Self-Neglect	8	0	0	0	2	15	0	25
Sexual Abuse	0	0	1	4	3	52	0	60

	Barnsley Health & Wellbeing Services (incl. Children's Services)	CAMHS	External Agencies	Forensic Services	LD and Adult ASD & ADHD Services	Mental Health Services	Support Services	Total
Sexual Exploitation	0	0	0	0	0	2	0	2
Suspected Fab Illness/Perplexing Issues	0	0	0	0	0	1	0	1
Think Family	0	1	0	0	2	20	0	23
Call booked/unable to contact therefore call closed	0	0	0	2	0	33	0	35
TOTAL	**47**	**10**	**6**	**37**	**78**	**986**	**1**	**1165**

Safeguarding Child advice call totals April 2025 – March 2026

	Barnsley Health & Wellbeing Services (inc. Children's Services)	CAMHS	Ext Agencies	Forensic Services	LD and Adult ASD & ADHD Services	Mental Health Services	Support Services	Trustwide	Total
Child Exploitation	0	21	0	1	0	1	0	0	**23**
DNA/Was Not Brought	1	14	0	0	0	1	0	0	**16**
Domestic Abuse	0	19	0	0	0	28	0	0	**47**
Early Help-EHA	1	26	0	0	0	17	0	0	**44**
Emotional Abuse	0	38	0	1	0	13	0	0	**52**
Escalation	0	5	0	0	0	2	1	0	**8**
Finance and Material	0	1	0	0	0	0	0	0	**1**
Historical Sexual Abuse	0	0	0	0	0	1	0	0	**1**
Info Sharing	3	129	4	1	1	31	0	1	**170**
Neglect and Omission	4	52	0	0	0	12	1	0	**69**
Non-recent Sexual Abuse	0	5	0	0	0	7	0	0	**12**
Other see below*	2	44	0	0	0	6	0	0	**52**
Parental Learning Disability	1	0	0	0	0	0	0	0	**1**
Parental MH	0	20	0	0	0	13	0	0	**33**
Parental Sub Misuse	0	2	0	0	0	7	0	0	**9**
Perinatal Mental Health	0	0	0	0	0	2	0	0	**2**

	Barnsley Health & Wellbeing Services (inc. Children's Services)	CAMHS	Ext Agencies	Forensic Services	LD and Adult ASD & ADHD Services	Mental Health Services	Support Services	Trustwide	Total
Person in Position of Trust.	0	0	0	0	0	1	0	0	**1**
Physical Abuse	0	30	0	0	0	21	0	0	**51**
Psychological	0	0	0	0	0	1	0	0	**1**
Radicalisation	0	0	0	0	0	1	0	0	**1**
Self-Harm	0	8	0	0	0	3	0	0	**11**
Self-Neglect	0	2	0	0	0	1	0	0	**3**
Sexual Abuse	1	53	0	0	0	16	0	0	**70**
Suspected Fab Illness/Perplexing Issues	0	1	0	0	0	0	0	0	**1**
Think Family	0	7	0	0	0	9	0	0	**16**
Call booked/unable to contact therefore call closed	0	10	0	0	0	4	0	0	**14**
	13	**487**	**4**	**3**	**1**	**198**	**2**	**1**	**709**

*Advice given to practitioners which could not be classified against the specific categories fields above included:

- fall in residential home sustained fracture
- had a gun
- thoughts of harm
- threats to kill public.
- Resolved before call back.
- about domestic abuse training
- threats to kill staff member
- Forced marriage
- neighbour threats
- not engaging with service
- anonymous info about patient seeking aesthetic treatment from multiple practitioners
- young person viewing inappropriate online content
- home invasion
- cuckooing

- medication error
- asked if service husband can visit unsupervised as the police have found no safeguarding concerns
- staff member received texts in derogatory manner from a service users' partner
- issues around worker's rights and dog bites
- aggression
- substance misuse
- alcohol abuse
- conflict between siblings
- received sexually explicit messages from another SU, unwanted
- theft of online images
- housing Issue, domestic
- clinical matter
- DVLA reporting
- asked if want to be girlfriend and said no
- staff member Info Governance Issues
- worried about cats in the home
- threats to bring weapon to school
- forced marriage
- carers stress
- stalking and harassment

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 10.8

Private/Public paper:	**Public**		
Title:	**Drugs and Therapeutics Sub-Committee Annual Assurance Report 2025/26**		
Lead Director:	**Professor Subha Thiyagesh Chief, Medical Officer**		
Mission/values:	The Report demonstrates D&T Sub-Committee's commitment to the Trust's values and to ensure and improve the safe and effective use of medicines within the organisation and for service users. The report covers achievements and outcomes in 2025/26 relating to business-as-usual activities and new and emerging issues.		
Purpose:	The purpose of this paper is to provide assurance to Trust Board that the Drugs and Therapeutics Sub-Committee has fulfilled its delegated remit during 2025/26 by advising the Trust on the safe, effective, appropriate and cost-effective use of medicines, related products and ECT, and by overseeing the governance systems that support medicines safety, availability and service-interface assurance.		
Strategic aims:	Live Our Values	✓	The report supports quality, value, partnership and innovation by evidencing medicines governance, digital prescribing progress, safer prescribing practice, system collaboration and productivity opportunities across pharmacy services.
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	5.1 Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively. 5.2 Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision.		

With **all of us** in mind.

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships.	• Active partners in Integrated pharmacy and medicines optimisation boards and area prescribing committees established in both South and West Yorkshire. • Area prescribing committees ensure equitable access to appropriate medicines • Digital developments including EPMA. • Reducing health inequalities in particular the burden of overprescribing and physical health impact of adverse effects of medicines, including in people with a learning disability or autism. • Reducing unwarranted variation in care through evaluation of medicines use and pharmacy service provision.
Any background papers / previously considered by:	The AAA reports are submitted bimonthly to the Quality and Safety Committee and update of ongoing activities and issues. The annual report was approved at the September Quality & Safety committee. Medicines optimisation and pharmacy framework (2026-31) was approved at the April 2026Quality & Safety Committee.
Executive summary:	The Drugs and Therapeutics Sub-Committee has maintained effective governance and assurance across its core remit during 2025/26, with evidence of strengthened clinical governance links, continued medicines safety oversight, delivery of digital prescribing milestones and measurable value-for-money improvement. Progress against the Pharmacy and Medicines Optimisation Framework and Plan 2026–31 (attached) is evident through Electronic Prescribing and Medicines Administration (EPMA) implementation completion across inpatient wards and intensive home-based treatment teams, further Electronic Prescribing Service implementation, lithium and clozapine safety template development, and strengthened system partnership working. The principal in-year risk has been continued disruption to medicines supply, including issues with paliperidone long-acting injection, which had potential implications for patient care and value for money; these risks were managed through established clinical pathways, governance and escalation routes. **Key achievements 2025-2026** Stopping over medication of people with a learning disability, autism or both (STOMP) - Work group is well established and linking with system partners, An audit of prescribing has been undertaking as part of improvement work. Electronic prescribing and transmission of prescriptions to community pharmacy (EPS) implemented in three further teams in Barnsley, Breathe service, Frailty and intermediate care virtual wards. Scoping and planning work has been undertaken for EPS in community mental health services with the pilot team Adult ADHD going live in July 2026. Following evaluation this will be rolled out across the CMHTs with completion expected by October 2026. EPMA implementation is completed for all inpatient wards including Cheswold Park Hospital and intensive homebased treatment teams trust-wide. SystmOne templates are developed for lithium and clozapine safety.

	Swap to Save campaign to ensure value for money on medicines spend and use of disposable multi-compartment compliance aids continues and is monitored though non pay group. Savings of £65,000 have been realised. The Sub-Committee continues to promote and monitor POMH audits and action plans leading to significant improvements. New pharmacy service introduced, post discharge follow-up by primary care mental health pharmacy team offered. Yellow Card Adverse drug reaction reporting. Summary Report 2024/25: The trust was the top yellow card reporter in the North of England. https://yellowcard.mhra.gov.uk/ **Key priorities 2026/27, deliverables and measures of success** **Best Value:** deliver a focused medicines productivity programme, including continued monitoring of procurement opportunities, Swap to Save benefits and cost-effective prescribing, with savings and avoided cost reported through governance routes. **Best place to work and learn:** strengthen workforce capability through independent prescribing development, advanced practice progression, structured support for newly registered pharmacists and technicians, and measurable appraisal and job-planning completion. **Best Partner and Best Quality:** improve access to pharmacy expertise for community mental health and specialist services, embed neighbourhood-working pharmacy input, and use digital developments to strengthen medicines safety, prescribing standards and equitable service access.
Recommendation:	**The Trust Board members are asked to:** • **RECEIVE and APPROVE** the Drugs and Therapeutics Sub-Committee Annual Assurance Report 2025/26 and note the assurance provided on medicines governance, safety oversight, value for money, digital prescribing progress and 2026/27 priorities. • **RECEIVE** the Medicines Optimisation and Pharmacy Framework.

DRUG & THERAPEUTIC SUB COMMITTEE (D&T)

(Covering April 2025 – March 2026)
ANNUAL REPORT

Introduction

The Drugs & Therapeutics Committee is a multidisciplinary Sub Committee of the Quality and Safety Committee with the remit of advising the Trust on policy related to the appropriate use, availability and cost of medicines, related products and ECT. Also, to ensure there are systems and processes in place to ensure the safe and effective use of medicines within the organisation and at service interfaces.
The D&T Terms of Reference are included as *Appendix 1*.

List of abbreviations:

ADHD:	Attention deficit hyperactivity disorder.
AHP:	Allied Health Professionals
ADIoS	Abusable Drug Investigational Software
DMS:	Discharge Medicines Service
ECT:	Electroconvulsive therapy
ECTAS:	Electroconvulsive Therapy Accreditation Service
EPMA	Electronic Prescribing and Medicines administration
EPS	Electronic Prescription Service
ICB:	Integrated care boards
ICS:	Integrated health and social care systems
JAPs:	Joint Academic Psychiatric Seminar
MaPPs:	Medicines: a Patient Profile Summary
MDT:	Multidisciplinary Team
NICE:	National Institute for Health and Care Excellence
OMG:	Operational Management Group
POMH:	Prescribing Observatory for Mental Health
PSIRF:	Patient Safety Incident Response Framework
SAS doctor:	Specialty and specialist
STOMP:	Stopping over medication of people with a learning disability, autism or both with psychotropic medicines

Meeting

There were 12 D&T meetings held over this period.

Summary of Achievements

Business as usual continued throughout the year, including reviewing and addressing medication incidents, complex clinical queries and response to medicines supply shortages. Updates to clinical and medicines code sections continue but staffing pressures have impacted on capacity. A plan is proposed to review whether sections are policy or procedure to streamline review.

Stopping over medication of people with a learning disability, autism or both (STOMP) - Work group is well established and linking with system partners. An audit of prescribing has been undertaken.

Electronic prescribing and transmission of prescriptions to community pharmacy (EPS) implemented in three further teams in Barnsley, Breathe service, Frailty and intermediate care virtual wards.

Scoping and planning work has been undertaken for EPS in community mental health services with the pilot team Adult ADHD going live in July 2026. Following evaluation this will be rolled out across the CMHTs with completion expected by October 2026.

Further scoping of outstanding teams and development of a bespoke plan for clozapine and long acting injection (depot) prescriptions will be the next step.

Electronic prescribing and medicines administration (EPMA) has been successfully implemented across all intensive home based treatment teams, Section 136 suites and Cheswold Park Hospital.

Systmone templates developed for lithium and clozapine safety.

Swap to Save campaign to ensure value for money on medicines spend and use of disposable multi-compartment compliance aids continues and is monitored though non pay group. Savings of £65,000 have been realised.

Involvement in Cheswold Park integration, including review of policies to ensure fitness for purpose and involvement in medicines management quality improvement work continues. A major contract review and tender are underway for Cheswold Park and supply services in Barnsley continues.

Medicines Optimisation and Pharmacy framework and 5-year plan was agreed.

Significant improvements seen in POMH audits, in particular clozapine in schizophrenia, physical health monitoring and recording on GP records. Audit results show the trust above national sample in the majority of standards with year-on-year improvements shown since the original audit in 2018.

Significant medicines shortages including paliperidone long-acting injection managed without impact on service users or services.

New pharmacy service introduced; post discharge follow-up by primary care mental health pharmacy team offered with evaluation planned.
Yellow Card Adverse drug reaction reporting. Summary Report 2024/25: The trust was the top yellow card reporter in the North of England. https://yellowcard.mhra.gov.uk/
Further details can be found in the reports to Quality and Safety Committee reports in Appendix 2

During the period covered by this report D&T considered:

SWYT Medicines Related Guidelines/ Protocols
Sections of the SWYT Medicines Policy ie Medicines Code
Shared Care Guidelines
Clinical audit reports
Patient Group Directions (PGDs)
Quarterly CD Accountable Officer's reports
Complex clinical queries
New to market medicines
Medicines shortages/ withdrawals managed
Medicines related financial issues
Medicines related training packages
IMT issues to do with medicines
Issues regarding the provision of medicines related information to service users
Medicines related interface issues
Risks added to the medicine's management risk register (which D&T review quarterly)
Patient safety alerts such as those from the NHS National Patient Safety and MHRA (Medicines and Healthcare products Regulatory Agency)
NICE and other national guidelines
Changes in medicines related legislation

D&T Sub-groups

i. Safe medicines practice sub group
ii. ECT sub-group
iii. Non-Medical prescribing steering group
iv. Clozapine SIG
v. STOMP LD Autism or both

The sub-group chairs annual reports are attached in *Appendix 3.*

Areas for Priority from the annual planning meeting April 2026

The D&T annual planning meeting in April discussed the work plan for 2026. These actions include areas which were identified from the Medicines Optimisation and Pharmacy Strategy engagement events and link to trust priorities.

Best Quality
Medicines Safety
Medicine Management and optimisation quality improvement
Clinical pharmacy standards – establish and embed
Improving clinical medicines pathways
Clinical guidelines review and audit
Horizon scan and plan for new medicines and technologies to improve medicines use and personalise care such as genomics

Inclusive pharmacy practice – ensuring equitable access to culturally competent and patient-centred pharmaceutical care and services for all individuals and communities, especially those who are marginalised or underserved.
Pharmaceutical care must be environmentally sustainable and align to the trust's social responsibilities.
Reduction in unplanned hospital admissions and timely lengths of stay in services supported by:
Evidence of structured and gradual reductions of medication to reduce reliance on long term medication and prevention of over prescribing.
Research.

Best Value
Ensure value for money and operational productivity for the procurement of medicines and clinical pharmacy services.
Support safety and productivity in community teams.
prescribing of medicines through digital advances.
Support cost effective use of medicines.

Best place to work and learn
Development of independent prescriber role.
Line management development.
Wellbeing and support.
Ensure newly registered pharmacists and technicians are supported. in their first 6 months of registration.
Develop pharmacists and technicians to advanced practice.
Support continuous professional development of pharmacy professionals and support staff.
Inclusive pharmacy practice – workforce.
Effective appraisal checklist and job planning.
Leaders and teams communicate effectively.
Training for other clinical staff on basic medicines optimisation principles, medicines management standards and clinical use of medicines in a way that meets the needs of individuals i.e. Face-to-face, drop-in sessions, videos, e-learning, remote etc.

Best Partner
Investigate improved access for community mental health and specialist service to pharmacy expertise in order to ensure marginalised communities receive comprehensive and equitable support.
Understand Neighbourhood working and pharmacy input to proactively support health and well-being, especially in underserved populations.

An **additional priority** identified subsequent to the D&T away day and framework action plan will be to develop an improvement plan to **Increase timely access to clozapine by reducing barriers to initiation and monitoring whilst maintaining safe care.**
This will include increasing access to community clozapine initiation.

2026-27 Action Plan

Medicines Optimisation Priority	Actions	Outcomes and Measures
Medicines Safety	Produce, monitor and update PSIRF for medicines and medicines safety improvement plan Learning from incidents and errors – monitoring for learning and performance.	Plan in place Monitor improvement in identified areas
	Improve staff engagement in incident reporting by actively promoting a culture of encouraging all staff members to complete Datix incident reports, to look back and learn as part of reflective practice and supervision.	To assess the effectiveness of Datix reporting by the pharmacy team, tracking the number of Datix reports submitted by each team. This measure will identify trends, highlight areas of concern, celebrate increased reporting of incidents and near misses and improved learning.
	Develop medicines safety in line with national strategies and any changes in national guidance or mandates.	Medicines safety Officer links with Patient Safety team, national and regional networks.
Medicines management and Optimisation quality improvement	Safe and secure handling of medicines, assurance checklists including correct procedures for wase medicines and cytotoxic agents.	Feedback to ward and department staff, identify key areas of concern and provide training and support.
	Develop a new collating and reporting process.	Digital solution for collecting data and producing reports in place.
	Overprescribing and polypharmacy	Identify key topics, starting with co-prescribing of lorazepam, promethazine and hypnotics and anticholinergic burden. Working with partners and other health care settings.

	Stopping over medication of people with a learning disability and autistic people (STOMP). and supporting treatment and appropriate medication in paediatrics (STAMP).	STOMP audit and action plan.
Clinical pharmacy standards- establish and embed	Launch the co-produced clinical pharmacy standards.	Increased availability and visibility of pharmacy staff and expertise i.e. drop-in clinics/ward based. teams/CMHT input/ primary care roles.
	Develop KPIs and audit compliance with the standards.	Performance monitoring report available and monitored.
Improving clinical medicines pathways	Understand local geography and population information.	Utilise data from POMH audits and other intelligence.
		Discharge medicines service (DMS) KPI.
	Medicines review; Stop/Start tool, anticholinergic burden.	
	Pharmacy input/led clozapine clinics, including review of physical health and adherence.	Six monthly reviews of clozapine prescriptions to standardised procedure.
	Develop measures of pharmacy activity, look at ways to improve productivity and release time from inpatient areas to provide services into community mental health teams	Activity and performance dashboard in place.
	Ensure patients are provided with appropriate choice and medication information dependent on different levels of literacy amongst patients.	Range of products available and advertised to service users, carers and professionals.
Clinical guidelines review and audit	Ensure guidelines reflect current best practice and evidence base. Identify, understand and plan to address key health inequalities and health literacy.	Target 2-3 areas per year, year one, clozapine and pneumonia.

Horizon scan and plan for new medicines and technologies to improve medicines use and personalise care such as genomics.	Regular review of Specialist pharmacy services updates and horizon scanning documents.	New medicines introductions are planned. Care is individualised (structured medication reviews are undertaken).
Inclusive pharmacy practice – ensuring equitable access to culturally competent and patient-centred pharmaceutical care and services for all individuals and communities, especially those who are marginalised or underserved.	Identify and understand any key health inequalities in pharmaceutical care.	
	Tailoring pharmacy services to the specific needs of different groups and understanding the social determinants of health.	Training and awareness for all pharmacy staff using the trust toolkit.
	Cultural and linguistic communications and information about medicines; options; etc.	Understand what data is available.
	Data Driven approach to targeting diverse/ deprived communities.	
	Consider strategies around flexible appointments in targeted groups	
	Use of translators, cultural awareness, autism awareness training, STOMP/STAMP, tailored care for individual needs.	Our staff will have a basic awareness as appropriate to their role through team or external training.
Pharmaceutical care must be environmentally sustainable and align to the trust's social responsibilities	Medicines will be procured, transported and disposed off following good practice guidance to reduce the impact on the environment.	Principles shared and action plan produced.
	We will reduce the use of single use multi compartment compliance aids (MCAs) using alternative ways to improve medicines capability (self-administration).	Number of MCAs dispensed and replaced.
	In our dispensary and offices, we will reduce the use of paper, plastic and cardboard use: dispense in full packs to reduce packing down, use of paper bags, electronic registers/dispensing.	Less plastic bags are ordered and reduced ordering of other consumables.

Reduction in unplanned hospital admissions and timely lengths of stay in services supported by: **Evidence of structured and gradual reductions of medication to reduce reliance on long term medication and prevention of over prescribing.**	Evidence gathered through the discharge medicines service to show this reduces admissions.	Number of DMS referrals monitored and optimised.
Ensure value for money and operational productivity for the procurement of medicines.	Review Procurement and supply SLA with Bradford Teaching Hospitals and Rowlands Pharmacy.	Review completed value for money contracts or services agreed.
Ensure value for money and operational productivity for the procurement of medicines and clinical pharmacy services.	Review pharmacy service provision for Cheswold Park.	Options appraisal and review completed contracts agreed. Tender process undertaken if indicated.
Support cost effective use of medicines.	Formulary review.	Review formulary status of medicines and make document more user friendly.
	Treat well for less.	Campaign materials published with annual refresh.
	Budget analysis with clinical teams.	
	Continue to promote use of patients own medication and green bag scheme.	
	Review of transport arrangements.	
	Bulk ordering: only needing to carry out process once instead of multiple times for fast moving lines as part of procurement review.	
	Active management of out-of-stock alternative products to	

	ensure timely switch back to most cost effective product.	
	Increase near patient dispensing numbers.	
Development of independent prescriber role.	Independent pharmacist prescribing framework.	Defined roles for independent prescribing pharmacists dependent on their knowledge and experience.
Line management development	Produce a training framework for line managers utilising available resources in the trust and externally.	Improved staff survey results
Wellbeing and support	Wellbeing champions. Monthly locality team meetings.	Improved staff survey results.
Support continuous professional development of pharmacy professionals and support staff	Review learning bites and other medicines related learning for pharmacy and other professionals (Medicines management training matrix).	Have a learning offer for all pharmacy staff identified at appraisal.
	Offer a programme of refresher training ensuring that everyone stays up to date and relevant.	Review of medicines optimisation training matrix.
Inclusive pharmacy practice - workforce	Review Pharmacy WRES information • Use feedback and insight, such as staff surveys, to address an inequalities or differences in experience of staff groups. • Support and training for cultural awareness, protected characteristics etc.	Staff survey results.
Effective appraisal checklist and job planning	Develop appraisal checklist and implement	Standardised appraisal and paperwork.
	Defined education and training pathways linked to roles and responsibilities. Have clearly defined roles and optimise skill mix effectively.	
	Review of job descriptions inclusive of new initial education and training standards and aligning to neighbouring Trusts.	
Training for other clinical staff on basic medicines	Review of medicines optimisation training matrix.	We have a clear picture of training offer and uptake.

optimisation principles, medicines management standards and clinical use of medicines in a way that meets the needs of individuals i.e. Face-to-face, drop-in sessions, videos, e-learning, remote etc.	Re-establish Drug and therapeutics education and training sub-group.	
Investigate improved access for community mental health and specialist service to pharmacy expertise in order to ensure marginalised communities receive comprehensive and equitable support.	Clinicians Service users and carers	Increased presence in MDT and business meetings.
Understand Neighbourhood working and pharmacy input to proactively support health and well-being, especially in underserved populations.		

Appendix 1

DRUG & THERAPEUTIC SUB COMMITTEE (D&T)

TERMS OF REFERENCE

1. Main aims and functions

- To advise the Trust on policy (Medicines Code) related to appropriate use, availability and cost of medicines, related products and ECT to be used within the Trust. With consideration to relevant up to date evidence, standards including NICE guidance, National strategies and other government directives.

- To develop and regularly review the Trustwide Pharmacy and Medicines Optimisation Strategy.

- To advise the Trust on the medicines optimisation, management and safety requirements for national regulators such as the Care Quality Commission.

- To manage the entry/exit of new medicines, new licensed indications and related products into the Trust, making reference to the impact on patient care, experience, effectiveness, safety, workload and cost implications to the Trust and local health economy.

- To develop and manage the Trust Formulary using appropriate technology and ensure mechanisms are in place to monitor compliance.

- To manage and monitor the medicines budget utilising the refine/define software and reporting to operational, corporate and medical meetings.

- To promote evidence based, cost effective medicines management by:
  - Developing and updating medication and therapeutic related guidelines and protocols.
  - Regulating and advising on unlicensed medicines and unlicensed indications.
  - Regulating medicines management with special consideration to vulnerable groups.
  - Regulating medicines management within non-medical prescribing.

- To ensure safe and effective use of all medicines in complex situations e.g. treatment resistance, off licence, occasional unlicensed and outside BNF use of medication by providing peer support, guidance and review, under the clinical queries mechanism.

- To ensure safe and effective use of medicines, review of medicine related incidents, learning responses, good catches, improvement plans, regularly refining systems and leading on learning and the sharing of lessons learnt.

- To regular review of the Medicines Management risk register.

- To ensure safe and effective use of ECT in keeping with national guidance and benchmarking our practice through subscription to ECTAS.

- To work collaboratively with partners in the local health economy and groups such as the Chief Pharmacist networks and the Regional Medicines Optimisation Committees around medicines management including sharing of policies, procedures, guidelines.

- To identify the priority list for each year of the medicine related audits for the Trust including national benchmarking audit activity such as POMH. To review audit findings, make recommendations and oversee the Care Group implementation of improvement plans across the Trust by receiving assurance that they are being delivered by the Care Groups.

- To set and review the framework for education and training in medicines management for the Trust and education activities aimed at service users, carers and the local community eg by the Recovery Colleges.

- To develop and provide information in a suitable format for the use of service users and carers.

- To involve and encourage contribution from service users, carers and other members of the public into the Trust's medicines management strategy.

- To collaborate internally with operational groups within the Care Groups, OMG, corporate meetings and appropriately utilise Trust assurance systems and to communicate externally with the local health economy including the two APCs, Pharmacy Leadership Group and the two Local Intelligence Networks.

2. The D&T Subcommittee is accountable to:

- The Trust Board via the Clinical Governance and Clinical Safety Committee and Executive Management Team.

- An annual report will be sent to the Executive Management Team and Clinical Governance & Clinical Safety Committee.

- The medicines management strategy is to be reviewed and ratified by Clinical Governance & Clinical Safety Committee annually.

3. The D&T collaborates with:

The clinical governance group, OMG and Care Groups internally and the local health economy, including the two APCs and pharmacy leadership group externally. In addition, D&T collaborates with regional and national groups through the chief pharmacist networks.

4. The D&T develops its strategy and responsibilities through several Sub-groups including:

1 Safe medicines practice sub group
2 ECT sub-group
3 Education and training sub group
4 Non-Medical prescribing steering group
5 Clozapine SIG
6 Audit subgroup
7 STOMP

A large number of staff who are not formal members of the D&T sub-committee contribute to these sub-groups.

5. Membership

The Drugs and Therapeutics Sub Committee will have the following membership:

- Chief Medical Officer
- Chief Pharmacist and Accountable Officer for Controlled Drugs
- Medicines Safety Officer (Deputy Chief Pharmacist)
- Representative from the Directorate of Nursing, Quality and Professions
- Representative of Director of Finance
- AHP representative
- Medical representative for community services on invitation
- Consultant Psychiatrists: Consultant and/or SAS Doctor (minimum of two)
- Trainee medical staff representative
- Senior Care Group Lead/ Lead Pharmacists
- Service user/carer
- Executive Board member (if not one of the above)
- Non-medical prescriber
- Nurse consultants
- Representative from the Commissioning Medicines Optimisation Teams

A quorum will be at least seven people including one medical, one pharmacy member and one nursing member.

The Chief Medical Officer as Chair will appoint the Deputy Chair.
Secretarial support will be provided through the Chief Pharmacist.

6. Frequency of meetings

The group will meet monthly if diaries permit on the first Wednesday afternoon of the month. The annual planning meeting is held in March (in line with the Trust's annual planning process).

7. Responsibilities of Members

Members must declare conflicts of interest to the chair in writing at least once a year or if a new conflict occurs.

If an individual fails to attend three meetings consecutively without apology the Chair will write to the individual to ask if they wish to continue to serve on the sub-committee.

8. Authority and Decision Making

Any medicines related guidelines, procedures, protocols or prescribing stationary developed must be approved by D&T.

Medicines Policy ie the Medicines Code must be approved by the Executive Management Team following recommendation for approval by D&T.

Clinical queries that cannot be approved at Care Group level are approved by the Chief Pharmacist/ Chief Medical Officer.

Documents that require approval outside the D&T meeting will be circulated to D&T members for comment within two weeks then signed off by Chief Pharmacist/ Chief Medical Officer.

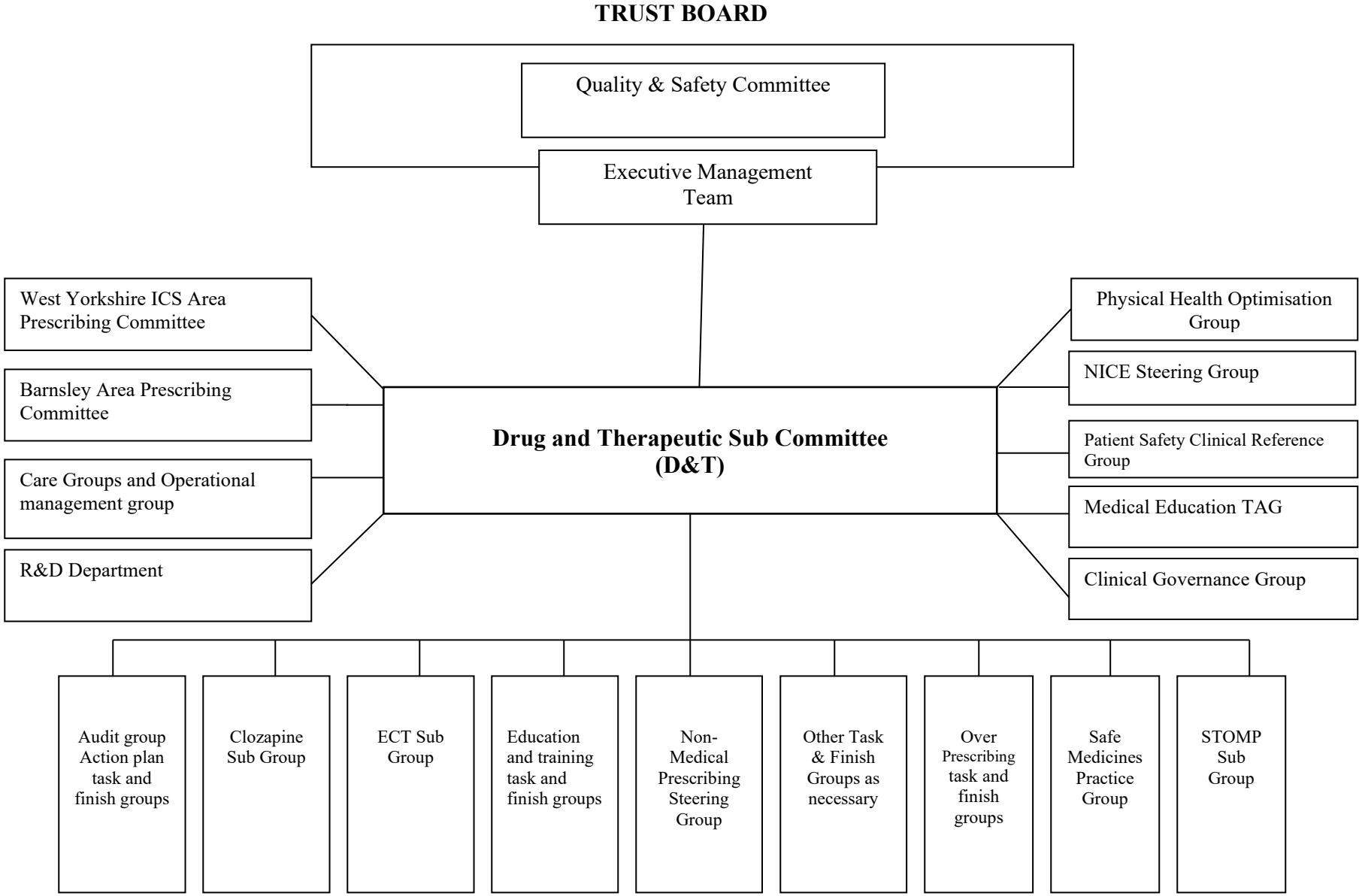
Issues requiring an urgent decision will be considered by the chair and/or deputy chair and reported at the next meeting under chair's action.

9. Communication

D&T uses the following as methods of communicating both internally and externally to the Trust.

- JAPS to ensure prescribers are informed of D&T information.
- Greenlight/bluelight Trust wide alerts.
- Key messages document summarises monthly D&T meetings to clinical governance committee.
- Messages sent to Trust communication bulletins.
- Urgent messages cascaded by additional communication and support of pharmacy team.
- Pharmacy website
- Quarterly reports (AAA) to Quality and Safety Committee.

- Attendance and reporting at APC and pharmacy leadership group meetings within the integrated care organisations.
- Monthly Chief Medical Officer's Webinar.


TRUST BOARD
Quality & Safety Committee
Executive Management Team
West Yorkshire ICS Area Prescribing Committee
Barnsley Area Prescribing Committee
Care Groups and Operational management group
R&D Department
Drug and Therapeutic Sub Committee (D&T)
Physical Health Optimisation Group
NICE Steering Group
Patient Safety Clinical Reference Group
Medical Education TAG
Clinical Governance Group
Audit group Action plan task and finish groups
Clozapine Sub Group
ECT Sub Group
Education and training task and finish groups
Non-Medical Prescribing Steering Group
Other Task & Finish Groups as necessary
Over Prescribing task and finish groups
Safe Medicines Practice Group
STOMP Sub Group

Appendix 2

D&T Activity

Month	Alert	Advise	Assurance
April 2025		The Medicines Optimisation and Pharmacy Strategy engagement sessions have begun. Presentations and workshops were delivered at extended EMT and the Medical Staffing meeting in March. Valproate Guidance: confirmed current good practice to review valproate use in males under 55 years of age who are admitted to an inpatient unit or referred into secondary care community mental health services was still applicable. Agreed that due to the serious risks relating to fertility, testicular toxicity and birth and development defects this recommendation should remain. Covid vaccinations to be offered to inpatients in eligible groups in line with Spring 2025 campaign. Work has begun to consider access to weight loss medication tirzepatide in line with NICE TA to those service users who cannot access through primary care. **Approved**	Update received on the Interim **pharmacy and medicines optimisation Strategy 2024/2025**. Thanks, expressed to pharmacy team for to amount of work completed or on-going against the strategy. Baseline assessment tool for NICE guideline on drug allergy CG183 and NG215: EPMA has been added and RiO has been replaced by SystmOne. Items assessed as not met are not relevant to the Trust. Baseline assessment tool for medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults (NG215) It was agreed the assessment remains as partially met and to feed into the overprescribing steering group. Baseline assessment tool for Controlled Drugs: Safe use and management (NICE medicines practice guideline NG46) – Reassessment. All fully met.

		Rapid Tranquillisation eLearning Course. Medicine Code Section 29 – Self Prescribing for family members, friends and colleagues. Updated approved and renamed Self-prescribing and administration of medicines for family members, friends and colleagues. Pharmacist responsibilities and Amendments. Guidelines for EPMA. Formulary review (Section 1) updated with current guidance and formatted to make clearer and easier to navigate. Greenlight medicines safety alert promethazine. Greenlight medicines safety alert Olanzapine LA injection. Lithium Annual Review and Monitoring SystmOne Template developed due to the publication of the recent Lithium Shared Care Guidelines and the need for standardisation of the annual review. STOMP LD Steering group report received. Key activities this month include raising awareness of training available, linking with Greenlight champions and	Controlled Drug accountable officer reports reviewed. Awaiting approval of medicines code section to update the workbook to address some of the recording issues. *Datix reports continue to be monitored by the Chief Pharmacist and the Medicines Safety Officer as they are reported. Safe medicines practice group meeting continues to review trends and patterns.* *Assurance checklists for safe and secure handling of medicines and controlled drugs have continued and issues actioned.*

		continuing work on the audit tool. Clozapine Clinic template for SystmOne approved to bring all information about clozapine treatment into one place.	
May – June 2025	Position statement to provide assurance that the supply of controlled drugs to off off-site units including Cheswold Park is legal and meets home office licensing requirements for NHS Hospitals.	Medicine Code Section 5: Patient Group Directions – updated to include details of entering onto the electronic medication record in line with the EPMA guidance. Clozapine Policy (for ratification at CPPRG and EMT prior to dissemination). Significant update to include community initiation to improve access and enhanced guidance for adverse effects. Medicines Code section 14 Controlled Drugs – EIA completed and assessed. Awaiting approval at EMT Registered Occupational Health Nurses written instruction to administer BCG vaccination Registered Occupational Health Nurses written instruction to administer MMR vaccination Registered Occupational Health Nurses written instruction to administer Varicella vaccination	**Recording of clozapine in GPs records**: Trainee pharmacist audit report Noted a high level of compliance overall, **89%** of services users had clozapine recorded on their GP record. This represents an improvement since The Prescribing Observatory for Mental Health (POMH)audit report 2021. Most of the GP surgeries in Wakefield had received communication of potential adverse effects. Improvements may be linked to the introduction of standards for pharmacy led 6 months prescription check and follow up in community by primary care mental health pharmacy team. Areas for improvements included information sharing about physical health and blood test monitoring and spreading the good practice in Wakefield regarding provision of information to GPs about potential adverse effects. Improvements may be seen by the introduction of a standardised SystmOne template and letter to GPs.

		Mental Health formulary section on antidepressants approved. One final section is to be reviewed and will then be published to support evidence based practice, safety and value for money procurement. Post discharge follow up leaflet. Describes a new service offer for patients. Clinical Pharmacy standards, describe core activities and define an agreed standard of practice that pharmacy staff will work to within the organisation. The guiding principle to providing a clinical pharmacy service is that services across SWYFT are equitable and to an agreed high standard. Describes for services what are basic, standard, enhanced of service offer. Electronic treatment advice note.	**Pregabalin prescribing for generalised anxiety disorder**: Trainee pharmacist audit. Areas to improve, adherence with prescribing guidance, reviewing and monitoring doses and an improved risk assessment for misuse and acting on results. Areas of good practice were prescribing correct dose adjusted for renal impairment. A targeted piece of work updating clinicians on the guidance for prescribing pregabalin (greenlight) and reviewing those prescribed it is being planned.
July – October 2025	.	Medication shortages and discontinuations continue to disrupt supply and require additional management. Currently affected: Procyclidine injection: has been discontinued; current stock sufficient for 6 months. Alternatives are being explored, including imports or unlicensed preparations.	Accountable Officer for controlled drugs reported noted. STOMP LD Steering Group have produced a set of Audit Standards and have begun data collection.: for information. STOMP Audit Collection Tool: for information. **POMH UK** Anticholinergic medicines

		Venlafaxine XL tablets: memo sent to colleagues. Galantamine – resupply date mid-July. **Medicines safety** Greenlight: GLP1 Receptor Agonist Medications including information on safety of online and internet acquired supplies. Greenlight alert, potting up in response to incidents and intelligence Green light alert Compliance aid, highlighting incidents which have occurred and lessons learned. Valproate safety guidelines updated in response to clinician enquiries relating to women who do not accept the pregnancy prevention programme. Information has been shared following media coverage of reports in the United States to reassure clinicians and service users. Paracetamol and pregnancy - reminder that taking paracetamol during pregnancy remains safe - GOV.UK **EPMA** All four Intensive home based treatment teams are now live on EPMA using a modified version of	in older people – data collection open.

		the inpatient module. **The business case for electronic prescription service for out patients, has been written and submitted** **Cheswold Park** The business case to decommission the stock control system and directly employ a pharmacy technician for medicines management has been approved will achieve financial savings and increased quality. The options appraisal for the supply and clinical pharmacy service has begun with stakeholder engagement. **Inpatient vaccinations Autumn 2025** Both Covid-19 and flu vaccines are being offered to eligible inpatients with procedures and consent forms updated to the relevant variant. **Approved** PGD: Haemophilus influenzae type b and meningococcal C conjugate vaccine (Hib/MenC). Meningococcal groups A, C, W) and Y (MenACWY) Conjugate Vaccine Patient Group Direction (PGD) The Management of Meticillin Resistant Staphylococcus aureus (MRSA) including screening. Appendix 2: Decolonisation Treatment Regimes:	

		D&T approved the treatment options. Medicine Code Section 22: Community based practitioners. Clozapine policy, Clozapine special interest group working on implementation and improved safety monitoring. Controlled drug procedures 1,2,3,8 and 12 updated in line with policy and approved. Pharmacy are linked in to the **Intensive and Assertive Community Health action plan** and task and finish group looking at adherence and support for medicines management and non -compliance in the community. ***Inactivated influenza vaccine (IIV) Patient Group Direction (PGD)*** ***Human papillomavirus (HPV) vaccine Patient Group Direction (PGD)*** Live attenuated influenza vaccine nasal spray suspension (LAIV) Patient Group Direction (PGD) Written instruction for Registered Professionals to administer Quadrivalent Inactivated Seasonal Influenza Vaccine as part of an Occupational Health Peer to Peer	

		immunisation Scheme (2025-26). Medicine Code Section 15 Use of Complementary and Alternative Medicines. Defining Boundaries Between NHS and Private Healthcare Guidance SWYT Patient Group Directions for podiatry • Clarithromycin • Doxycycline • Flucloxacillin • Metronidazole PGD for the issue of varenicline for smoking cessation.	
November 2025 – Jan 2026		**Medicines Optimisation and Pharmacy Strategy 2026-31** approved for submission to EMT and then QSC. See separate paper. Pharmacy colleagues attended a recent annual CQC engagement meeting. Received positive feedback in the meeting and interest was shown in our work with primary care, deprescribing and STOMP work. Treat well for less campaign has realized approximately £65,000 savings. **Medicines safety** Greenlight Alerts: ○ Benzodiazepines and the risk of suicide. ○ Rivastigmine Patches:	Accountable Officer for controlled drugs report noted. Risk register reviewed, noted reduction in a number of risks In November 2025 National Patient Safety Alert was issued about the risk of harm from inadvertently recording patients' penicillin allergies as penicillamine allergies in electronic prescribing and medicines administration (EPMA) systems. There are reports of healthcare staff incorrectly recording a patient's penicillin allergy as a penicillamine allergy in electronic prescribing systems. This error risks a patient with a known penicillin allergy being administered a penicillin-based antibiotic and having a potentially fatal

		EPMA (Electronic prescribing and medicines administration) EPMA is now live in Section 136 suites for those identified for admission. Implementation of EPMA for the inpatient wards at Cheswold Park Hospitals are underway with the first go live planned for January 2026 and completed by March 2026. **The business case for electronic prescription service for out patients, has been written and submitted, feedback received and further case submitted.** The team also responded to a system request to accelerate the implementation of EPS for the virtual wards and intermediate care beds in Barnsley. Both teams are now live, further work to be done on formulary and business continuity. **Cheswold Park** The options appraisal for the supply and clinical pharmacy service has identified two preferred options which are being worked through with support from contracting and business development colleagues. **Inpatient vaccinations Autumn/Winter 2025-6** Flu vaccines are still available and	anaphylactic reaction. Action plan agreed, EPMA system reviewed and assured that the risk is minimal with our system. A greenlight alert to remind prescribers has been produced and pharmacy staff will be undertaking medicines reconciliation to check allergy status with the patient. **POMH QI Programme: Topic 18c Use of Clozapine** Audit results show the trust above national sample in the majority of standards with year-on-year improvements shown since the original audit in 2018. Pretreatment screening, on-going physical health monitoring and annual review show excellent results with 98.5% of our patients receiving an annual review by a senior clinician and 95-100% compliance on physical health monitoring parameters. For the treatment target “The initiation of clozapine in patients with treatment-resistant schizophrenia should be preceded by adequate, documented discussion with the patient and/or carer(s), outlining the potential benefits and possible side effects of the medication”. Results for our trust 2018 70%, 2021 100%

		being offered to eligible inpatients with procedures and consent forms updated to the relevant variant. **Approved** Community Podiatry Antibiotic Policy Foot and Ankle infection Guide To be used alongside podiatry PGD's for antibiotics (previously approved by D&T). Administration of Tuberculin PPD RT SSI (2 T.U. per 0.1ml) Using the Mantoux method – document approved. Inactivated influenza vaccine (IIV) PGD Measles, mumps rubella and varicella (MMRV) vaccine PGD Measles, mumps and rubella vaccine Patient Group Direction (PGD) Response to Lancet article - First League table of antidepressants following media coverage, shared with prescribing colleagues to help address any concerns raised by service users. Medicine Code Section 6: Ordering, receipt and storage of medicines: approved as a procedure - to take to the Clinical Policies Ratification Review Group.	2025 100% Total National Sample 78% *94% of service users have clozapine recorded on their GP record up from 88% in 2021 and compared to the national sample of 76%. Pharmacists check on discharge and at 6 month prescription review, this increases the safety of clozapine as it alerts GPs to interactions and adverse effects of clozapine.* Agreed to participate in the 2026 QI programme: for information. **Topic 17c**: Use of antipsychotic medication for relapse prevention in patients with a diagnosis of schizophrenia (Data collection **2 Mar - 30 April**) **Topic 11d**: Prescribing antipsychotic medication in people with dementia (Data collection **1 Jun - 31 July**) **Topic 25a**: Use of Propranolol in anxiety -system wide (Data collection **1 Oct - 30 Nov**)

		Medicine Code Section 22: Community based practitioners: approved as a procedure - to take to the Clinical Policies Ratification Review Group.	
February – March 2026	**Paliperidone Long acting injection**. There has been a major recall of all batches of Paliperidone from one manufacturer. This is having impacts on the whole supply chain. This may impact over 300 service users. Pharmacy is looking at clinical information should we be unable to acquire the required strengths. D&T was made aware of the following potential risks: May need to look at doses and whether service users could have a lower dose and oral supplementation, three monthly if stable subject to individual reviews. Clinical information will be available for clinicians to make decisions should they be required. Significant cost implications – approval received from the Directors of Service to purchase the unlicensed product which will have an impact on their budgets. Receiving advanced approval from D&T to purchase the unlicensed products if required (licensed in Europe, not the UK). **Supported** It was noted new patients will not be started on paliperidone until we are aware of the longer-term situation.	Approved: Patient Group Direction for the supply of Bupropion (Zyban) tablets Greenlight Alert: Buprenorphine "Look Alike Sound Alike" Medicine Good practice guideline for Anticholinergic medication. Use of 2 monthly and 3 monthly preparations of long-acting antipsychotics injections as an alternative to monthly injections. This does not increase the cost of the medication but reduces dispensing fees and nursing time and has a positive effect on patient experience. EPMA formulary will be removing the expensive preparations from treat well for less campaign as part of the behavioural change approach. The products will still be available to prescribe but prescribers will need to take an extra step and justify the choice.	POMH Sharing Best Practice report: Trust initiatives to improve prescribing practice prompted by participation in POMH Quality Improvement Programme. SWYT did not contribute to the report therefore a summary report has been produced demonstrating the work that had been done by SWYT. All agreed it was an excellent report that showcases our work and did not identify any further areas for action. Yellow Card Adverse drug reaction reporting. Summary Report 2024/25: The trust was the top yellow card reporter in the North of England. https://yellowcard.mhra.gov.uk/ Topic 20c: The quality of valproate prescribing in adult mental health services: Action plan required. Noted a reduced number of service users being prescribed valproate however documentation of risk acknowledgement forms and other standards requires improvement. Task and finish group to be established.

		EPMA (Electronic prescribing and medicines administration) EPMA is now live on all wards at Cheswold Park The business case for electronic prescription service EPS for community mental health and outpatient prescriptions out patients has been approved. Work has commenced with a scoping and an initial pilot in the Adult ADHD team planned for April to June with a wider roll out over the next twelve months.	
April, May, June 2026	Discontinuation of Procyclidine injection used to treat serious adverse effects of antipsychotics. National guidance has been released on using Benztropine as an alternative when supplies have run out. D&T agreed to go in line with national guidance and the Royal College of Emergency Medicines guidance on acute dystonia. Acknowledging a robust governance plan is needed to ensure compliance.	PGD for the supply of Cytisinicline (cytisine) for smoking cessation. D&T's annual objectives (aligned with the Trust's strategy and medicines optimisation framework and plan objectives) approved. This will require a multidiscipline approach to fulfil. Section 28 The recommendation by Trust Dietitians of Advisory Committee on Borderline Substances ([ACBS], Special Dietary Products) Medicine Code Section 8: Preparation and administration of medicines for in-patients. With addition of requirement to record the	Two "Prevention of future Deaths (Regulation 28) reports: D&T discussed the learning and how this will be shared. Milligrams and millilitres and clozapine toxicity – actions agreed for sharing relevant learning. Baseline assessment tool for medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults (NG215) 91% fully met 6% partially met. Agreed that there were currently no changes but would look at the partially met areas for future audits. HSSIB report – Insulin: supporting safe self-administration for patients in the community with a mental health received and recommendations being

		placement of transdermal patches on a body map. The Ten Rights of Medicine Administration poster: To be posted on the intranet Medicines Safety pages, displayed in clinic rooms and electronic Comms will be available. Diphtheria, tetanus, acellular pertussis, inactivated poliomyelitis, Haemophilus influenzae type b and hepatitis B vaccine (DTaP/IPV/Hib/HepB) Patient Group Direction (PGD) Administration of Methyl-prednisolone with or without Lidocaine PGD. Antipsychotic Induced Hyperprolactinemia Guidelines Medicines with respect (Intensive Home Based Treatment Teams): Assessment of the administration of Oral Medicines – approved as a working draft. Reflux GP letter and Reflux patient information: Approved with the inclusions of an H2-receptor antagonist as an alternative reflux treatment if PPIs are unsuitable	reviewed. Joint system work planned with West Yorkshire ICB. Controlled Drugs (CD) Accountable Officer (AO) Report – Quarter 3 2025/26. All incidents have individually been followed up. GLP-1 agonists and ECT- Safety alert has been received regarding GLP-1 due to an incident raised in London where it was linked back to the weight loss medication. All to be aware if patients are taking this the anaesthetist should be informed as there could be a risk of reflux. Topic 22b: Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services: Report received. Whilst the results are satisfactory with improvements in some areas, there are actions required. It was agreed to disseminate the results together with the newly approved Guidance for use of medicines with anticholinergic properties document. Medicines reconciliation on admission by pharmacy – targets. Data is now pulled off from SystmOne. Current targets are 80% within 24 hrs and 90% within 72 hrs. Due to the dashboard's strict timing criteria and

		EPMA (Electronic prescribing and medicines administration) and Electronic prescription service (EPS) EPS has had a slight delay of one month due to an issue with the suppliers requiring some additional configuration and training materials to be rewritten and training repeated. All is now resolved and plan on track to complete phase 2 by end of September 2026. **Inpatient vaccinations** Covid vaccinations, Spring booster: The campaign is running until 30th June. The eligible groups are patients over 75 and those in a care home for older people as well as those who are immunosuppressed. D&T agreed this includes all patients on our older people's wards. METRIC study {METfoRmin In psyChosis (METRIC) for Weight Gain Prevention}: The Trust has been approved as a site for the METRIC study.	weekend and bank holiday admissions, the latest report showed a percentage decrease for the 24-hour reporting period. To be discussed as a quality improvement activity at Pharmacy Improvement Group

Appendix 3

ANNUAL REPORTS FOR THE D&T SUBGROUPS

ECT Subgroup Annual Report 2025
(January 2025 - December 2025)

The ECT Subgroup met on 6 occasions in 2025 via MS Teams

1. ECT services in both sites (Wakefield and Calderdale) functioned normally for most part throughout 2025.
2. Excellent collaborative efforts continued between the ECT team members from both SWYPFT and the respective acute Trusts in maintaining the ECT service delivery.
3. Both sites continued to offer ECT training for psychiatry residents, higher trainees and international fellows. Both sites undertook ECT induction for the new psychiatry residents in February and August 2025.
4. 1 higher specialist trainee attended ECT as his special interest subject. He developed a feedback form for ECT induction. He will attend this until March 2025 but hopes to be able to extend this for a further 6 months.
5. The ECT link nurse training has remained stalled due to staffing shortage elsewhere in the services. Therefore, this has not been an agenda topic in the subgroup meetings in 2025.
6. Annual ECT audit (against NICE): Data for 2025 was discussed and the final report submitted.
7. Service user/carer feedback: The Chat-pads have not been operational due to malfunction. The ECT service has had to revert back to paper feedback forms
8. Staffing:
    - Good senior Anaesthetist cover on both sites.
    - Psychiatrist Supervisors: The subgroup notes that the nurse administered ECT has been key in maintaining the service without disruption, except in instances of staff sickness. The Halifax site has been ably supported by International Fellows such as Dr Gunaseelan and the recently recruited SAS doctor, Dr Smith
    - Nursing staffing: The ECT service delivery was affected in a couple of instances due to sickness absence on both sites at different times in the year.

9. Nurse-administered ECT: ECT manager has been offering nurse administered ECT with senior medical supervision. A further registered nurse has also been administering ECT only on an ad-hoc basis due to lack of resources; this situation remains under review. This has helped to allow the ECT service to continue treating patients without disruption except in instances of staff sickness.

10. ECTAS standards review: Both sites had their ECTAS reviews in 2025 and were certified as passed.

11. To ensure policy and practice are in line with national guidelines, a review of the ECT policy was undertaken in 2025.
12. New ECTAS standards 16th edition were reviewed and policy amendments completed.
13. System One: As the ECT documents cannot be completed electronically, they continue to be scanned and uploaded on to SystmOne. There were no further developments on this matter in 2025.
14. Training and Development. Most of the ECT teams on both sites attended the Resus Council UK ILS training in December 2025. The ECT Nursing staff continued to attend regional special interest group meetings; they continue to be part of the North-East and North-West Specialist interest groups (SIG). Clare continues to be the chair of the North-East group and sits on the NALNECT and is part of the training team delivering training on nurse administered and foundation courses. The ECT medical supervisors and ECT nurse administrators had a ECT discussion session where they discussed clinical practice points and discussed cases from a learning perspective. Some of the team members attended the RCPsych Neuromodulation conference in November 2025.
15. In 2025, due to the resource challenges, there were no further progress towards developing a rTMS service after a business plan was submitted to the Trust Board in 2024.
16. New windows and doors were fitted at the Briarfields unit which are more insulating and heat efficient.

In summary, the action plans from last year's report were mostly met
Notable achievements:

1. ECTAS standards review: Both sites had their ECTAS reviews in 2025 and were certified as passed.
2. A short intro video to Briarfield unit developed by the ECT service Manager. This was also runner up for the Barry Renolds awards with NALECT for this.
3. The ECT service developed an easy read leaflet for Learning disability service users and carers.
4. ECT manager was selected in December 2025 to be a member of the ECTAS advisory group for a 3-year tenure.

Key messages:

1. Both ECT clinics in the Trust continued to provide ECT as usual in 2025 except in a couple of instances where the ECT session had to be cancelled due to staff sickness.
2. Both sites continued to offer ECT training for psychiatry residents, higher trainees and international fellows. Both sites also offer opportunities for medical, nursing, OT, physio students to observe ECT with patient's consent for awareness and as a learning experience.

Plans for 2026:

1. Produce an audit (against NICE) report for 2025. This is a rolling annual audit which is completed yearly.

2. Produce an audit (against World Health Organisation checklist) report for 2025. This is also a rolling annual audit which is completed yearly.
3. Produce an annual report and action plan from the Service User & carer questionnaire for 2025. This is yet another rolling yearly audit which is completed annually.
4. Complete annual ECTAS dataset audit
5. Representation at the Royal College Training days by ECT Subgroup members.
6. Representation at the NALNECT (National Association of Lead Nurses in ECT) Training days by ECT nursing staff.
7. Ensure that our current documentation reflects the latest ECTAS standards and the Department of Health and Social care (DHSC) guidance.
8. Ensure and maintain sufficient numbers of the trained workforce for safe delivery of ECT.
9. A JAPS presentation by the Trust ECT service has been planned for September 2026 to enhance ECT awareness.
10. Review ECTAs standards 17th edition when these are launched in 2026.
11. The ECT service will be looking to appoint one of its service users to be a “lived experience” expert as part of the Lived Experience Project.
12. The ECT service will offer opportunities for FY1 and FY2 doctors to observe ECT as a learning experience.

Dr Prem Kumar
Chair of ECT subgroup
ECT Lead for Wakefield Locality
17/03/2026

STOMP Steering Group 2025 Report

The STOMP Steering Group met on 4 occasions in 2025 via MS Teams.

1. STOMP Trustwide steering group meet every 2 – 3 months where best practice is shared /teams provide updates on their STOMP work / relevant updates are shared. Representation is multidisciplinary and from community LD teams, pharmacy team, inpatient teams. Representatives from all Trust localities are invited to join.

2. Monthly locality STOMP MDT meetings and each team has a link named pharmacist. Staffing challenges have meant that these the MDT meetings did not occur in Barnsley in 2025. We understand that these meetings have recently been reinstated. During these meetings, medication regimes are considered and optimisation strategies / concerns discussed which are then taken into account during next patient consultation.

3. Teams have collected data on STOMP audit tool. Data was received from the final site in December 2025 and is currently being analysed. Results to be shared when available.

4. MindEd STOMP e-learning has been shared with clinicians and managers (to consider sharing as part of greenlight strategy). Modules are aimed at different target groups. Some at specialist LD professionals, some at other professionals who may work with people with LD and some aimed at families / carers / people with LD. MindEd Hub

5. Group members linked into national LD practitioner forum and shared relevant information:
   a. Anticholinergic burden management in LD
   b. National STOMP standards consultation
   c. NHS England MEDSIP programme - Helping people with learning disability, avoid harm from psychotropics'

6. LD awareness week (June 2025)– 'STOMP' and Medication information stalls.

7. Standardised RAG ratings (for risk stratification) are now routinely being used across all LD community teams. Each team have a database for tracking cases and RAG ratings.

Future Plans

- Review SystmOne STOMP template to minimise need to manually record/report.
- Electronic Transfer of Prescriptions (ETP) rollout in community LD teams.
- To ensure STOMP principles continue to be embedded in practice across Trust services.
- Review Group Terms of Reference.

Introduction

Non-Medical Prescribing Subgroup Annual Report

The non-medical prescribing (NMP) steering group for South West Yorkshire Partnership NHS Foundation Trust meets (monthly) to co-ordinate the implementation of the non-medical prescribing policy for the Trust and to promote the strategic development of non-medical prescribing within the organisation, in line with service transformation and modernisation.

The steering group chair is Richard Clibbens (Nurse Consultant). Each meeting agenda includes the following standing items:

- Notes from the last meeting and matters arising
- Update on prescribers
- Information sharing/courses
- Key Points for D&T

NMP Steering Group Membership 2025/2026

Richard Clibbens (chair) Nurse Consultant & non-medical prescribing lead.
Sarah Hudson, Pharmacist lead for non-medical prescribing. Deputy Chief Pharmacist and Medicines Safety Officer.
Rebeca Rowlands Wound Care Specialist Podiatrist
Andrew Stones Nurse Consultant, Dementia service Barnsley.
Samantha Bell Senior Learning & Development Facilitator (professions).

Steering Group meetings held since April 2025 to date:

31st April 2025
21st May 2025
24th September 2025
29th October 2025
26th November 2025
25th February 2026
25th March 2026
26th April 2026

Trust Non-Medical Prescribing Forum

Periodic trust non-medical prescribing forums have been organised, with a focus on specific topics that have been requested by Trust NMP's. All NMP's are invited.

Upcoming Topics for a booked Forum in June 2026 are:

- Implementation of EPS
- Cosmetic Prescribing
- Updated Anticholinergic guidance

Annual Non-Medical Prescribing audit summary (2026).

There are 197 Independent and Supplementary Non-medical prescribers (NMP's) actively prescribing in SWYPFT as at May 2026 (includes prescribers currently on maternity leave). This includes: **7 AHP** Prescribers and **8 Pharmacist** Prescribers

There are **24 Community Practitioner prescribers** actively prescribing as at May 2026.

Examples of services where Independent/ Supplementary NMP's practice within the Trust (This is not an exhaustive list as this is continually developing)

Physiotherapists

- Musculoskeletal service Barnsley
- Older people's mental health Kirklees

Podiatrists

- Diabetes Barnsley
- Lead podiatrist Barnsley

Nurses

Wakefield

- Primary Care Mental Health Team
- OPMH Lithium Service
- OPMH CMHT
- Nurse Consultant OPMH
- Advanced nurse practitioner memory service
- Memory nurse
- Learning Disability Service
- Perinatal Mental Health
- Senior Clinical Pharmacist
- Enhanced team west
- Core Team West
- Insight Team

Calderdale

- Insight Team
- CAMHS
- Core Pathway
- Adult IHBT
- CMHT
- OPS CMHT
- MH wellbeing service
- EIP practitioner
- Elmdale
- Beechdale
- Lyndhurst

- Advanced nurse practitioner memory service
- Memory service
- Perinatal Mental Health

Kirklees

- Dual Diagnosis
- Clinical nurse specialist LD
- Advanced Clinical Pharmacist
- Senior Pharmacist
- Advanced nurse practitioner memory service
- Memory nurse
- Mental health treatment & wellbeing team
- Young onset dementia team
- CAMHS
- In-patient mental health rehabilitation
- Mental health outreach team
- North Kirklees treatment team
- Enhanced team
- Early Intervention team
- Perinatal Mental Health
- Insight Team

Barnsley

- Community Matron
- ADHD
- Stroke Unit
- Stroke Community Service
- CAMHS Practitioner
- CAMHS Pharmacist
- Parkinson's Nurse
- Assistant community matron
- Macmillan clinical nurse specialist
- Rapid response team leader
- Rapid Response Team (Physical health)
- Tissue viability nurse specialist
- Tissue viability
- District nurse
- British heart foundation nurse
- Specialist nurse health integration team
- Intermediate care
- Musculoskeletal service
- Recovery & wellbeing team

- Specialist nurse health integration
- Nurse Consultant dementia
- Advanced nurse practitioner memory service
- Memory nurse
- OPMH CMHT
- CAMHS

Action from provisional audit results
The Steering group identified any late audit responders. The Steering Group chair contacted any NMP's who had not responded and are still employed within the Trust, to clarify that they would not continue to be approved to prescribe unless the CPD audit proforma was completed and to advise that their manager would be contacted if there was no response within a set deadline period.

Governance
The Steering Group maintains a database of current prescribers (administrated by Zoey Reilly), with an annual requirement for all practicing prescribers to submit a completed Continual Professional Development (CPD) return in relation to their current prescribing activity each year. There is an annual audit commissioned by the Steering Group, to identify the number of current active non-medical prescribers within the Trust.

All prospective non-medical prescriber trainees have been approved to complete the course utilising the clear process set out within the Trust Policy, with sign off via the External Study Leave process.

A clear process for the approval of newly qualified non-medical prescribers is in place to ensure that the scope, nature and location of their prescribing is identified, with sign off from the Trust non-medical prescribing lead and Deputy Chief Pharmacist in accordance with the Trust NMP Policy.

All independent/supplementary prescribers have been requested to identify how they access supervision for their prescribing role and the job role/ profession of the person providing this supervision.

Progress with current workstreams:

1. Within the Trust, **25** Non-Medical Prescribers have been signed off as independent Prescribers following successful completion of the course since March 2025.
2. An effective pathway is in place between the Learning & Development Team in the Trust and the NMP Trust Steering Group to ensure external study leave forms have been completed and authorised, prior to any staff member accepting a place on the non-medical prescribing course at local Universities.
3. The L&D Team update the NMP Trust steering group monthly on allocated NHS funded course places for NMP and any funded places remaining on offer at local Universities.
4. There is an effective system in place for the EPMS/ EPS team to confirm approved active non-medical prescribers via shared secure access to the live database of Trust NMP's.

Any barriers/ Challenges, eg. resource/ clinical issues:
There is a continued need to ensure that non-medical prescribing us utilised in a cost effective way to enhance service provision, in line with service delivery requirements.

Trust Non-Medical Prescribing Policy
The updated version of this policy was approved by the Trust board in **February 2025**
The following Excerpt from the policy describes the eligibility requirements for health care practitioners to undertake the Independent/ Supplementary non-medical prescribing course:

5.3 Non- Medical Prescribing Training

5.3.1 Selection Criteria

The selection of health care professionals for non-medical prescribing training must be dependent upon the role they will undertake on successful completion of the course; all candidates must be professionally practising in an environment where there is an identified need for the individual to regularly use non-medical prescribing.

The following criteria apply to aspiring independent and supplementary prescribers, that they:

- Are registered with a professional regulatory body e.g. NMC, HCPC, GPhC,
- Hold a first level qualification
- Are able to study at a minimum of level 6 (degree level)
- For nurses, have a minimum of one year post registration experience
- Have support from their service manager
- Have agreed access to a designated prescribing supervisor (NB: it is the responsibility of the trainee non-medical prescriber to engage a designated (supervising) medical practitioner and/ or designated prescribing practitioner see section 5.3.2)

For nurses the NMC have identified the following: “Under the NMC ‘Standards for Prescribing Programmes’ (2018), readiness for entry onto a prescribing programme is now determined by whether you can evidence the necessary Page 12 of 44 skills, knowledge and experience to undertake the programme. If you trained under the new nursing standards Under the new Future Nurse proficiencies, (NMC 2018), newly qualified nurses are identified to have a higher level of proficiency in skills such as assessment, diagnostics, care planning and management, pharmacology and leadership. These are all important skills for prescribers. However, if you’ve qualified under the new standards, it shouldn’t be considered an automatic step to go straight onto a V100/150 community prescribing programme, or onto a V300 independent prescribing programme after a year. You’ll need to prove to the approved education institution (AEI) delivering your chosen prescribing programme that you're capable of safe and effective practice at a level of proficiency appropriate to the programme undertaken and your intended area of prescribing practice. You'll also need to show that you have the necessary skills in clinical and health assessment, diagnostics, care management and the planning and evaluation of care.” (Becoming a Prescriber: nmc.org.uk, 2024)

All health care professionals employed by SWYPFT who wish to undertake a non-medical prescribing course for independent & supplementary prescribing must follow the process shown in the flowchart (appendix 5). Nurses undertaking a PG Dip Community Specialist Practitioner course will complete the V300 as part of the course (unless already holding this qualification).

Eligible professionals undertaking an ACP Masters course will complete the V300 as part of the course (unless already holding this qualification).

Additionally, all prospective prescribers must have:

- Access to shared service user records
- Agreed prescribing budget
- Agreed with their DPP a formulary of drugs from which they can prescribe
- Prescription pro forma i.e prescription pad/in-patient drug card/depot card
- Appropriate pharmacist advice relevant to the area of practice e.g. mental health, palliative care, substance misuse, community nursing.
- Access to the BNF (on-line, app or print) and Trust approved prescribing protocols
- Professional supervision related to prescribing
- The agreement of their line manager to allow attendance and completion of all elements of the prescribing course, the necessary period of supervised prescribing following qualification as a prescriber, and study leave for updating on relevant prescribing issues Knowledge of: Trust Medicines Code; Drugs and Therapeutics Sub Committee objectives and terms of reference,
- Access to South West Yorkshire Partnership NHS Foundation Trust approved prescribing guidelines • Access to South West Yorkshire Partnership NHS Foundation Trust approved unlicensed medicines list.

The HCPC identify that the following professions may complete additional post registration training to become:

<u>Supplementary prescribers</u>:
Chiropodists/podiatrists
Dieticians
Paramedics
Physiotherapists
Diagnostic radiographers
Therapeutic radiographers

<u>Independent prescribers</u>
Chiropodists/podiatrists
Paramedics
Physiotherapists
Therapeutic radiographers
Optometrists

Ongoing Areas of work:

- Continued governance of non-medical prescribing.
- Facilitation of a Trust wide NMP Forum for active prescribers.
- Strategic development of Pharmacist Prescribing roles in the Trust
- Annual NMP audit due to be undertaken in 2027.
- Quarterly Sub Group update reports to be provided to the Drugs & Therapeutics Sub-committee.

- Continued work with to integrate Non-Medical prescribing into workforce reviews and planned service transformation.
- Continued links with Organisational workforce plans and strategies (such as the Nursing Strategy and development of Advanced Practitioner roles).
- Attendance at regional Non-Medical Prescribing Leads Meeting (Y&H).

Safe Medicines Practice Group

Meetings
The six planned meetings were carried out January 2025 to December 2025

Membership
Attendance has at times been very varied. Improved as now on teams but still varied due to clinical commitments. Cheswold Park has been represented since October 2024.

Activities by and on behalf of SMPG
- Safety bulletins, Greenlights and learning lessons
  - Olanzapine LAI
  - Promethazine
  - GLP 1 Agonists
  - Compliance Aids
  - Potting Up
  - Benzo withdrawal
- Monitoring medicines omissions via EPMA
- Prescribing hypnotics poster
- SBAR insulin incidents
- SBAR Clozapine assays
- Several Serious incident investigations and action plans.
- Attendance at Patient Safety Strategy group and PSOG.
- Input learning from investigations and incidents into Medicine Code update
- Regular review of all medication incident reports
- Third party incidents of concern reported on to appropriate agency.
- Controlled drug reports to accountable officer
- Active support to and joint working with the local and regional medicines safety officer networks including chairing MH MSO group
- Shared reports with Clinical Governance Group
- Review of regulation 28 coroners reports for future learning

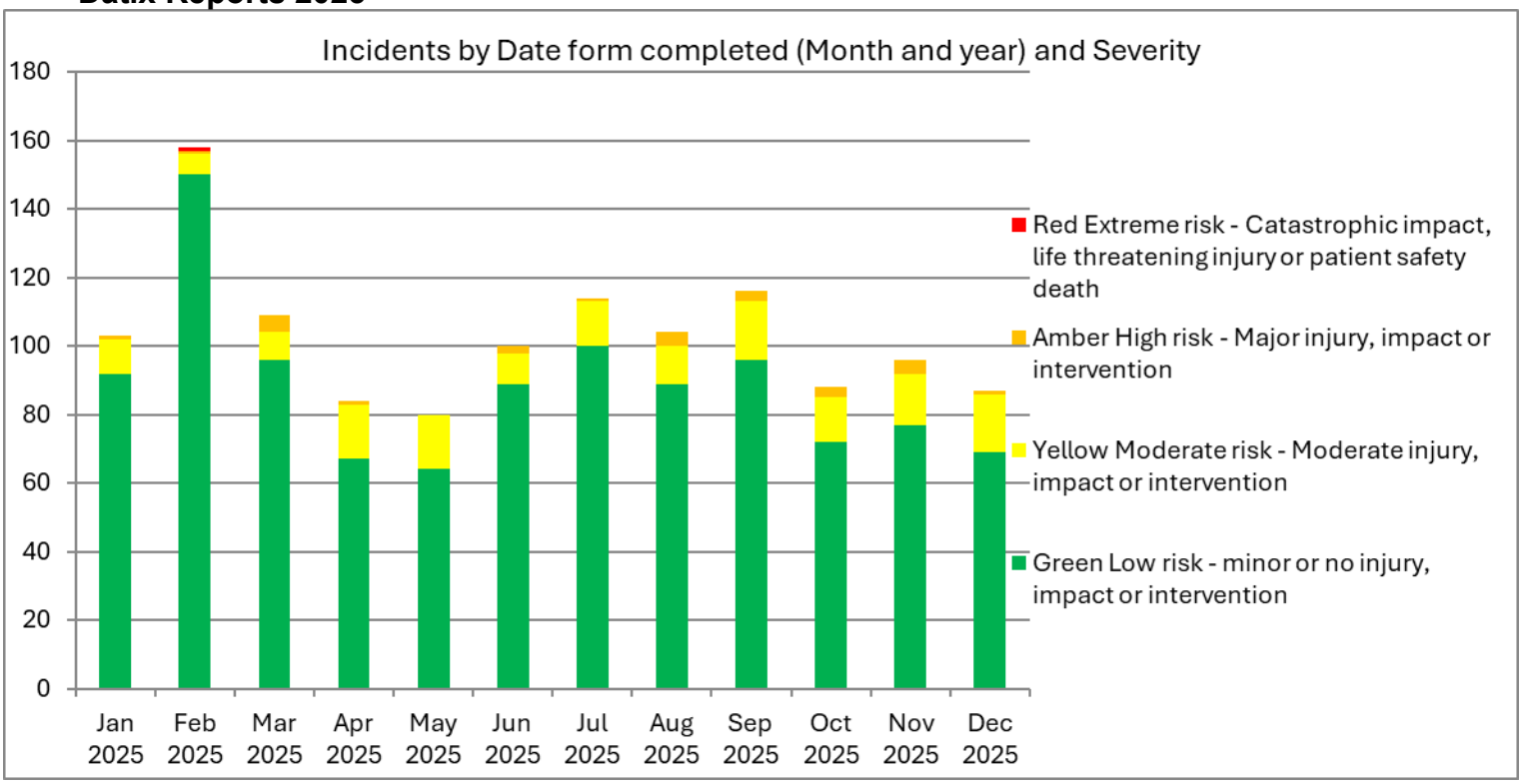
Future Objectives (some on-going)
- Prescription chart audit review in light of EPMA
- Continued review of incidents
- Promotion of reporting through continued feedback of current safety issues using the Greenlight and SBAR format.
- Respond to NHS England patient safety alerts or equivalent.
- Quality improvement work to reduce medicines omissions
- Consider use of validated safety tools such as the STOPP-Start and PINCER tools
- Work to improve the quality of incident reporting
- Work with patient safety team to ensure any incidents which involve medicines but are not categorised as such are captured.
- Work with customer services to ensure incidents reported to them from service users and carers are captured.
- Support work of EPMA team to increase medicines safety incl. monitoring
- Continue roll out of DMS to increase medicines safety on discharge

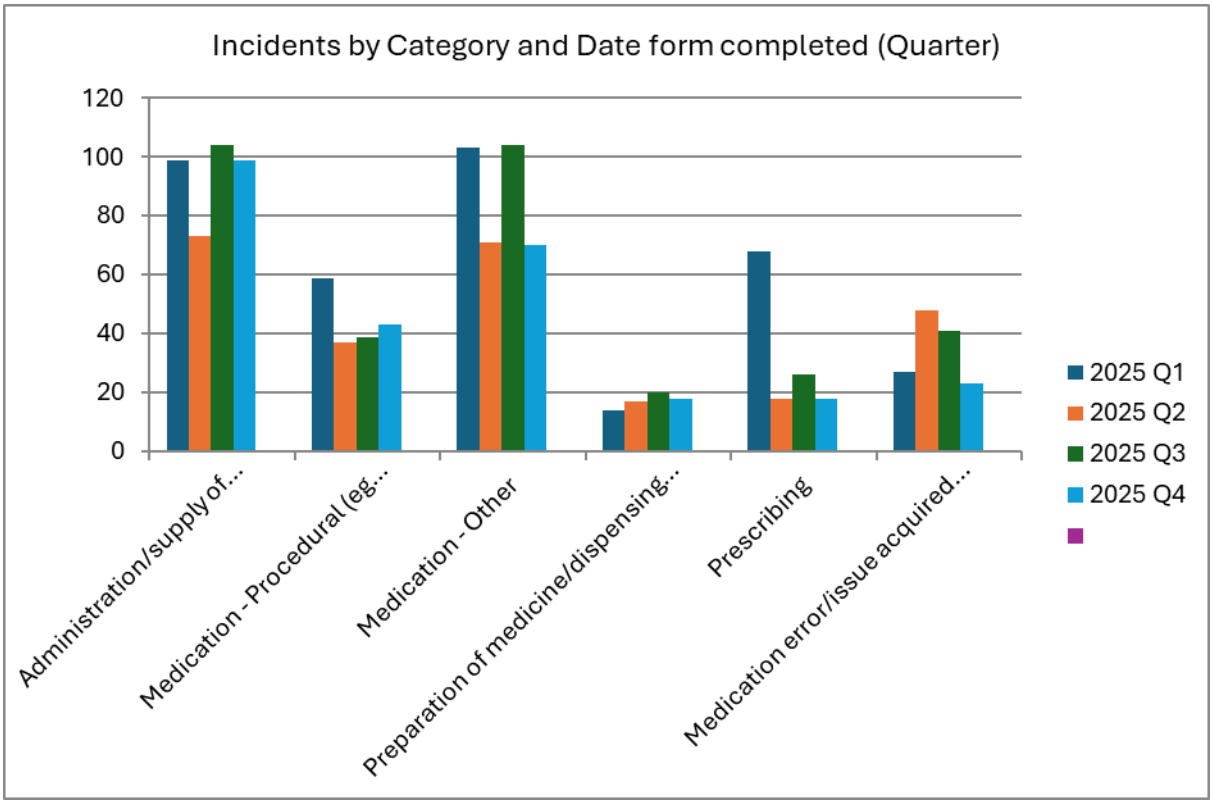
Incident reports

January 2025 to December 2025 inclusive	1248
January 2024 to December 2024 inclusive	1208
January 2023 to December 2023 inclusive	1362
January 2022 to December 2022 inclusive	1182
January 2021 to December 2021 inclusive	1226
January 2020 to December 2020 inclusive	1116
January 2019 to December 2019 inclusive	1044
January 2018 to December 2018 inclusive	912
January 2017 to December 2017 inclusive	804
January 2016 to December 2016 inclusive	873
January 2015 to December 2016 inclusive	859
October 2013 to September 2014 inclusive	829
October 2012 to September 2013 inclusive	775
October 2011 to September 2012 inclusive	791
October 2010 to September 2011 inclusive	649
October 2009 to September 2010 inclusive	619
October 2008 to September 2009 inclusive	491
October 2007 to September 2008 inclusive	426
September 2006 to August 2007 inclusive	335
October 2004 to September 2005 inclusive	144

A small increase in incidents

Datix Reports 2025





Sarah Hudson
Deputy Chief Pharmacist and Medicines Safety Officer April 2026

Clozapine Special Interest Group

Meetings
The six planned meetings were carried out between January 2025 to December 2025

Membership
Attendance has at times been very varied. Attempted meetings on different days to improve attendance

Activities by and on behalf of Clozapine subgroup

- Updated Clozapine Policy
- Implementation of clozapine template
- Supporting Community Initiation and Titration of clozapine
- SBAR Clozapine assays

Future Objectives (some on-going)
- Action Plan for clozapine audit
- Continued review of clozapine incidents
- Moving Cheswold Park Hospital to zaponex brand
- SOP for clozapine assays
- SOP for clozapine red results

Sarah Hudson
Deputy Chief Pharmacist and Medicines Safety Officer
April 2026

South West Yorkshire Partnership Teaching
NHS Foundation Trust



Medicines optimisation and pharmacy Framework

Five year plan 2026 - 2031

Delivering medicines optimisation and a pharmacy service which works collaboratively and compassionately with all services, service users and carers to provide integrated, high quality, person centred care.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Contents

1.1	Introduction	4
1.2	Our Organisation and partners	6
1.3	National and regional context, our population and the people who use our services	8
2.0	Our Pharmacy Services	10
2.1	Our strategy 2018 to 2024	13
2.2	People who use our services, their families and carers	14
2.3	Our Pharmacy workforce	17
3.0	Clinical Principles from the Clinical Strategy	18
4.0	Medicines Optimisation and Pharmacy Priorities	20
5.0	Implementation	21
6.0	Our clinical future - what does 2030 look like?	40
7.0	Next Steps – deployment and evaluation	41

Executive Summary

Delivering medicines optimisation and a pharmacy service which works collaboratively and compassionately with all services, service users and carers to provide integrated, high quality, person centred care.

The Medicines Optimisation and Pharmacy Framework and plan outlines how the Trust will maximise the benefits of medicines for service users while reducing clinical risk, waste, environmental impact and unwarranted variation. It aligns with the Trust Strategy and Clinical Strategy, supporting ambitions to deliver outstanding, person-centred, safe and sustainable care.

Medicines play a central role in treating mental and physical health conditions, yet challenges remain nationally and locally: high rates of polypharmacy, avoidable harm from adverse drug reactions, increasing demand, rising costs, workforce pressures, widening health inequalities and significant environmental impacts. Our strategy is to respond to these issues by setting out a clear plan for improvement across five years.

Pharmacy services across the Trust already deliver extensive activity each month, including medicines reconciliation, ward visits, clinical interventions, dispensing, medicines information and medicines safety oversight. Primary care-based teams provide medication reviews, contribute to discharge safety and support continuity across settings. Feedback from service users, carers and staff has strongly informed the framework, emphasising the need for better communication, clearer information about medicines, improved discharge processes, more consistent pharmacy input, culturally competent care and more joined-up working with primary care.

Six clinical principles shape all priorities: equitable access and outcomes, consistently safe and responsive care, inclusive improvement, reducing inequalities, digital enablement, and trauma-informed, recovery-focused practice. Across these principles, medicines use must be safe, evidence-based, sustainable and personalised, with service users actively involved in decisions.

Key priorities for delivery include strengthening medicines safety and PSIRF learning; tackling overprescribing and polypharmacy; improving clinical pathways such as shared care, clozapine management and transitions of care; embedding clinical pharmacy standards; expanding inclusive pharmacy practice; advancing digital systems such as electronic prescribing and administration and electronic prescribing; reducing environmental impact; and improving research, evaluation and data-driven insight. The framework also focuses on best value by optimising procurement, automating processes, improving stock management, reviewing service models and ensuring medicines are used cost-effectively.

A sustainable, skilled and valued pharmacy workforce underpins the strategy. Actions include expanding independent prescribing, supporting training and preceptorship, strengthening advanced practice pathways, improving staff experience, enhancing leadership capability and ensuring equitable opportunities.

By 2030, pharmaceutical care across the Trust will be safer, more equitable, digitally enabled, environmentally responsible and fully integrated across the health and care system. Pharmacy professionals will play a key role in prevention, personalised care, neighbourhood

working and reducing health inequalities—delivering high-quality medicines optimisation that improves outcomes for all service users.

1.1 Introduction

The purpose of this framework is to set out what we want to achieve for medicines optimisation and pharmacy across our clinical and pharmacy services and how we will achieve it.

Our strategy is to align with the Trust Strategy and the Clinical Strategy and sets out our ambitions to improve and aim to be outstanding in the care we give and the experience the people that use our services receive.

As with the Trust Strategy, our medicines optimisation and pharmacy framework is our road map for our journey to being outstanding across all our clinical services.

The Trust's pharmacy and medicines optimisation strategy is to provide an essential framework to support the Trust meeting its strategic aims by maximising the benefits of medicines for our service users whilst minimising the clinical, financial and environmental risks. The plan looks to the future with an aim to ensure that developments within medicines and medicines related health care are considered.

This strategic plan is a key enabler to developing the capability and capacity to deliver the vision, values and strategic priorities outlined in our Trust Strategy. It will also support the delivery of the Clinical Strategy.

Medicine optimisation is a person-centred approach to getting the most from medicines for both patients and the NHS, ensuring the safe and effective use of medicines to deliver the best outcomes. It covers the way medicines are chosen, purchased, transported and stored through to how they are prescribed, ordered, dispensed, taken and disposed of in line with procedures.

Medicines are central to the provision of quality health care. The effective use of medicines contributes significantly to achieving successful outcomes for service users, is usually the mainstay of treating patients with severe mental health problems and short term or long-term conditions, and is known to significantly reduce relapse, and improve quality of life when used appropriately. Medicines have a key role in preventing ill health and improving long term health outcomes.

Publications illustrate that 98% of inpatients are prescribed medicines. The average number of prescription items per year for any one person in England increased from 13 in 2003 to 19 in 2013 to 21 in 2023.

The optimal outcomes of medicines use can be affected by adverse drug reactions, side effects, adherence and medication incidents. Medicines use can have significant impacts on patient safety and physical health.

6.5% of admissions to hospital have been attributed to patient harm caused by adverse drug reactions, 80% of which are judged to be avoidable either in the form of inappropriate

prescribing or medicines errors. The projected annual cost of these admissions to the NHS is £466 million.

Since our last strategy the impact of medicines production, supply chain, use and waste on the environment has become more significant and concerning. We have an environmental responsibility to address this.

It has been estimated that between 30% and 50% of medicines prescribed for long term conditions are not taken as intended. This outcome impacts on both service user outcomes and the environment.

The NHS business services Authority estimated total NHS spending on medicines in England in 2023 - 2024 was £19.9 billion. This compares to £13 billion in 2010/11 and £17.4 billion in 2016/17

The current spend on medicines within SWYPFT is around £4.6 million pounds per year (excluding stop smoking services) and has remained relatively consistent in recent years.

The first medicines management strategy for the Trust was approved by the Trust Board in 2003. The subsequent revisions sought to keep medicines management high on the Trust agenda and to build on the Trust's established medicines management systems and processes whilst modernising and moving from management to optimisation.

This refreshed framework and plan is aligned to the Trust's strategic aims; the objectives and principle aims are to

- Optimise the safe, evidence based and cost-effective use of medicines as an integral part of person-centred care.
- Involve active engagement with and empowerment of service users and carers, improving their experience.
- Provide clear clinical leadership and accountability.

The pharmacy workforce is addressed as a key objective, ensuring we have a sustainable workforce with the right skills and knowledge. The changes to the initial education and training of pharmacists and pharmacy technicians have opened new opportunities to develop staff and the role they can play in clinical services. Medicines optimisation is everyone's responsibility and having key links with other staff groups is vital.

There are defined responsibilities and accountabilities within the Medicines Code for the Chief Executive Officer, Chief Medical Officer, Chief Pharmacist and Operational Managers. Healthcare professionals involved in medicines optimisation have defined responsibilities and standards through professional bodies and organisational policies and procedures.

There are key statutory roles relating to medicines, the Medicines Safety Officer and Accountable Officer for Controlled Drugs, definitions and responsibilities are included in the medicines code and other policy documents.

Effective medicines optimisation delivery also involves information management and technology teams, estates and facilities teams, patient safety teams, finance teams and workforce development.

Ensuring cost- effective use of medicines with a robust evidence base will help support financial sustainability and ensure resource is available for new and emerging medicines and medicines related technologies.

Advances in available digital technology such as electronic prescribing and medicines administration (EPMA) and electronic transfer of prescriptions to community pharmacy will enable accessible, efficient care, support safer care, demonstrate improved outcomes with the potential to increase clinician time delivering patient facing activities. It will also allow us to access data previously unavailable and enable us to use a data driven approach to addressing health inequalities, targeting diverse or deprived populations.

1.2 Our organisation and partners

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 medicines optimisation and pharmacy plan.

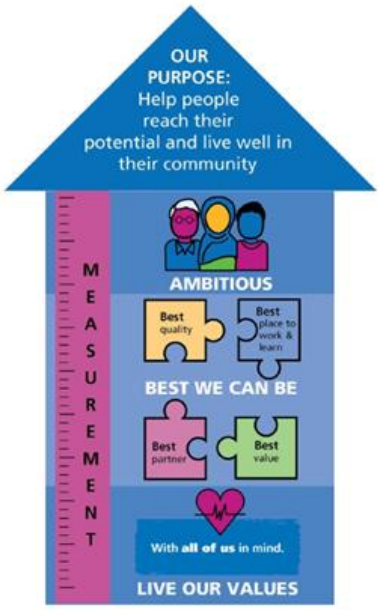
To help people live well in their communities we understand that services need to be joined up, responsive and delivered as close to people's homes as possible. We know that to achieve this we need to work together across the whole health and social care sector including secondary care, primary care and community pharmacy colleagues. 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. We are integral members of both the South Yorkshire Integrated Care System and West Yorkshire Health and Care Partnership through area prescribing committees and medicines optimisation committees.

The relationships between our strategy and our partnerships



SWYPFT has developed an ambitious overarching Trust Strategy that 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.

The Trust Strategy and Values





Our Clinical Strategy has been developed to help us to achieve that vision and to drive the delivery of our Strategic Aims.

- **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**

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.

1.3 National and regional context, our population and the people who use our services

The Clinical Strategy details much of the national and regional context in relation to key issues in healthcare, healthy life expectancy, health inequalities and the physical health and wellbeing of our populations. Medicines have a key role in prevention, improving quality of life, reducing mortality and morbidity. There are also details in the clinical strategy of the population we serve and our communities with descriptions of the nuances in terms of race,

culture and deprivation at each of the four main places where services are delivered as well as a picture of health at our four places.

Clinicians have a much wider range of treatments, medicines and interventions available to deploy. In 1996, the number of prescription items dispensed in primary care and the community in England was 10 per head. By 2016, it had doubled to 20 and has continued to rise. There are more people taking the same medicine for months or years to treat a long-term condition. Repeat prescriptions make up around three-quarters of all prescription items.

There are also more people taking multiple medications. Currently, around 15% of people in England are taking five or more medicines a day, with 7% on eight or more. In some cases, people are taking one medicine to deal with the side effects of another[1].

In identifying aims and priorities we have also considered the NHS Long Term Plan and the priorities therein to prevent ill health, reduce health inequalities and unwarranted variation in care and a focus to improve the management of medicines through joined-up care across a broad range of organisations.

Other influences on our priorities include

- Changes to integrated health and social care systems and integrated care boards (ICS and ICB).
- Community mental health transformation and the Long-Term Plan.
- Roles of community pharmacy and primary care pharmacy including Pharmacy First.
- Changes in the initial education and training of pharmacists and pharmacy technicians.
- Development of the Consultant Pharmacist role.
- RPS Chief Pharmacist Standards.
- NHS England's Patient Safety incident response Framework.
- Fit for the Future: 10-year health plan for England.
    - From hospital to community: the neighbourhood health service.
    - From analogue to digital.
    - From sickness to prevention.

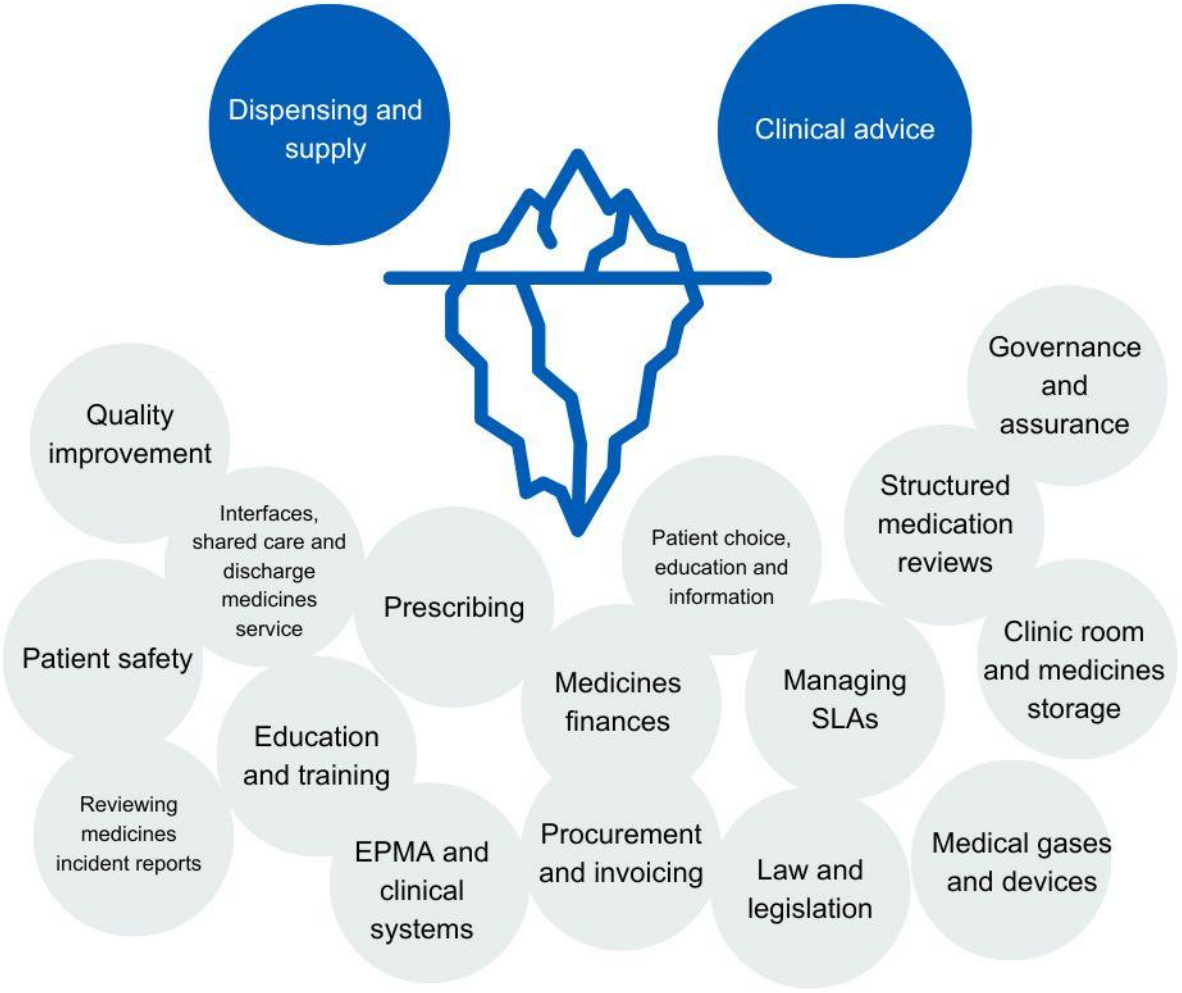
The more recent NHS Long Term Workforce Plan highlights the changing health needs of our population and alongside that the increasing number of healthcare staffing vacancies across the country. SWYPFT recognises the importance of supporting more training and alternative training routes into health care such as apprenticeships and the development of new roles. We understand that supporting people to remain in our organisation through a trauma informed lens and a culture of supporting career pathways and helping our staff to grow is fundamental to the success of the Medicines optimisation and pharmacy framework and plan.

[1] National Overprescribing Review

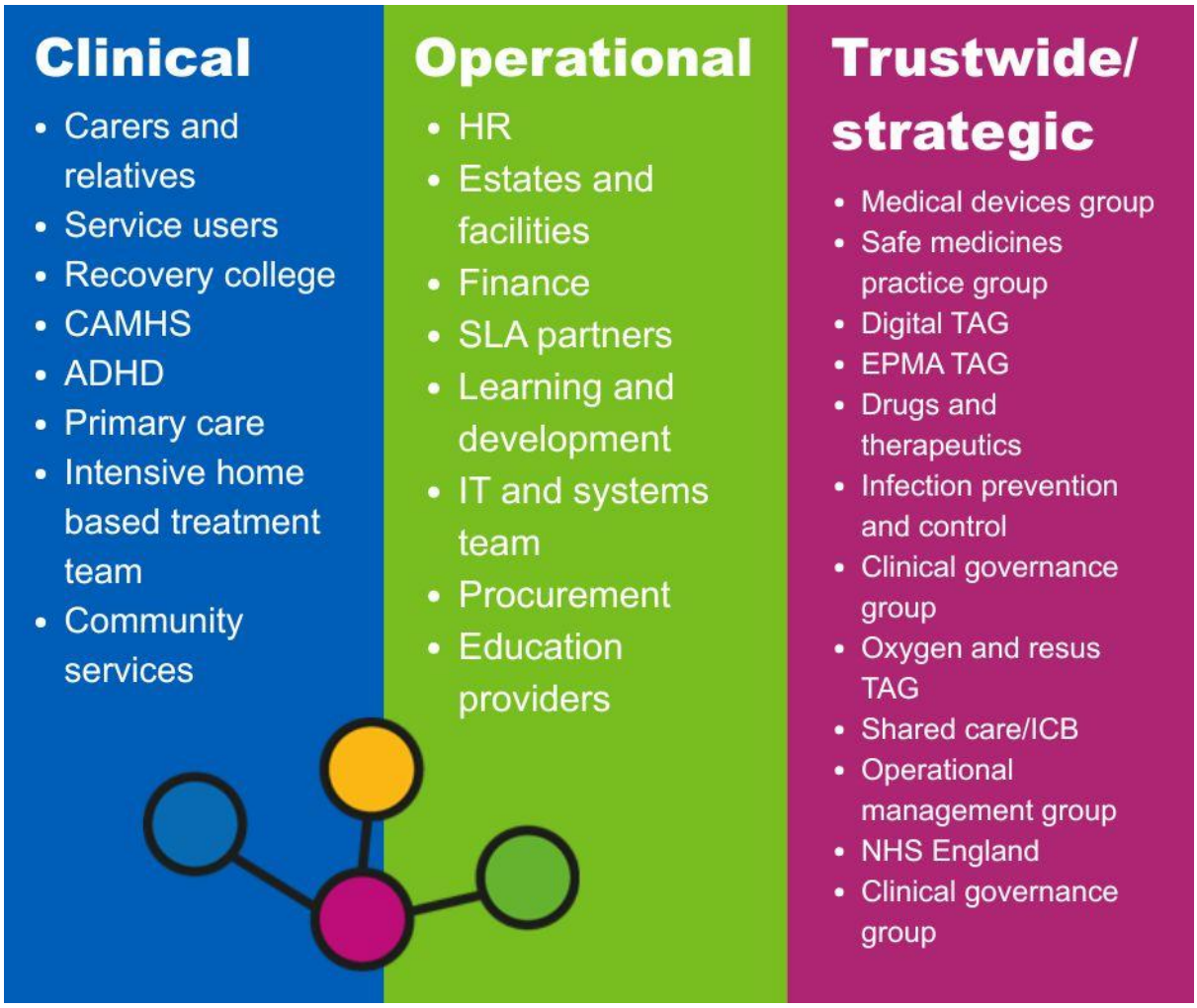
This strategy will be underpinned by the Trust's Quality Strategy. It aligns with and supports our Sustainability and Social Responsibility Strategy, and Research and Development Strategy and supported by the innovation and new ways of working as set out in our Digital Strategy.

2.0 Our Pharmacy Services

What we do



Our partners and stakeholders



Current pharmacy services: where are we now

Background to pharmacy services
Since the establishment of the Trust in 2002 the provision of pharmacy services has changed significantly from being provided mainly under service level agreements with local acute trusts to being provided by a team of directly employed mental health and specialist pharmacists and dedicated technicians and support staff in all localities.

The Trust has a dispensary hub providing and delivering services to Calderdale, Dewsbury, Huddersfield and Wakefield and we have contracts with private providers for supply and dispensing in Barnsley and Cheswold Park in Doncaster.
The procurement of the dispensing computer system which manages the stock control and dispensing was brought in house during 2017. A procurement service level agreement is in place with an NHS acute trust to manage contracts and procurement.

On average each month our secondary care pharmacy team:

- Completes around 620 ward and clinic visits making a total of 800 patient specific interventions or contributions and 110 direct patient consultations.
- Dispenses or orders around 8,500 individual items. This includes managing 140 multi-compartment compliance aids (Dosette© boxes).
- Places 150 orders with our suppliers to procure medicines valued at around £110,000; and at any given time, we stock medicines valued at around £101,634.97.
- Conducts around 130 inpatient medication reconciliations completed on patient's admission to hospital.
- Reviews about 100 medication incidents, writes one greenlight safety alert, contributes to 3 learning responses in relation to medicines safety incidents, near misses and good catches.
- Responds to about 600 medicines information enquiries and 18 out of hours calls
- Sends out between 40 and 50 FP10 prescription pads to prescribers.
- Supplies antipsychotic depots injections valued at around £195,000 and clozapine to an approximate value of £23,000 per month.

On average each month our Primary care pharmacy teams in Calderdale, Kirklees & Wakefield:

Receive 40 referrals

Complete 60 medication reviews

Answer 15 medicines information queries

Reconcile discharge medication for 50 patients on discharge and make clinical interventions on 25 of these **

**Only in Calderdale and Kirklees as no pharmacy technician post in Wakefield

2.1 Our strategy 2018 to 2024

We said, we did...

Person-centred care

- Implemented MAPPS and DMS
- STOMP reviews
- Mental health champions
- Care home secondments
- Updates to clinical guidelines
- New initial education and training requirements
- Near patient dispensing

Management

- Options appraisals for supply and procurement contracts, tenders and bids
- Improved attendance at Trustwide meetings
- KPIs introduced
- Drug cost efficiencies



Safety

- EPMA
- Shared care harmonisation
- West Yorkshire
- Valproate
- Lithium
- POMH audits
- Patient safety plan
- Dispensing and checking competence assessments

Workforce review

- Clinical supervision
- Reviewed structure and consulted, recruited
- Primary care mental health pharmacy
- Independent pharmacist prescribers increased
- Our first technician to complete Psych certificate
- Learning bites
- Job planning

We also did…

- Covid vaccinations and treatments.
- Managed increasing numbers of supply disruptions and medicines shortages.
- Supported the reducing restrictive practices workstream, reducing prone restraint.
- Smokefree environment.
- Addressing Overprescribing; steering group, targeted campaigns for clonazepam, anticholinergic medicines, opioid analgesics and propranolol.
- Excellence awards for EPMA in inpatients and Sustainability and Social responsibility
- Cheswold Park.
- Trained new staff and trainees.
- Pharmacy improvement group.
- Stock list reviews.
- PSIRF.

2.2 People who use our services, their families and carers

We are committed to hearing from and listening to the voice of our patients, service users and carers and staff. Their input into how our services are established, developed and run is integral for the successful delivery of clinical care. We have used feedback from the consultations on the Trust and Clinical strategies, and we conducted conversations, events, focus groups in early 2025 to help us shape this update. We have also used feedback from other sources such as the Community Mental Health Survey and Inpatient Patient Experience Survey.

Pharmacy time out ideas



Feedback from strategy consultation and insight report

- *Medications side effects and impact on patients could be better explained (e.g. increased appetite, weight gain, sedation, drooling, speech affected). When medications were stopped in community, service users reported becoming unwell with behaviour escalated, some led to criminal activity and arrests by the police.*
- *Issues with approach to reviewing medication for those with a disability.*
- *Many feel there are delays in gaining reasonable adjustments and have little / no access to medication, benefits, and services. Neurodivergent people and healthcare experiences.*
- *Inpatient drugs prescribed with little discussion – more information and communication about medication needed.*
- *Medication and discharge are an issue if GP and service hand over means medicine management and prescribing is not understood or available to GP.*
- *Medication and talking therapies should be aligned – both together and not one without the other.*
- *People reported issues around medication and understanding the system.*
- *Language barriers caused issues around understanding of and identifying medication and purposes.*
- *Thinking more about diversifying our approach to delivering health services to include non-medical approaches through examples such as creative arts and recovery-based approaches.*
- *The trust Dr`s to speak with GP to help advise on medication changes rather than having to come back to the trust DR.*
- *Being prescribed the best prescription and not just the cheapest or the medication that a surgery has an allegiance to be re referred into services"*
- *Speed up the discharge process especially the hospital pharmacy process.*
- *review medications before patient leaves the hospital to ensure they are not on medication / dosage that is inappropriate.*
- *involve them more, explain medication side effects.*
- *involve them more, talk to families and care of side effects of medication.*
- *Disposal of unused medication waste.*
- *Recycling packaging.*
- *As a patient: When unwell, easy read information is preferable to complex and lengthy documents. My personal medical history and family medical history were not explored with me, prior to mental health medication being prescribed whilst an in-patient and it was only following discharge home, when I was provided (for the first time) with the medication patient information leaflets by my local pharmacy, that I came to realise that one of the medications was not suitable for me from a physical health perspective and in consultation with the out-patient psychiatrist, a phased cessation was actioned.*
- *Using the right medication for the illness as appose to the cheapest.*
- *The whole picture should be looked at and not just medication, other things that are happening in the person's life should be considered.*
- *Focus on reducing overprescribing and medication reviews.*
- *The medical model is still far too dominant in this trust. Polypharmacy is widespread and not enough resources are allocated to psychosocial approaches to mental health.*

- *To invest in the service so patients have a better and quicker experience of accessing appropriate health education and medications.*
- *Tackling overprescribing and supporting deprescribing.*
- *Ensuring access to appropriate medicines for those who need them, including preventative.*
- *More consideration of medications and impact on weight management.*
- *More accessible pharmacy / medication support and information for staff and service users would be helpful, especially out of hours.*

Staff engagement questions and feedback

- Is there any work on the environmental pollution caused by medications? I heard ADHD meds were up 10x in recent surveys of environment.
- I know it's a work in progress, but community electronic prescribing would really advance community work by improving safety, efficiency and linking in with primary care. It would also enable the deprescribing work that you talk about Vikas and we do a lot of in STOMP/LD work.
- Is there a dedicated Clinical pharmacist's input to community teams? unfortunately there seems to some gaps, for example in Barnsley.
- How is it decided which teams in the community pharmacists work in to?
- In terms of the principles of medicines optimisation, it's the basics surely of thinking if medication is required at all ,if it is what is the most appropriate agent, what dosage is required and is this regularly reviewed, has the patient's condition changed so that existing medication is now unsuitable et cetera et cetera.
- Information in the SystmOne medication section is not being used. I'm thinking here of the simple stuff such as checking likely compliance e.g. looking at script issue dates and doing medication histories which are easy on SystmOne rather than best guessing on the most appropriate agent.
- People are discharged on medicines which are intended for short term use, and they are never reviewed either because the GP isn't given any information or they don't feel confident to stop them.
- Pharmacy checks to improve legality of prescribing and checks on T2/3.
- Effective stock control and centralising ordering and reducing inefficiencies.
- Managing out of date stock and things not in use and waste management of these.
- Community EPMA roll out and how this will improve.
- Improved discharge medication systems.
- Centralised monitoring of fridge temps to reduce stock waste and alert problems.
- Reduced volume of medication TTO.
- FP10 savings.
- More support needed to help people reduce and come off meds safely particularly in LD population.
- Improving regular review of need for continued medication.
- Addressing inequalities in communication, protected characteristic.
- Involving carers more.
- Provision of information in different forms.

2.3 Our Pharmacy workforce

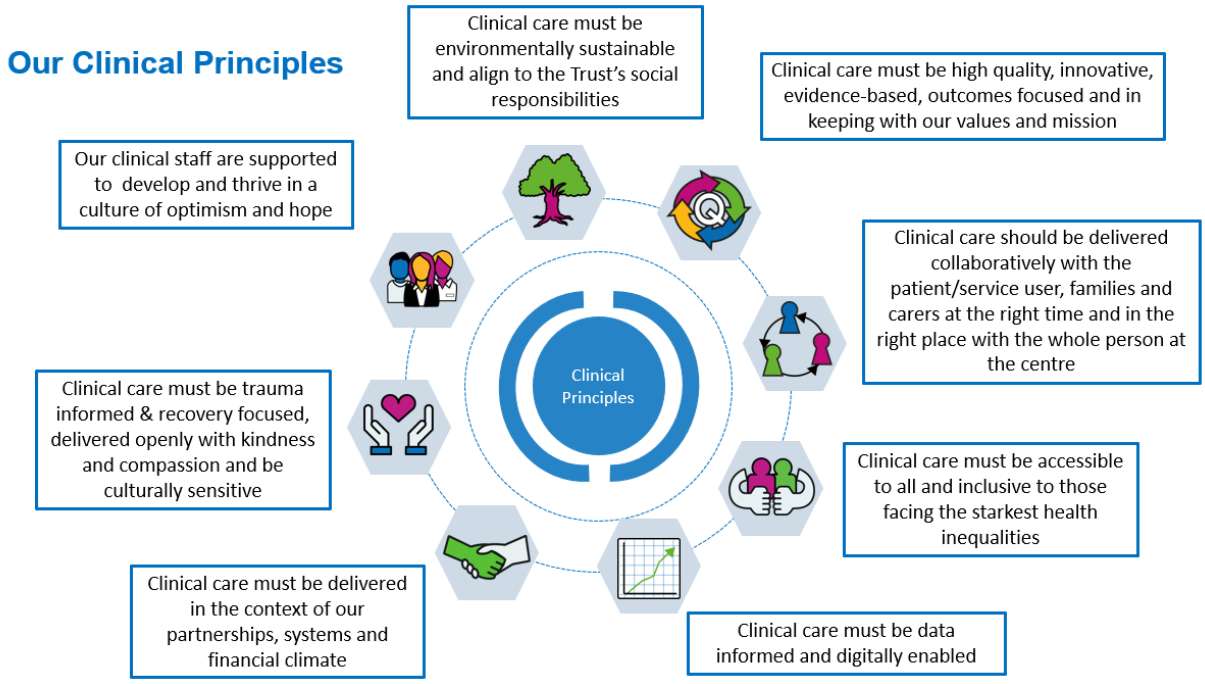
There are 24 pharmacists within our staffing establishment including the Chief pharmacist, Deputy Chief Pharmacist, locality Lead pharmacists and our newly established primary care teams. We have 20 pharmacy technicians including our Chief and lead Technicians and our newly established primary care teams.
We have 7 pharmacy assistants.
We have one operational services manager, 1 secretary and 1 administration assistant in our team.
The EPMA system manager is also part of our team.
We support 2 trainee pharmacists and 2 pre-registration technicians. The pharmacy team comprises just 1 per cent of the trusts workforce
Many of our team work part-time or flexibly.

The Chief Pharmacist is the organisation's Accountable Officer for Controlled Drugs and the Deputy Chief pharmacist is the organisations Medicines Safety Officer.

3.0 Clinical Principles from the Clinical Strategy

Our clinical principles set out how we will deliver care across all clinical services, there is a strong link between these principles and our strategic objective to provide the best quality of care:

- We will ensure equitable access, experience and outcomes for all.
- We will ensure our services are consistently safe, responsive, personalised and effective.
- We will ensure continuous inclusive improvement is integral to developing and delivering creative and innovative services.
- We will consistently address health inequalities across our services, ensuring we are inclusive and working to minimise the impact of deprivation.



For all these principles the words clinical care can be substituted for pharmaceutical care or medicines use.

Clinical care must be environmentally sustainable and align to the trust's social responsibilities	Medicines will be procured, transported, packaged and disposed of following good practice guidance to reduce the impact on the environment. Prescribing, administration and dispensing processes will aim to be as sustainable as possible and green principles applied, using resources responsibly
Clinical care must be high quality, innovative, evidence based, outcomes focused and in keeping with our values and mission	Medicines use will be consistent without unwarranted variation and in line with current guidance and evidence. This may include reviewing and stopping medicines where that is appropriate. Effective communication between professionals supports safe high quality care. Medicines safety should be at the heart of all decision making.
Clinical Care should be delivered collaboratively with the patient/service user, families and carers at the right time and in the right place with the whole person in the centre.	Medicines use should be collaborative and holistic, considering all health conditions, lifestyle, needs and choice. Remembering that these may change with time. A non-judgemental approach should be used when talking to service users and carers about medicines use.
Clinical care must be accessible to all and inclusive of those facing the starkest health inequalities	Medicines use and information must be accessible to all and inclusive of those facing the starkest health inequalities.
Clinical care must be data informed and digitally enabled.	Medicines use and pharmaceutical care must be data driven and digitally enabled for both service users and staff. This will include learning from incidents and errors and reflective practice.
Clinical care must be delivered in the context of our partnerships, systems and financial climate.	Medicines use must be delivered in the context of our partnerships, systems and financial climate. Managing medicines is everyone's business. Medicines Safety should be address with a whole system approach.
Clinical care must be trauma informed and recovery focused, delivered openly with kindness and compassion and be culturally sensitive.	Medicines must be prescribed and administered in a trauma informed way with a focus on recovery and prevention. Medicines use and pharmaceutical care will be delivered openly with kindness and compassion and be culturally sensitive.
Our clinical staff are supported to develop and thrive in a culture of optimism and hope	Our clinical staff are supported to develop and thrive in a culture of optimism and hope

4.0 Medicines Optimisation and Pharmacy Priorities

The Trust has developed six clinical priorities which have been formulated using the feedback from our patients, service users, carers and clinicians. The priorities are routed in the changing health needs of the diverse communities that we serve, as well as national and local drivers, our systems and partnerships and other recently developed Trust strategies. Each priority will be underpinned by our clinical principles. Our medicines optimisation and pharmacy priorities are informed by these clinical priorities and the trust's strategic aims.



Transform our models of clinical services through engagement, co-production, quality improvement, research, innovation and spread to prevent ill health and keep people living well at home.



We will identify areas to improve clinical services that will have the biggest positive impact on addressing health inequalities through continuous and inclusive review.



Support the delivery of effective, sustainable clinical services on our journey to being outstanding by normalising and embedding academic, teaching and research delivery opportunities into service delivery roles and clinical care.



Improve the clinical offer in our services and support the career structures for clinicians within our Trust by growing and supporting the implementation of new roles within teams.



Through compassionate leadership we enable clinicians to deliver high quality care in a culture of openness, honesty and transparency.



Deliver truly holistic care by embedding a multi-professional team across all clinical pathways and ensure parity of esteem between mental and physical healthcare.

5.0 Implementation

Supporting the delivery of the medicines optimisation and pharmacy priorities by setting realistic targets, goals and key performance indicators.

The action plan runs from year 1 in 2026/27 to year 5 2030/31. Many of the actions are on-going, such as PSIRF. They will develop and evolve over the 5 year period of the framework in response to emerging themes or changes to legislation or overall NHS and Trust priorities. Detailed action plans will be managed and monitored by the relevant groups within pharmacy, Drug and Therapeutics Committee, Operational management group (transforming clinical pathways) and subgroups of DTC such as safe medicines practice group, STOMP Steering group and clozapine special interest group.

Best Quality

Medicines Optimisation Priority	Actions	Outcomes and measures	Target date
Medicines Safety	• Produce, monitor and update PSIRF for medicines and medicines safety improvement plan Learning from incidents and errors – monitoring for learning and performance.	Plan in place Monitor improvement in identified areas.	Years 1-5 - Continuous
	• Use of EPMA reports to improve safety and make efficiencies.	Standard report or dashboard available for teams and specialist advisors.	Year 2
	• Improve staff engagement in incident reporting by actively promoting a culture of	To assess the effectiveness of Datix reporting by the pharmacy team, tracking the number of Datix reports submitted by each	Year 2-3

	encouraging all staff members to complete Datix incident reports, to look back and learn as part of reflective practice and supervision. • Develop medicines safety in line with national strategies and any changes in national guidance or mandates.	team. This measure will identify trends, highlight areas of concern, celebrate increased reporting of incidents and near misses and improved learning. Medicines safety Officer links with Patient Safety team, national and regional networks.	 Year 1 and continuously
Medicines management and optimisation quality improvement	• Safe and secure handling of medicines, assurance checklists including correct procedures for wase medicines and cytotoxic agents. • Develop a new collating and reporting process. • Overprescribing and polypharmacy.	Feedback to ward and department staff, identify key areas of concern and provide training and support. Digital solution for collecting data and producing reports in place Identify key topics, starting with co-prescribing of lorazepam, promethazine and hypnotics and anticholinergic burden. Working with partners and other health care settings. Audit or EPMA reporting to monitor.	Year 1 and continuous Year 1 Years 1 to 5 (target 3 areas per year). Year 1 and 2

	• Stopping over medication of people with a learning disability and autistic people (STOMP) and supporting treatment and appropriate medication in paediatrics (STAMP)	STOMP audit and action plan.	Year 1 and 2
Clinical pharmacy standards – establish and embed	• Launch the co-produced clinical pharmacy standards. • Review pharmacy procedures, training and competence assessments • Implement the same procedures across pharmacy teams to ensure quality – e.g. clinical standards, clozapine prescription review, medicines reconciliation. • Develop KPIs audit compliance and performance.	• Increased availability and visibility of pharmacy staff and expertise i.e. drop-in clinics/ward-based. teams/CMHT input/ primary care roles. • Equity of pharmacy. services across all areas • Clear pharmacy service offer including collaboration with stakeholders to scope pharmacy service offer and what is required/needed. • Performance monitoring report available and monitored.	Year 1 to 3 Year 2 Year 1

Improving clinical medicines pathways	• Shared care guidelines harmonisation and development. • Work with partners on developments relating to shared care and neighbourhood working. • Neighbourhood working; ensuring consistent and accessible pharmacy services across different communities and collaborating with local healthcare providers, there's an opportunity to standardise care and reduce difference in health outcomes, especially through improved medicines management and safety. • Understand local geography and population information. • VCFSE Collaborations were this can be achieved • Integration of inpatient and primary care teams	Work with West Yorkshire and South Yorkshire area prescribing committees on programme of harmonisation. Antipsychotic amber guidance, developed and agreed. Work with West Yorkshire and South Yorkshire area prescribing committees on programme of harmonisation. Taking into account planned national formulary. Utilise date from POMH audits and other intelligence. Identified opportunities for referrals for social prescribing.	Year 2-5 Year 1 Year 2 to 3 Year 1 Year 2 to 3 Year 4-5

	to provide seamless transition of care. • Use of technology to support patients to take their medicines i.e. text reminders, use of apps etc. • Improve seamless transfer of care i.e. Discharge medicines service, assessing discharge summary reports, discharge follow up, linking and referring to primary care pharmacy teams, care groups and commissioners • Medicines review; Stop/Start tool, anticholinergic burden • Pharmacy input/led clozapine clinics, including review of physical health and adherence. • Identify from POMH data any groups underrepresented in clozapine population and produce and action plan.	Imanagemymeds and national My meds app. Discharge medicines service (DMS) as KPI. Evaluate and monitor discharge follow up service. Six monthly review of clozapine prescriptions to standardised procedure.	Year 2-3 Year 1 Year 2 Year 4-5 Year 1-3 Year 1-2 Year 1

	• Identify and understanding the number of patients prescribed clozapine compared to benchmarked expectations and produce action plan with clozapine teams and community mental health teams for community initiation.		Year 2-3
	• Increased input into IHBTT and community teams to support medicines use and reduce admissions.		Year 2
	• Increase pharmacy MDT attendance promote and support shared decision making around medicines.		Year 2-3
	• Have access to all providers of care for that person e.g. primary secondary and specialist.	Looking into the value of Interweave in pharmacy – this platform facilitates the secure sharing of clinical information across the Yorkshire and Humber region, offering improved continuity of care.	Year 1
	• Establish a medicines advice helpline or service		Year 3

	for clinicians and service users and carers • Explore referral system from other providers/healthcare professionals where pharmacy input is identified. • Develop measures of pharmacy activity, look at ways to improve productivity and release time from inpatient areas to provide services into community mental health teams • Identify resources to aid service user decision making • Ensure patients are provided with appropriate choice and medication information dependent on different levels of literacy amongst patients.	Activity and performance dashboard in place Resources shared with service users and carers Range of products available and advertised to service users, carers and professionals	Year 4-5 Year 1 Year 1 to 5 ongoing
Clinical guidelines review and audit	Ensure guidelines reflect current best practice and evidence base.	Target 2-3 areas per year, year one, clozapine and pneumonia.	Year 1

	Identify, understand and plan to address key health inequalities and health literacy .		
Horizon scan and plan for new medicines and technologies to improve medicines use and personalise care such as genomics	Regular review of Specialist pharmacy services updates and horizon scanning documents.	New medicines introductions are planned. Care is individualised (structured medication reviews are undertaken).	Year 1-5 On-going
Inclusive pharmacy practice – ensuring equitable access to culturally competent and patient-centred pharmaceutical care and services for all individuals and communities, especially those who are marginalised or underserved.	• Identify and understand any key health inequalities in pharmaceutical care • Ensuring equitable access to medicines and medicines information • tailoring pharmacy services to the specific needs of different groups and understanding the social determinants of health. • Cultural and linguistic communications and information about medicines; options; etc • Data Driven approach to targeting diverse/ deprived communities • Consider strategies around flexible	Training and awareness for all pharmacy staff using the trust toolkit. Understand what data is available	Year 1 Year 2-3 Year 1 Year 1 Year 1

	appointments in targeted groups • Develop communication pathways for patients to access pharmacy services i.e. appointments, referrals etc. eg helpline • Use of translators, cultural awareness, autism awareness training, STOMP/STAMP, tailored care for individual needs • Investigate pharmacy involvement to support medicines administration on wards	Our staff will have a basic awareness as appropriate to their role through team or external training	Year 2-3 Year 1-2 Year 4-5
Pharmaceutical care must be environmentally sustainable and align to the trust's social responsibilities	Medicines will be procured, transported and disposed of following good practice guidance to reduce the impact on the environment. Prescribing, administration and dispensing processes will aim to be as sustainable as possible and green principles applied. *We will encourage our prescribers to only prescribe what is needed and in*	Principles shared and action plan produced. We will aim to find a way of calculating our carbon footprint for medicines use and monitor	Year 1 and on-going Year 2-3

	appropriate quantities to reduce waste, *We will encourage service users to only order what they need and to dispose of medicines via their community pharmacy* *Develop paperless ordering and dispensing.* We will reduce the use of single use multi compartment compliance aids (MCAs) by the use of alternative ways to improve medicines capability (self-administration). In our dispensary and offices, we will reduce the use of paper, plastic and cardboard use: dispense in full packs to reduce packing down, use of paper bags, electronic registers/dispensing.	Process in place Number of MCAs dispensed is reduced Less plastic bags are ordered and reduced ordering of other consumables	Year 2 Year 1 and on-going Year 1
• Reduction in unplanned hospital admissions and timely lengths of stay in services supported by: Evidence of structured and gradual reductions of medication to reduce reliance on long term medication and prevention of over prescribing	Evidence gathered through the discharge medicines service to show this reduces admissions. Structured medication reviews extended to inpatients, develop template on Systmone to record and report.	Number of DMS referrals monitored and optimised. Template in place and report available to monitor and improve.	Year 1 on-going Year 2

	Specialist overprescribing reviews in primary care.	Referrals in place.	Year 2
• Research	Participate in and deliver research projects and service evaluations Investigate options for Clinical trials pharmacist.	Research projects undertaken Publish work on primary care service. Options explored.	Year 2 Year 3

BEST VALUE

Ensure value for money and operational productivity for the procurement of medicines	Review Procurement and supply SLA with Bradford Teaching Hospitals and Rowlands Pharmacy.	Review completed value for money contracts or services agreed.	Year 1
Ensure value for money and operational productivity for the procurement of medicines and clinical pharmacy services	Review pharmacy service provision for Cheswold Park.	Options appraisal and review completed contracts agreed. Tender process undertaken if indicated.	Year 1
	Skill mix review i.e. assistant/tech led dispensary, pharmacist prescribing/de-prescribing, ward-based roles for assistants etc. Optimise technicians roles to increase their participation in patient counselling, attending MDT, and actively engaging in discharge planning processes.	Establishment and structure reviewed. All staff working to optimal level.	Year 2

	Maximising use of electronic systems i.e. interoperability, templates, tasks etc. to standardise activity and streamline workflow.		Year 2
	Review of staff distribution, ensuring adequate staffing resourced based on bed base, acuity	Caseload/activity figures reviewed and assessed.	Year 2
	We will investigate adopting the use of AI for medicines information queries etc.		Year 3
Support safety and productivity in community teams prescribing of medicines through digital advances	Implementation of Electronic Prescribing and prescription transmission for community teams and outpatients.		Year 2-3
	Review digital options for ordering, automation and bar codes Exploration is needed to assess whether digital solutions could streamline stock management, reduce manual workload, and enhance overall efficiency.		Year 3-5
	Investigate electronic Controlled drug cupboards and registers.	Visit local trusts who have this technology, assess applicability and cost effectiveness.	Year 3

Support cost effective use of medicines	Formulary review.	Review formulary status of medicines and make document more user friendly.	Year 1
Support cost effective use of medicines	Treat well for less.	Campaign materials published with annual refresh.	Year 1 and on-going
Support cost effective use of medicines	Budget analysis with clinical teams.		Year 1 and on-going
	• Continue to promote use of patients own medication and green bag scheme. • Increase near patient dispensing numbers. • Pharmacy tracking system, reduce interruptions and support workflow. • Maximising use of electronic systems i.e. automated ordering, electronic controlled drugs registers. interoperability between SystmOne and CMM® (pharmacy stock control system). • Review of transport arrangements. • Bulk ordering: only needing to carry out process once instead of multiple times for	More productive ward teams.	Ongoing Year 1 Year 2 Year 2-3 Year 1 Year 1

	fast moving lines as part of procurement review. • Dedicated procurement team to ensure we are sourcing medicines at the best price and at the right time. • Active management of out of stock alternative products to ensure timely switch back to most cost effective product.		Year 2 Year 1 ongoing

Best Place to work and learn

Development of independent prescriber role.	Independent pharmacist prescribing framework.	Defined roles for independent prescribing pharmacists dependent on their knowledge and experience	Year 1
	Work with operational colleagues during annual planning to promote the role and its opportunities.		Year 2-5
Line management development	Produce a training framework for line managers utilising available resources in the trust and externally.	**Improved staff survey results**	Year 1 on-going
Well being and support	Well being champions Monthly locality team meetings	**Improved staff survey results**	Year 1 on-going
Ensure newly registered pharmacists and technicians are supported in their first 6 months of registration	Develop preceptorship training and competence framework.		Year 2

	Work within the Royal Pharmaceutical Society (RPS) /North of England NHS foundation pharmacist programme.		
Develop pharmacists and technicians to advanced practice	Advanced practice frameworks for pharmacists and technicians, utilising nationally recognised frameworks where available eg RPS, College of Mental Health Pharmacy (CMHP).		Year 2
Support continuous professional development of pharmacy professionals and support staff	• Review learning bites and other medicines related learning for pharmacy and other professionals (Medicines management training matrix).	Have a learning offer for all pharmacy staff identified at appraisal	Year 1
	• Core training for new starters i.e. schizophrenia, depression, dementia etc. • Regular training sessions on common mental health conditions and appropriate treatments. • Tailored training to meet the needs of different learning styles i.e. face to face, group etc. • Develop training framework for advanced practice covering topics such as	Part of learning bite review to include these sessions. Utilise West Yorkshire Framework.	Year 2 On-going Year 2

	finance, performance management, audit and service development. • Offer a programme of refresher training ensuring that everyone stays up to date and relevant. • Utilising programmes such as ESR to record essential to job training/re-validation requirements.	Review of medicines optimisation training matrix. Monitored by re-established education and training subgroup	Year 1 Year 2
Inclusive pharmacy practice - workforce	Review Pharmacy WRES information • Use feedback and insight, such as staff surveys, to address an inequalities or differences in experience of staff groups • Support and training for cultural awareness, protected characteristics etc.	Staff survey results	Year 1 On-going Year 1
Effective appraisal checklist and job planning	• Develop appraisal checklist and implement • Defined education and training pathways linked to roles and responsibilities. Have clearly defined roles	Standardised appraisal and paperwork.	Year 1 Year 1

	and optimise skill mix effectively. • Review of job descriptions inclusive of new initial education and training standards and aligning to neighbouring Trusts.		Year 1
Leaders and teams communicate effectively	Develop and implement pharmacy communication approach.	Everyone knows how we will communicate and gets messages.	Year 2
• Retention of trainees once completed training.			
• Training for other clinical staff on basic medicines optimisation principles, medicines management standards and clinical use of medicines in a way that meets the needs of individuals i.e. Face-to-face, drop-in sessions, videos, e-learning, remote etc.	Review of medicines optimisation training matrix. Develop other offers Monitor uptake and effectiveness Re-establish Drug and therapeutics education and training sub-group	We have a clear picture of training offer and uptake. As part of mandatory training review figures are available through ESR	Year 1 Year 2-3 Year 2 Year 1

BEST PARTNER

Medicines Optimisation Priority	Actions	Outcomes	Target
Investigate improved access for community mental health and specialist service to pharmacy expertise in order to ensure marginalised communities receive comprehensive and equitable support	Clinicians Service user and carers	Increased presence in MDT and business meetings	Year 1
Understand Neighbourhood working and pharmacy input to proactively support health and well-being, especially in underserved populations			Year 1-3
Work with acute care and primary care colleagues to review medicines.	• STOMP and equality, Stop over prescribing medicines for people with a learning disability, autism or both.		On-going
• Working with local universities to support training of under graduates		Increased number of undergraduate placements supported	On-going
• Collaborate with other Trusts on initiatives, sharing good practice and reducing duplication.			On-going

• Continued pharmacy presence in Trustwide meetings i.e. clinical governance, operational management etc.			On-going

6.0 Our clinical future - what does 2030 look like?

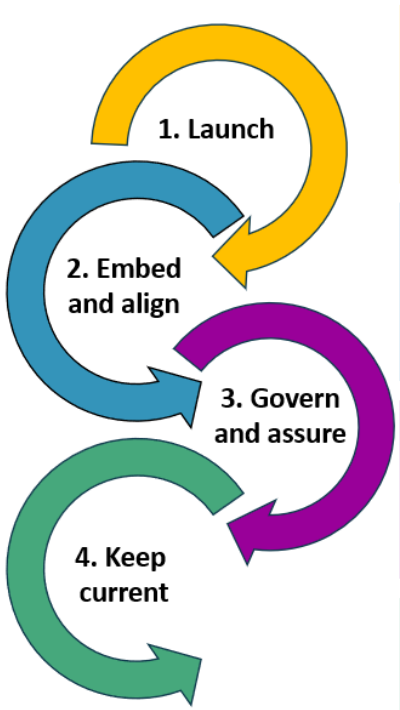
In line with our clinical strategy





7.0 Next Steps – deployment and evaluation

The deployment of the Medicines Optimisation Framework will align with the wider Clinical Strategy and Trust Strategy plan and be structured around four domains:



Communicating the strategy to key partners including patients, service users, carers, communities and clinicians and demonstrating how their contribution has influenced the development of the clinical principles and priorities

Delivering on the actions set out in the strategy by assigning them to teams and services aligning them to key milestones and deliverables.

Ensuring that those responsible for delivering on the actions set out in the clinical priorities are held to account through a robust reporting and accountability structure and that the strategy is evaluated against the proposed measures of success

The Clinical Strategy will remain focused on the changing needs of the communities we serve and as such will be a dynamic document that is regularly reviewed as part of the annual planning cycle or more often as the need arises

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 10.9

Private/Public paper:	**Public**		
Title:	**Freedom to Speak Up Report**		
Lead Director:	**Caroline Johnson, Chief Nurse and Director of Quality and Professions**		
Mission/values:	Putting the person first by enabling concerns about patient and staff safety to be heard and acted upon. Supporting a respectful, honest, open and transparent culture in which staff feel safe to speak up. Using concerns and feedback to learn, improve and strengthen quality. Maintaining arrangements that respond to emerging concerns and changes in national oversight.		
Purpose:	The purpose of this paper is to provide an update on Freedom to Speak Up for Quarter 1 and 2 of 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):	The following BAF risks align with this paper: 1.1 Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience 1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience. 2.3 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 having a robust system and structure for Freedom to Speak Up is crucial to ensuring that the needs and concerns of our patients and staff are identified, listened to and acted on.		
Any background papers / previously considered by:	FTSU update to EMT (September 2026) FTSU Update report to Audit committee (April 2026) FTSU report to Audit Committee (July 2026)		
Executive summary:	51 FTSU enquiries were reported during Q1 and Q2 2026/27, comprising 22 in Q1 and 29 in Q2. Both quarters were above the Trust quarterly average of 18.		

With **all of us** in mind.

	19 enquiries required dedicated FTSU Guardian support, with the majority occurring in Q2. There are currently 27 open enquiries, of which 13 require specific Guardian input. Worker safety and wellbeing remains the most frequently reported category. Increases were also seen between Q1 and Q2 in concerns relating to patient safety/quality and bullying and harassment. Themes of case include team culture and dynamics, leadership and management behaviours, staff relationships, fairness of people processes, staffing and work pressures, and attitudes and behaviours. Localised patterns have been identified within some services. These are being triangulated with quality intelligence, with targeted monitoring and support in place where appropriate. Three cases of reported detriment have been identified during 2026/27. The Trust has strengthened how potential detriment is identified through using feedback captured in FTSU surveys at case closure and at three and six months after closure. No cases have met the definition of a Public Interest Disclosure, and no complex case review has been required during Q1 or Q2. Case feedback demonstrates evidence of organisational learning and action, including review of rota allocation, changes to an assessment template and clarification of appropriate safeguarding routes. Benchmarking indicates that the Trust remains in quartile 1 for overall numbers of concerns raised compared with peer organisations. This will continue to be monitored alongside wider intelligence about speaking-up culture. Ongoing data triangulation occurs with our nursing directorate and people directorate to look at areas of concern to help inform the appropriate level of support to the area.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** and **DISCUSS** the Freedom to Speak Up Update Report.

Making **Freedom to Speak Up** business as usual.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Freedom to Speak Up Update Report

Trust Board 27 October 2026

1. Introduction

This report provides an update on Freedom to Speak Up (FTSU) activity during Quarter 1 and Quarter 2 2026/27 and an update on the Trust's FTSU Reflection and Planning Tool Action Plan.

Since the last report to EMT and Audit Committee in April 2026, there have been a number of changes nationally to the oversight of Freedom to Speak Up.

Following the closure of the National Guardian's Office, NHSE has taken over oversight of Freedom to Speak Up. The Trust has put in place the required arrangements to continue to report on FTSU to NHSE.

The Thirlwall report has been published. It recommends that "FTSU Guardians remain in place; that their work – and the responses to it by the hospitals/other healthcare settings – is properly monitored and reported upon; and, importantly, that there is an external body with powers to act, to whom FTSU Guardians and others may go when they have serious concerns that are not being dealt with by the hospital or healthcare organisation." It also recommends that the Parliamentary and Health Service Ombudsman is best placed to carry out this role. The Trust will continue to monitor changes to reporting and oversight and adapt to any new arrangements.

2. Case update

In Q1 and Q2 2026/27, a total of 51 cases were reported to NHS England via the national data portal: 22 cases in Q1 and 29 in Q2.

All cases are recorded by category as set by the National Guardian's Office and NHSE. It is worth noting that cases can be recorded in more than one category. The reported enquiries are summarised in Table 1.

Table 1: FTSU enquiries reported in 2026/27

2026/27	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27	**Total to date**	**2025/26 total for comparison**
Total number of FTSU enquiries reported to NGO	22	29	-	-	**51**	**69**
No related to patient safety/quality	4	9	-	-	**13**	**20**
No related to bullying and harassment	5	7	-	-	**12**	**15**

2026/27	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27	Total to date	2025/26 total for comparison
No of cases where an individual perceives they have suffered a detriment *	2	1	-	-	**3**	**0**
No of cases submitted anonymously	8	5	-	-	**13**	**23**
No related to worker safety or wellbeing	10	20	-	-	**30**	**48**
No related to inappropriate attitudes or behaviours	6	6	-	-	**12**	**26**

*Cases of perceived detriment are those where individuals have either told the FTSU Guardian directly that they feel they have suffered detriment or reported through the Trust's FTSU survey that they perceive they have suffered harm as a result of raising a concern. The survey is carried out when a concern is closed and at three and six months after closure.

Of all enquiries received, some require basic signposting to other avenues of support (e.g. line manager, HR support, wellbeing support or Staff Side), while others need more dedicated support from the FTSU Guardian. Of the 51 enquiries reported in the first two quarters of 2026/27, 19 required dedicated case support from the FTSU Guardian. These cases are broken down by category in Table 2.

Table 2: Cases needing intervention from managers escalated by FTSU Guardian

2026/27 FTSU CASES	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27	Total Numbers to date	Total numbers 2025/26
Number of FTSU cases needing significant FTSU input	4	15	-	-	**19**	**25**
No. related to patient safety/quality	2	7	-	-	**9**	**11**
No related to bullying and harassment	0	4	-	-	**4**	**2**
No of cases suffering a detriment	0	0	-	-	**0**	**0**
No of cases submitted anonymously	2	3	-	-	**5**	**13**
No related to worker safety or wellbeing	0	9	-	-	**9**	**16**
No related to inappropriate attitudes or behaviours	1	3	-	-	**4**	**12**

There are currently 27 open FTSU enquiries. Of these, 13 require specific input from the FTSU Guardian. The open cases relate to transformation, team culture and dynamics, implementation of the Patient Safety Incident Response Framework, staffing levels, patient notes, policy and process, and observation practices.

There has been no requirement to convene a complex case review to date in Q1 or Q2 2026/27.

3. Key messages from 2026/27 quarter one and quarter two data

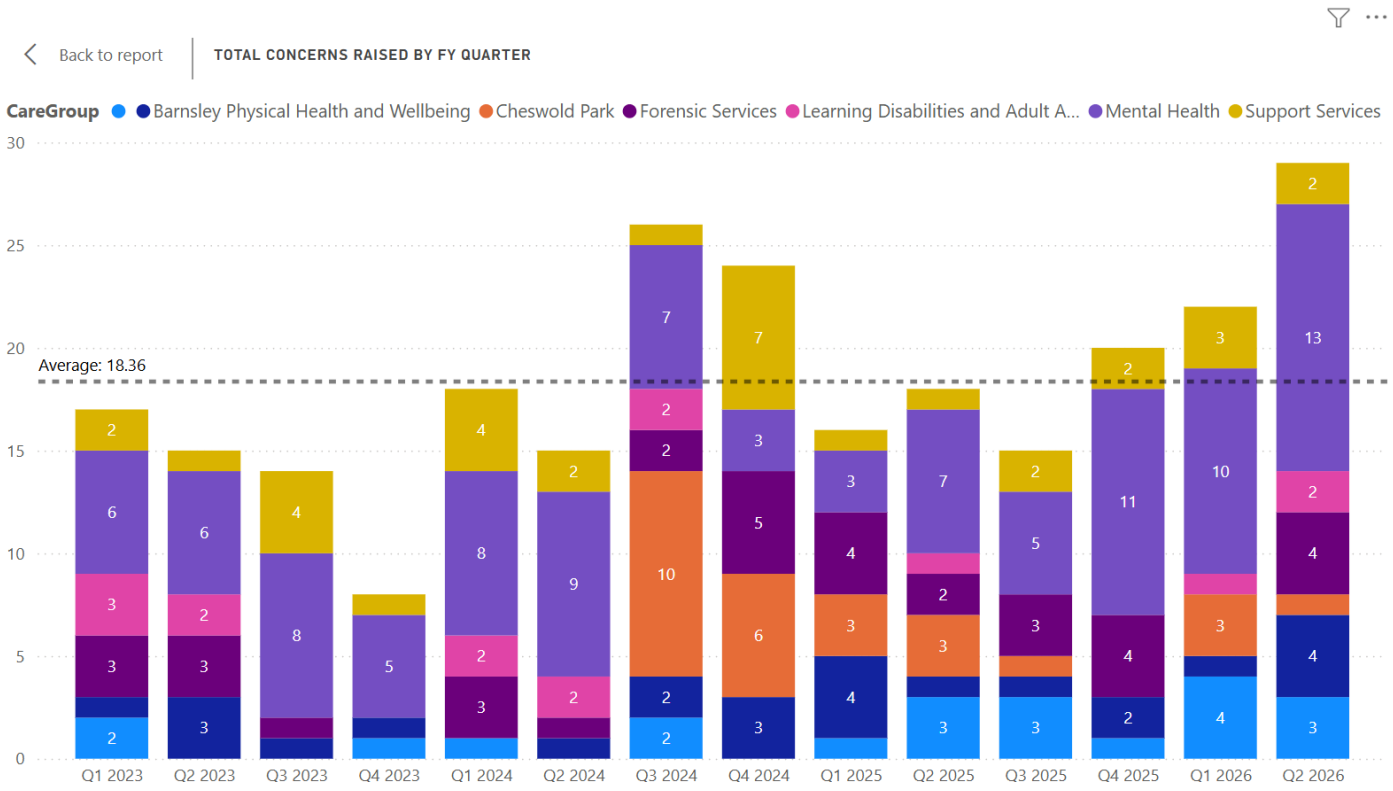
Numbers of concerns

The Trust has seen an increase in FTSU concerns reported in Q1 and Q2 of 2026/27.

Fluctuations in case numbers are not uncommon (as shown in Figure 1), but in both quarters the number of cases received exceeded the Trust's quarterly average of 18. The last increase in concerns was in Q3 and Q4 of 2024/25 and was attributed to the acquisition of Cheswold Park. The increase in Q1 and Q2 may reflect either an increase in concerns across the Trust or individuals raising concerns through FTSU that might ordinarily be raised through other routes. Case numbers will continue to be monitored. Routes for raising concerns and the purpose of FTSU were clearly communicated through The View in August 2026 and continue to be communicated at induction and during visits to services.

Cases continue to be reported from all care groups within the Trust. In Q1, the largest proportion of cases was from the Mental Health Care Group (10); this was also the case in Q2 (13). This care group has the highest number of staff within the Trust.

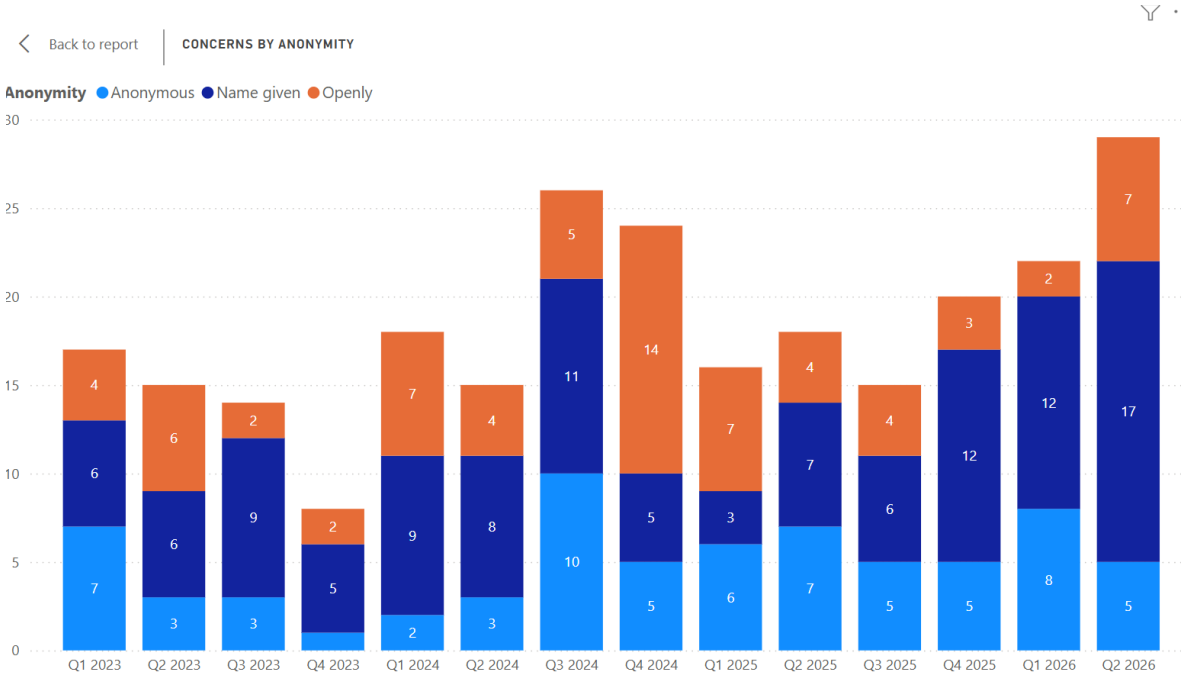
Figure 1: FTSU concerns by quarter, by care group, 2023–2026



Anonymous concerns

The number of concerns raised anonymously decreased from eight in Q1 2026/27 to five in Q2 2026/27.

Figure 2: Concerns by anonymity per quarter, 2023–2026

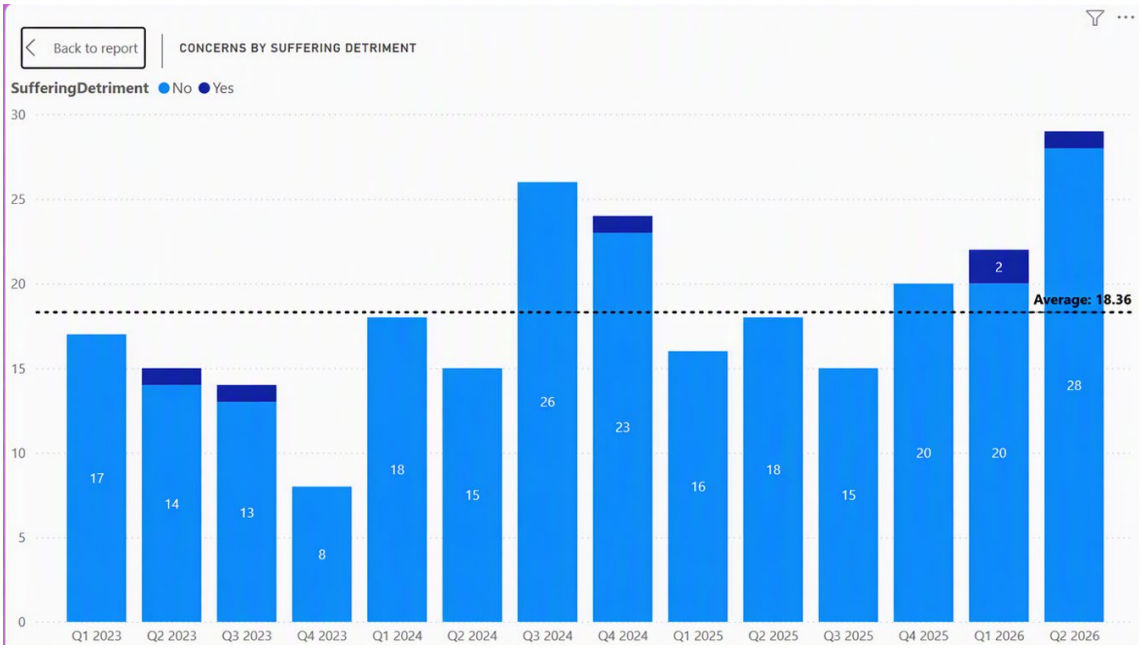


Detriment

The Trust has included the following in its reporting of perceived detriment:

Where an individual has come forward and stated that they believe they have suffered as a result of speaking up, or has reported through the Trust's FTSU survey that they perceive they have suffered detriment. The Trust carries out an anonymous survey and asks, "Have you experienced any unintended harm or negative consequences as a result of raising your concern?" when a concern is closed and at three and six months after closure. Where an individual answers yes, the Trust records the case as perceived detriment. Where the individual can be identified, the Trust is able to review the case independently and follow the process outlined in the Trust's FTSU internal operating framework.

Figure 3: Reported cases of detriment by quarter, 2023–2026

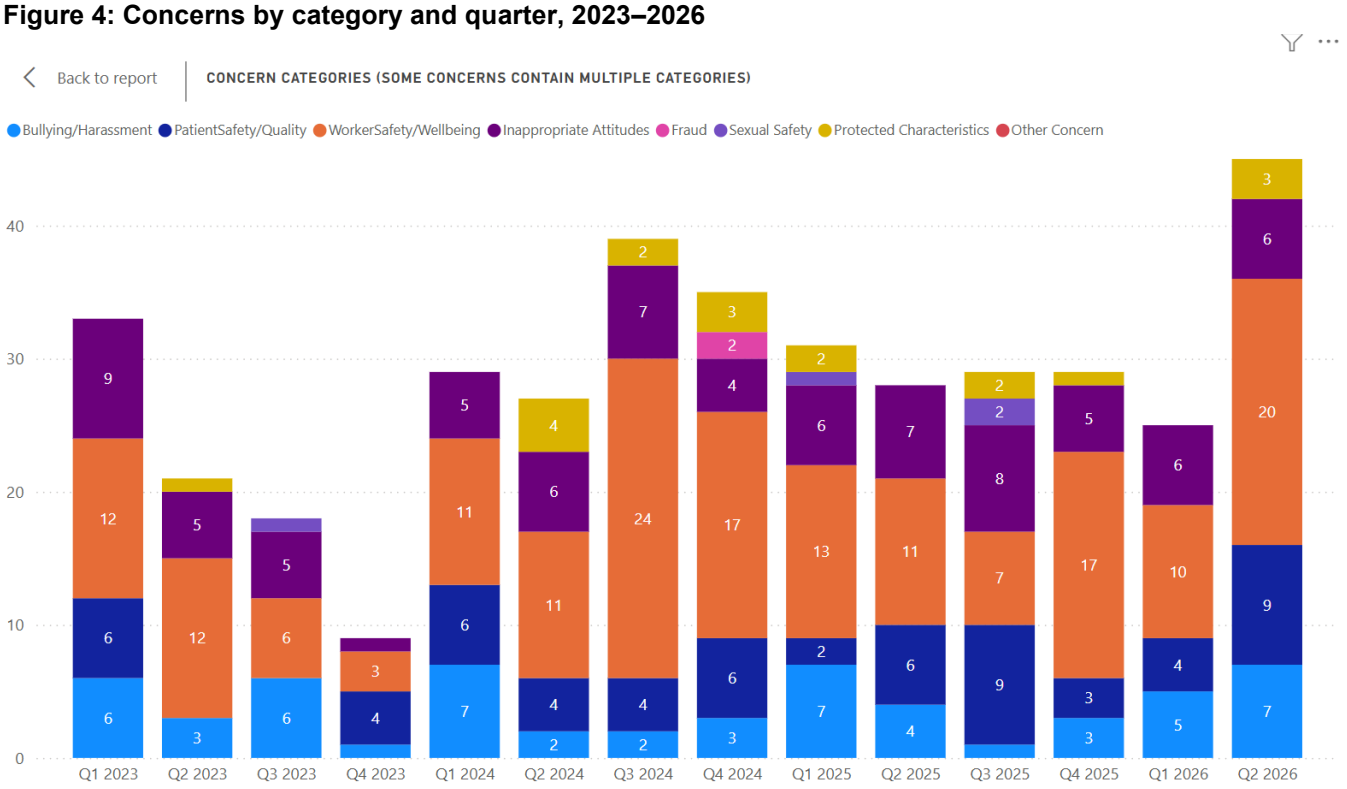


Categories of concerns

The Trust saw an increase from Q1 to Q2 in concerns categorised as relating to patient safety, worker safety and wellbeing, and bullying and harassment.

The most common nature of the concerns continues to be worker safety and wellbeing and concerns are raised from all care groups and all staff professional groups.

Figure 4: Concerns by category and quarter, 2023–2026



3.1 Patient Related Cases

Some of the cases reported relate to patient care.

In Q1 there were four concerns related to patient safety or quality issues.

In Q2 there were nine concerns related to patient safety or quality issues.

However, it is acknowledged that all cases may indirectly affect patient care. Issues raised through enquiries during Q1 and Q2 2026/27 in relation to patient safety included:

- Medication error and flexible working.
- Patient care pathway and team dynamics.
- Process around staff return to work following patient incident

Issues from FTSU cases requiring input from the FTSU Guardian were:

- Rota allocation fairness.
- Assessment templates
- Patient observation and infection control.
- Note recording accuracy
- Team dynamics impacting on work
- Being asked to complete tasks without training.
- Implementation of PSIRF process.

- Team work pressures impacting on staff.

3.2 Issues from all cases Q1 & Q2

Across all enquiries received during Q1 and Q2 2026/27, a broad range of issues was raised. The themes below reflect the concerns described by individuals and may overlap, as some enquiries related to more than one issue.

- Issues about job progression.
- Issues about manager attitudes, management style and ability to undertake the management role, including micromanagement.
- Issues around bullying and harassment, including the impact on individuals and the wider team.
- Concerns about performance management processes.
- Issues about performance processes and their impact on staff, including where disabilities and reasonable adjustments need to be considered.
- Issues around team dynamics, attitudes and behaviours towards colleagues.
- Issues around interpersonal disagreements and communication between staff.
- Concerns around assessment templates being used.
- Issues about staff behaviour during team meetings and expectations of colleagues to assist with transport to visits.
- Issues around flexible working arrangements.
- Issues about staff safeguarding (prevent concern).
- Issues about a staff role being eroded.
- Issues about fairness in rota allocation.
- Issues about staff safety.
- Issues with access to the centre kitchenette.
- Issues about fairness and transparency in selecting staff to attend an awards ceremony.
- Issues about transformation and operational changes within a service and the impact on the team.
- Issues about patient observations.
- Issues about expenses and time abatement for travel.
- Issues about patient notes and how they are recorded.
- Issues about staffing levels at night.
- Feedback alleging racism and sexism within the Trust.
- Issues around the MARS scheme where a manager is unable to support an application.
- Issues around communication between teams and the impact on patient care.
- Issues around the disclosure of personal information to the wider team.
- Issues about fairness of an interview process.
- Issues about fire risk assessments and restrictions on staff having their own electrical items in rooms.
- Issues about how the PSIRF process has been applied in practice.
- Issues about staff returning to work following absence and communication with their manager.
- Issues around volunteer role applications and clarity of the process.

It is recognised that a number of concerns have been reported from Forensic Outreach and Liaison Service between January 2026 and September 2026. Wards 18 and 19 have also seen a number of concerns between January 2026 and September 2026.

These concerns do not triangulate with intelligence from the Nursing Quality and Professions Team. However, the quality monitoring visit for Ward 18 was brought forward to December 2025, and the visit for Ward 19 took place in April 2026. Ongoing work is in place to support these areas, with oversight from the Director of Services.

4. Public Interest Disclosure at work (PIDA) cases

In 2026/27 no cases have met the definition of disclosures of public interest at work.

5. Update on detriment cases from 2026/27

Three cases of detriment have been reported in 2026/27 via the FTSU process. These were anonymous. Themes from these were alleged sexism and racism, a staff member having their contract terminated and the last case did not give details of the detriment they had suffered.

6. Update on the Reflection and planning tool action plan

The NHS England Board Reflection and Planning Tool and Action Plan was approved at Trust Board in October 2025. An update against the action plan is provided in Table 3. Regular updates against the action plan have been provided to the FTSU Oversight Group, Audit Committee and Trust Board.

Table 3: Reflection and Planning Tool update

Development areas to address in the next 12–24 months	Target date	Action owner
We are focussing on avoidable harm in our people processes and will highlight avenues for speaking up	April 2026 - 2027	People policies are being reviewed with an avoidable harm lens to include all avenues for speaking up. Ongoing work throughout 2026 alongside staff side colleagues.
As part of communication plan share more of the feedback of the experience from those using the FTSU service	April 2026 - 2027	Feedback survey data included as part of the report. Themes are shared at partnership meetings, people leadership team meetings and across the Nursing Quality and Professions directorate. Completed April 2026. More information to be shared via the newsletter from the feedback surveys without compromising anonymity.
Monthly meetings with Nursing Quality and Professions directorate and in particular the patient safety, quality governance and customer services team to assist with data triangulation.	November 2025 - 2027	Completed November 2025. Regular meetings are in place. FTSU to link in with PSIRF and input into the report

Development areas to address in the next 12–24 months	Target date	Action owner
A small sample of FTSU cases to be followed up as part of a sample to check improvements have been embedded as part of learning.	April 2026	One case from each care group was selected feedback will be taken via the Freedom to speak up oversight group and then to Audit committee. Completed April 2026 Feedback to oversight group and July 2026 Audit report.

7. Update on the Organisational Risk Register action plan

Risk 1887 in the Organisational risk register (ORR) describes a 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.

The actions and controls have been updated, and the current risk score is 3 x 3 (9) and is outside of risk appetite (1-6).

Work continues to monitor and mitigate this risk. This includes ongoing promotion of FTSU and support for a culture in which concerns are listened to and acted upon.

8. Communications and engagement update

The FTSU newsletter is now well established, with the latest issue circulated by the Communications Team and published on the intranet in the week commencing 10 July 2026. This issue provided an update on the annual report.

Ongoing visibility of the FTSU Guardians remains a key area of work, including site visits across the Trust. Bespoke awareness-raising sessions are organised with teams, and training is delivered as part of line manager development. FTSU continues to be promoted at Welcome Events. The Speak Up, Listen Up and Follow Up training modules are available through ESR.

Introduction meetings are also delivered to our resident doctors on rotation and our medical students so that they can meet the FTSU Guardian, understand the role and how to contact the team.

9. Training Update

Following a review of mandatory training the Speak up, Listen up and Follow up modules will move to be available via ESR for all staff.

Ongoing promotion of the training modules continues as part of the FTSU communication plan.

10. Feedback from cases and lessons learned

Lessons learned and feedback received from FTSU cases are summarised in Table 4.

Table 4: Feedback from cases and lessons learned

Theme of the concern raised	Learning from the case
Fairness around rota allocation	"A full review of the rota process has been undertaken by the General Manager and Matron following receiving the above report. This has included an audit of the previous 12 weeks of rotas looking specifically at shift allocations, in particular relating to fairness and equity of enhanced payment shifts (Nights and Weekend). Due to influencing factors (leave, sickness, skill mix requirement) there is some natural expected variation in allocations however over a long period these are largely equitable and no pattern or trend, in particular relating to specific staff members, has been identified. We are currently in the process of reviewing all flexible working patterns, in line with the trusts policy on rota management and publication and continue to do so on a 12 monthly basis."
Staff attitudes to a global situation	"Staff are confident to use FTSU process and the police have provided a really good response in relation to the concerns raised. Awareness about use of safeguarding as the route for this concern has been shared."
Issues about assessment template used	"Discussion had with medics and ward consultant about suitable places to complete ward-based assessments, also nursing team made aware of same to support advocating for patient. ACE 111 2012 version replaced with 2017 version on ward."
Job application process	"Recognised that this person has felt unhappy, however no applicable changes to be made"

11. Benchmarking data

The data from model hospitals including quarter one 2026/27 is included in Appendix 1. In summary our Trust records lower numbers of concerns raised than our peer organisations and remains in quartile 1.

12. Looking forward

The focus for the forthcoming year will be on maintaining links with the Nursing Quality and Professions Directorate and the People Directorate to support the ongoing work to strengthen the Trust's Freedom to Speak Up culture and improve the triangulation of information.

In addition, following analysis of Staff Survey results, work will take place with those areas identified as less likely to raise concerns to understand barriers to speaking up.

Work continues as part of the Patient Safety Incident Response Framework to triangulate issues from complaints, incidents, quality monitoring visits, FTSU and patient feedback. The Quality Assurance System (QAS) records the themes, and its outputs are used to develop targeted improvement work with teams and inform quality walkarounds through regular intelligence sharing between FTSU and the Quality Team.

Links with the People Directorate will support the integration of Freedom to Speak Up into business as usual, including through line manager development training.

Future reports will look at SPC charts to ascertain if there are any notable trends in the data.

October is Speak Up Month, and awareness sessions are being held across the Trust. A newsletter focusing on anonymous cases and the actions taken in response to the issues raised will be circulated through Trust Communications and reported to the Audit Committee.

13. Summary

The FTSUG continues to promote and support Freedom to Speak Up across the organisation in partnership with operational and corporate colleagues.

14. Recommendation

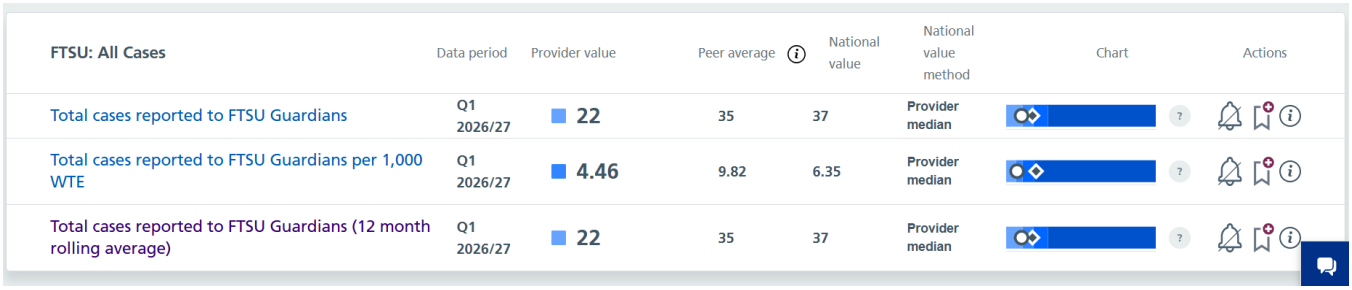
Trust Board is asked to RECEIVE and DISCUSS the Freedom to Speak Up update report.

Appendix 1.

Model Hospitals benchmarking data

Our peers are Bradford District Care NHS Foundation Trust, Derbyshire Healthcare NHS Foundation Trust, Greater Manchester Mental Health NHS Foundation Trust, Humber Teaching NHS Foundation Trust, Leeds and York Partnership NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust, Rotherham Doncaster and South Humber NHS Foundation Trust, Sheffield Health Partnership University NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust.

The data is split into quartiles with quartile 1 being the lowest score and quartile 4 having the highest scores.



FTSU: All Cases	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Total cases reported to FTSU Guardians	Q1 2026/27	22	35	37	Provider median		
Total cases reported to FTSU Guardians per 1,000 WTE	Q1 2026/27	4.46	9.82	6.35	Provider median		
Total cases reported to FTSU Guardians (12 month rolling average)	Q1 2026/27	22	35	37	Provider median		

In a rolling 12month average our Trust reported 22 cases putting us in quartile 1 compared to our peers. Bradford District Care NHS foundation trust and Sheffield Health Partnership University NHS foundation trust, Rotherham Doncaster and South Humber NHS foundation trust, Leeds and York Partnership NHS foundation trust sit in quartile 2.

Tees, Esk and Wear Valleys NHS foundation trust and Greater Manchester mental health NHS foundation trust are in quartile 3, whilst Nottinghamshire Healthcare NHS foundation trust reported the highest number of cases with an average of 191 in a rolling 12month period and sits in quartile 4.



FTSU: Cases relating to Bullying & Harrassment	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Bullying and harrassment cases reported to FTSU Guardians	Q1 2026/27	5	5	5	Provider median		
Bullying and harrassment cases reported to FTSU Guardians per 1,000 WTE	Q1 2026/27	1.01	1.18	0.99	Provider median		
Bullying and harrassment cases reported to FTSU Guardians as % of total cases	Q1 2026/27	23%	17%	16%	Provider median		
Bullying and harrassment cases reported to FTSU Guardians (12 month rolling average)	Q1 2026/27	5	5	5	Provider median		

In a rolling 12month average our Trust had 5 cases in the bullying and harassment category and sits in quartile 3 compared to our peers, also in this quartile are Leeds and York Partnership NHS foundation trust, Rotherham Doncaster and South Humber NHS foundation trust, Tees, Esk and Wear Valleys NHS foundation trust and Greater Manchester mental health NHS foundation trust.

Humber Teaching NHS foundation trust sits in quartile 1. Bradford District care NHS foundation trust sit in quartile 2.

Derbyshire Healthcare NHS Foundation Trust and Nottinghamshire Healthcare NHS Foundation Trust sit in quartile 4.

FTSU: Cases relating to Patient Safety & Quality	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Patient safety and quality cases reported to Freedom To Speak Up Guardians	Q1 2026/27	4	9	5	Provider median		
Patient safety and quality cases reported to FTSU Guardians per 1,000 WTE	Q1 2026/27	0.81	2.69	0.89	Provider median		
Patient safety and quality cases reported to FTSU Guardians as % of total cases	Q1 2026/27	18%	22%	15%	Provider median		
Patient safety and quality cases reported to FTSU Guardians (12 month rolling average)	Q1 2026/27	4	9	5	Provider median		

Over a rolling 12-month period, the Trust reported four patient safety concerns and sits in quartile 2, alongside Leeds and York Partnership NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust.

Humber Teaching NHS foundation trust, Sheffield Health Partnership University NHS foundation trust, Greater Manchester Mental Health NHS foundation trust sit in quartile 3.

Bradford District Care NHS Foundation Trust, Derbyshire Healthcare NHS Foundation Trust, and Rotherham Doncaster and South Humber NHS Foundation Trust are in quartile 4.

FTSU: Cases relating to Detriment as a result of Speaking Up	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Cases of Detriment as a result of Speaking Up reported to FTSU Guardians	Q1 2026/27	2	0	0	Provider median		
Cases of Detriment as a result of Speaking Up reported to FTSU Guardians per 1,000 WTE	Q1 2026/27	0.41	0.00	0.00	Provider median		
Cases of Detriment as a result of Speaking Up reported to FTSU Guardians as % of total cases	Q1 2026/27	9%	0%	0%	Provider median		
Cases of Detriment as a result of Speaking Up reported to FTSU Guardians (12 month rolling average)	Q1 2026/27	2	0	0	Provider median		

The Trust reported two cases of detriment over a rolling 12-month period and sits in quartile 4 with Rotherham Doncaster and South Humber NHS Foundation Trust, Greater Manchester Mental Health NHS Foundation Trust, Derbyshire Healthcare NHS Foundation Trust, and Nottinghamshire Healthcare NHS Foundation Trust.

FTSU: Cases reported anonymously	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Cases reported to FTSU Guardians anonymously	Q1 2026/27	8	0	2	Provider median		
Cases reported to FTSU Guardians anonymously per 1,000 WTE	Q1 2026/27	1.62	0.00	0.43	Provider median		
Cases reported to FTSU Guardians anonymously as % of total cases	Q1 2026/27	36%	0%	6%	Provider median		
Cases reported to FTSU Guardians anonymously (12 month rolling average)	Q1 2026/27	8	0	2	Provider median		

Our Trust has reported a total of 8 concerns anonymously in a 12month rolling average and we sit in quartile 4 with Derbyshire Healthcare NHS foundation trust.

Our peers Rotherham Doncaster and South Humber NHS foundation trust, Leeds and York Partnership NHS foundation trust, sit in quartile 3.

FTSU: Cases relating to Worker Safety	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Worker safety cases reported to FTSU Guardians	Q1 2026/27	10	11	13	Provider median		
Worker safety cases reported to FTSU Guardians per 1,000 WTE	Q1 2026/27	2.03	4.06	2.36	Provider median		
Worker safety cases reported to FTSU Guardians as % of total cases	Q1 2026/27	45%	41%	43%	Provider median		
Worker safety cases reported to FTSU Guardians (12 month rolling average)	Q1 2026/27	10	11	13	Provider median		

The Trust sits in quartile 2, with 10 concerns relating to worker safety over a rolling 12-month period. Greater Manchester Mental Health NHS Foundation Trust, Rotherham Doncaster and South Humber NHS Foundation Trust, Sheffield Health Partnership University NHS Foundation Trust, and Leeds and York Partnership NHS Foundation Trust are also in this quartile.

Humber Teaching NHS foundation trust and Tees, Esk and Wear Valleys NHS foundation trust in quartile 1.

Bradford District Care NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust sit in quartile 3.

Nottinghamshire Healthcare NHS foundation trust and Derbyshire Healthcare NHS Foundation trust are in quartile 4.

FTSU: Cases relating to other Inappropriate Attitudes and Behaviours	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Other Inappropriate Attitudes and Behaviours cases reported to FTSU	Q1 2026/27	6	17	16	Provider median		
Other Inappropriate Attitudes and Behaviours cases reported to FTSU per 1,000 WTE	Q1 2026/27	1.22	4.24	2.55	Provider median		
Other Inappropriate Attitudes and Behaviours cases reported to FTSU % of total cases	Q1 2026/27	27%	46%	41%	Provider median		
Other Inappropriate Attitudes and Behaviours cases reported to FTSU (12 Month Rolling Average)	Q1 2026/27	6	17	16	Provider median		

Variation data for cases involving inappropriate attitudes and behaviours is not available. The Trust recorded six cases over a rolling 12-month period.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 10.10

Private/Public paper:	**Public**		
Title:	**WRES/WDES Action Plan 2026/2027**		
Lead Director:	**Christine Brereton, Chief People Officer**		
Mission/values:	Our workforce is our greatest asset and ensuring that we have the right workforce in place to deliver safe and quality services is critical. As well as being our greatest asset, our workforce is our greatest financial investment, with workforce spend accounting for 80% of our total budgeted expenditure.		
Purpose:	The purpose of the report is to present to Board the WRES/WDES action plan which is required to be published on the Trust's website by 31 October 2026. The plan is developed to respond to the findings of the WRES/WDES which were published in May 2026.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	1.1 Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience. 1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience. 2.1 Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy. 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. 4.2 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.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships.	Workforce equality, particularly in relation to race and disability, remains a key NHS priority. WRES and WDES form part of the NHS Standard Contract requirements and support delivery of the NHS People Promise, NHS Long Term Workforce Plan, NHS Equality, Diversity and Inclusion Improvement Plan, and the Trust's People Strategy. The annual action plan contributes to system-wide objectives by improving staff experience, reducing inequalities, promoting inclusive leadership, strengthening workforce representation and supporting the delivery of equitable, high-quality care for all communities. Through this work, the Trust continues to contribute to Integrated Care System ambitions to reduce		

	inequalities, improve population health outcomes and create an inclusive workforce where all colleagues can thrive.
Any background papers / previously considered by:	he revised 2026/27 annual action plan has been considered at Executive Management Team (EMT) on the 3 September 2026, EDI ops group on 1 September. The WRES/WDES action plans were also submitted to People and Remuneration Committee 15 September 2026 and was approved (subject to strengthening of the success and outcome measures).
Executive summary:	The NHS Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are mandated through the NHS Standard Contract and associated NHS England to produce and publish a board-approved an annual report and action plan in response to the findings. The Trust submitted its 2025/26 WDES and WRES data returns to NHS England by the national deadline of 31 May 2026. In accordance with NHS England mandated requirements. The data was submitted to People and Remuneration Committee on 5 May 2026. This action plan has been produced to respond directly to the findings of the WRES/WDES and is a continuation of the WRES/WDES action plan produced in 25/26 which has had oversight and scrutiny by PRC. The 2025/26 Action plan focused on five priority areas: • Inclusive recruitment and career progression • Tackling harassment and discrimination • Representation and visibility in senior roles • Staff engagement and wellbeing • Governance and accountability Good progress and regular updates have been made across all themes, with the majority of actions completed or embedded into business-as-usual processes. **2025/26 Key Achievements** **Inclusive Recruitment and Career Progression** • Recruitment analysis and engagement activity completed to better understand barriers experienced by ethnic minority and disabled applicants. • Findings have informed targeted actions these are detailed within the revised 2026/27 plan. **Tackling Harassment and Discrimination** • Active Bystander resources introduced within people management essentials development programmes. • Enhanced partnership working together across the organisation to scope and design our the #AllOfUs campaign an action carried forward into the revised 2026/27 action plan. **Staff Engagement and Wellbeing** • Supporting Attendance workshops and wellbeing resources introduced. • Increased focus on workplace adjustments, wellbeing conversations and manager capability.

	Governance and Accountability • Objectives embedded within manager and leadership appraisal processes. • Staff Networks relaunched with strengthened governance, executive sponsorship and development support. • Improved staff voice and organisational accountability arrangements established. • Launch of the new "belonging and inclusion policy" together with manager procedure guidance in collaboration with networks and staff side colleagues. **Transition to the 2026/27 Action Plan** Review of progress demonstrates that while significant achievements have been delivered, several priorities remain central to improving workforce equality outcomes. These actions have been incorporated into the revised 2026/27 WRES and WDES Action Plan for review and discussion under this agenda item. The new plan has been developed in response to the 2026 WRES and WDES findings and is structured around three themes that link directly with our annual organisational people priorities. 1. Workforce Planning and Supply 2. We Are Compassionate and Inclusive 3. We Are Safe and Healthy The revised plan will continue to address workforce representation, career progression, staff experience, discrimination, wellbeing and leadership accountability, ensuring sustained focus on equality, diversity, inclusion and belonging across the Trust.
Recommendation:	**Trust Board members are asked to:** • **NOTE** the progress achieved through delivery of the 2025/26 WRES and WDES Action Plan. • **NOTE** the conclusion of the 2025/26 Action Plan. • **NOTE** that ongoing actions that have been incorporated into the 2026/27 WRES and WDES Action Plan. • **APPROVE** the planned publication of the 2026/27 Action Plan as the Trust's framework and approach for advancing equality, diversity, inclusion and belonging and responding to the findings of the WRES/WDES findings published in May 2026.

NHS
South West Yorkshire
Partnership Teaching
NHS Foundation Trust

Workforce Race & Workforce Disability Equality Standards (WRES/WDES) Action Plan 2026 / 2027

Introduction

This Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Action Plan has been developed specifically in response to the Trust's 2026 WRES and WDES findings, building on progress made through previous WRES/WDES action plans and targeting areas of underrepresentation, inequality and variation in staff experience identified through workforce data and staff feedback.

While informed by WRES and WDES requirements, this plan goes beyond compliance. It supports delivery of the NHS People Promise, NHS Staff Standards and the Trust's ambition to create a workplace where all colleagues feel valued, included and able to thrive.

Aligned to the Trust's People Strategy, the action plan contributes directly to the organisational priorities of Live Our Values and Best Place to Work and Learn, with a focus on improving workforce representation, inclusion, wellbeing and leadership accountability.

Organisational Themes:

This action plan is aligned to the Trust's People Strategy and is structured around three key workforce themes:

- Workforce Planning & Supply
- We Are Compassionate and Inclusive
- We Are Safe and Healthy

The nine actions within the plan have been designed to support these priorities through a focused and achievable programme of work that addresses inequalities in recruitment, career progression, staff experience, leadership representation and workplace culture that were specifically highlighted as areas for the improvement in the WRES/WDEs findings.

The plan also supports delivery of the objectives overseen by the Equality, Diversity and Inclusion Operational Group, ensuring a coordinated, evidence-based approach to improving equality outcomes. Through this work, the Trust aims to reduce disparities, strengthen inclusion and create a workforce that better reflects and serves the communities we support.

Purpose of the Plan

This action plan builds on the progress made through the 2025/26 WRES and WDES Action Plan and responds to the Trust's 2026 WRES and WDES findings and metrics. It sets out a targeted programme of work to improve workforce equality outcomes and embed equality, diversity, inclusion and belonging throughout the employee lifecycle. Progress will be monitored through established governance arrangements to ensure accountability, oversight and sustained improvement.

Workforce Planning & Supply

Ref	Metric (s) / Standard (s)	Actions	Timeline	Intended Outcome / Data	Lead (s)
1.1	**WRES metric** 1, 7, 9 **WDES metric** 1, 5, 10 **NHS Staff Standards** Tackling Racism Promoting Flexible Working	We will host a targeted community recruitment and engagement event to attract local talent that is diverse and represents the communities we serve. This will be achieved through a multi-disciplinary delivery team, across the people directorate, staff networks and clinical colleagues.	**Q3 2026:** Scope and planning **Q4 2026:** Pilot delivery **Q1 2027:** Business-as-usual rollout and embedding	Attract diverse talent into the organisation from the local community, assessed through the applications generated from events. Showcase the Trust as the best place to work and learn in our communities. Successful appointment of applicants received from events held.	Head of Recruitment; Belonging & Inclusion Lead and Networks

				See an increase in BME workforce representation from which is currently at 19.1%. Support improvement in WDES Metric 1 by increasing workforce representation of disabled staff and reducing underrepresentation in senior positions. Which currently sits at 11.4%	
1.2	**WRES metric** 7, 9 **WDES metric** 1, 5, 7, 9b, 10 **NHS Staff Standards** Line Management Promoting Flexible Working	We will promote our diverse leadership by building a program of information that shares stories through: • Blogs • Podcasts • Case Studies • Story Telling We will ensure leaders are supported and encouraged to update their own data on ESR with every interaction we	**Q3/Q4 2026:** Build, scope and EMT sign-off **Q1 2027:** Pilot delivery **Q3/Q4 2027:** BAU rollout and embedding	Demonstrate the Trust's commitment to inclusive leadership and diverse talent across all levels of the organisation. Keep staff groups engaged with organisation priorities via other engagement methodologies by assessing content engagement analytics.	Belonging & Inclusion Lead; Networks; OD Leads;

		have with them. E.g. Training, Recruitment, PD activities. We will run a campaign through our communication team that supports all colleagues to update their own data on ESR to help us identify talent across the organisation.		Reducing the precenting on "unknown" figures on protective characteristic data fields on ESR Improve NHS staff survey results – Equal opportunity in career progression / Feeling valued by organisation WRES Metric 7, reducing the current gap between White staff (62.1%) and ethnic minority staff (50.3%). Reduce unknown disability declarations on ESR (currently 3.7%) and increase visibility of disabled role models and leaders across the organisation.	
1.3	**WRES metric** 7, 9 **WDES metric** 5, 7, 9	We will scope, design and begin the implementation of a reciprocal mentoring programme for ethnic minority staff and disabled staff/those with a long-term condition.	**Q1 2027:** Scope and design **Q2/Q3 2027:** Pilot delivery	Support Two-way learning scoped from program attendees feedback forms	OD Lead / Belonging & Inclusion Lead

	NHS Staff Standards Line Management		**Q4 2027:** Review and improve **Q1 2028:** Rollout **Q2 2028:** BAU implementation and embedding	Improve leadership understanding of lived experience and strengthen inclusive leadership behaviours. Contribute to improvements in WRES Metric 7 (career progression), reductions in Metric 8 (workplace discrimination) and support longer-term improvements in Metric 9 by increasing progression pathways into senior leadership roles for underrepresented groups. Support improvements in WDES Metric 5 (career progression), Metric 7 (feeling valued) and Metric 9 (staff engagement) through increased visibility, confidence and access to career opportunities for disabled staff.	

				This action is also intended to support actions 1.1 & 1.2	
1.4	**WRES metric** 1, 2 **WDES metric** 1, 2 **NHS Staff Standards** Line Management Tackling Racism	We will analyse recruitment, shortlisting and appointment data by service line to identify disparities within that service. We will support managers to implement positive action approach in recruitment appointment decisions to support the building of diverse teams and services. Attention will be focused in areas identified through the analysis.	**Q3/Q4 2026:** Analysis and insight gathering **Q1/Q2 2027:** Manager support and implementation	Identify any hot spot in recruitment disparities by service line. Tailored support for recruitment by service line / roles to drive down the disparity rate from shortlisting to appointment. Increase awareness and confidence in managers by applying lawful positive action approaches to improve access and representation where underrepresentation is evidenced. Reduce recruitment disparities identified within WRES Metric 2 which currently is 2.74 white staff are more likely to be appointed from	Head of Recruitment; Belonging & Inclusion Lead

				shortlisting compared to BME staff. WDES Metric 2 Current position is: • Disabled candidates are actually more likely to be appointed than non-disabled candidates. • Relative likelihood = **0.59** This is a positive metric which action aims to maintain.	

We are Compassionate and Inclusive

Action 1.2 would also support this theme but is not replicated in the below table.

Ref	Metric (s) / Standards (s)	Actions	Timeline	Intended Outcome	Lead (s)
2.1	**WRES metric** 5, 6, 8 **WDES metric** 4a-c, 7 **NHS Staff Standards** Line Management Health and Wellbeing Championing Sexual Safety Tackling Racism	We will refresh our behaviour statement; these are several statements which bring to life "how we all behave every day" We will produce our refreshed behaviours, mobilise these across the organisation and begin the process of embedding these into manager development e.g. PME. We will introduce these into all our appraisal conversations.	**Q2/Q3 2026:** Complete refresh and redevelopment work **Q4 2026:** Mobilisation and implementation	Emphasise our Trust behaviours across the organisation, specifically those which cause discrimination and harm. Carry out analysis of the 2 additional local questions within staff survey by staff groups. Ensure Trust behaviours support an inclusive culture and are evidenced through performance and appraisal processes and reflected in the NHS staff survey questions on bullying and discrimination score. WRES metric 5, 6 and 8 - Seek to reduce current levels	OD Lead / Belonging & Inclusion Lead

				of 37.4% (patient/public harassment), 20.5% (staff harassment) and 13.0% (discrimination), while embedding organisational behaviours that support an inclusive workplace culture. WDES metric 4a, 4b and 4c – seek to reduce current levels of 28.3% (patient/public harassment), 7.2% (bullying from managers) and 15.9% (colleague bullying)	
2.2	**WRES metric** 5, 6, 8 **WDES metric** 4a-d, 7 **NHS Staff Standards** Line Management Tackling Racism	We will launch the Trust-wide #AllOfUs campaign, reinforcing the Trust's zero-tolerance approach to discrimination, bullying, harassment and hate incidents. We will introduce a Speak, Listen, Support and Act toolkit to support #Allofus with this campaign.	**Q2-Q4 2026:** Final design and implementation **Q1 2027:** Rollout and embedding	Increase staff confidence in reporting incidents and accessing support, especially those with protected characteristics done by analysing incident reporting rates. Increase confident on handling incidents assessed via campaign feedback loop and pulse survey.	Belonging & Inclusion Lead, OD Leads, Comms Team

	Championing Sexual Safety Violence and Prevention Reduction Health and Wellbeing			Increase feeling of being supported and cared for when staff fall victim of incidents, especially those with protected characteristics by analysing staff sickness rates. Deliver measurable improvements in WRES Metrics 5, 6 and 8, reducing the disparity between White and ethnic minority staff experiences and strengthening confidence that inappropriate behaviour will be addressed. Improve outcomes in WDES Metrics 4a-4d, maintaining high reporting confidence whilst reducing the prevalence of incidents experienced.	
2.3	**WRES metric** All	We will design WRES/WDES metric awareness sessions for managers, leaders and colleagues.	**Q4 2026:** Design and development	Increase leadership awareness and accountability on WRES and WDES metrics	Belonging and inclusion lead.

	WDES metric All **NHS Staff Standards** Line Management Tackling Racism Championing Sexual Safety Violence Prevent and Reduction	We will PILOT and then deliver these sessions quarterly embedding as a BAU offer from Q2 2027.	**Q1 2027:** Delivery and implementation	by analysing session pre/post survey. Increase leadership accountability for equality outcomes and stimulate local improvement activity across services. Stronger alignment between local service planning and Trust-wide EDI priorities. Improve WRES and WDES outcomes through sustained behavioural and cultural change, supported by evidence-based decision making.	

We are Safe and Healthy

Action 2.2 would also support this theme but is not replicated in the table below.

Ref	Metric (s) / Standard (s)	Action	Timeline	Intended Outcome	Lead (s)
3.1	**WRES metric** 5, 6, 8 **WDES metric** 4a-d **NHS Staff Standards** Line Management Health and Wellbeing Violence Prevention and Reduction Championing Sexual Safety Tackling Racism Promote Flexible Working	To support 2.2, we will create and implement support and toolkits around, Speak, Listen, Support and Act. Across teams and services identified through workforce intelligence, NHS Staff Survey, and other reporting mechanisms.	**Q3/Q4 2026:** Design and development **Q1 2027:** Implementation, aligned to Action 2.2	Direct support for teams and services where needed. Improve workplace culture and safety by analysing NHS staff survey results and conducting additional pulse surveys. Provide targeted support to teams where workforce intelligence identifies concerns and deliver improvements in WRES Metrics 5, 6 and 8. Current data • Metric 5 = BME 37.4% White 20.6% • Metric 6 = BME 20.5% White 13.7%	PBP / Belonging & Inclusion Lead

				• Metric 8 = BME 13.0% White 4.8% Improve disabled staff experiences through reductions in bullying, harassment and abuse measured through WDES Metrics 4a-4c. Current data • Patient / public = 28.3% • Manager bullying = 7.2% • Colleague bullying = 15.0%	
3.2	**WRES metric** 5, 6 **WDES metric** 6, 7, 8, 9 **NHS Staff Standards**	We will launch the Health and Wellbeing Conversations Toolkit across the Trust. We will support managers on the use of this tool kit which will be designed to support our colleagues with better wellbeing.	**Q2-Q4 2026:** Policy development and consultation **Q1 2027:** Policy launch and implementation	Promote health and wellbeing conversation competency across the Trust, especially with those with a disability. We will analyse staff sickness absence rates.	Head of Occupational Health and Wellbeing

	Line Management Health and Wellbeing Promoting Flexible Working	We will review and refresh policy and process to one that supports Wellbeing and Attendance oppose to managing sickness.		Improve manager confidence and capability in undertaking wellbeing conversations and supporting workplace adjustments for all staff but with a focus on those with a protected characteristic where there may be a need for specific focus and action to eliminate any issues. Support staff to stay safe and healthy whilst at work. Support in reducing absence. Deliver improvement in WDES Metric 6 (current 18.2%) by reducing pressure on disabled staff to attend work when unwell. Maintain strong performance in Metric 8 (currently 81.9%) regarding reasonable adjust-	

				ments, and contribute to improvements in Metrics 7 and 9 relating to feeling valued and staff engagement (currently 47.9%)	

Impact

Impact will be monitored through WRES & WDES Metrics with progress reported annually through the Trust's WRES submission and quarterly workforce equality reporting to committee.

Improving Our Understanding of WRES and WDES

Sustainable improvement in WRES and WDES outcomes requires more than monitoring workforce metrics. It requires all colleagues to understand the data, recognise lived experiences, and take responsibility for creating an inclusive culture.

To support this, the Trust will deliver quarterly engagement and learning sessions for managers, leaders and colleagues, focusing on WRES and WDES indicators, workforce equality data and local performance. This is illustrated in action 2.3.

These sessions will help increase understanding of recruitment, career progression, staff experience, reasonable adjustments and workplace culture, enabling informed decision-making and greater accountability. Through this approach, the Trust aims to strengthen leadership ownership, influence inclusive behaviours, support diverse talent and work with colleagues as partners in delivering the actions set out within this plan.

Success Measures

Progress against this action plan will be reported quarterly to the Trust governance structure. Success will be measured through the delivery of this action plan and improvement in WRES and WDES metrics, NHS National Staff Survey outcomes, workforce representation data, employee relations indicators, recruitment outcomes, staff network feedback and local engagement measures. This will ensure both quantitative and qualitative evidence is used to assess impact and inform continuous improvement. Additional some individual actions will be accompanied by their own bespoke feedback forms and pulse surveys to ensure impact can be measured and assessed

Workforce Race Equality Standards (WRES) Metrics

Metric	Definition
WRES 1	Percentage of staff in each Agenda for Change band and medical/dental grade by ethnicity
WRES 2	Relative likelihood of ethnically diverse applicants being appointed from shortlisting compared to White applicants
WRES 3	Relative likelihood of ethnically diverse staff entering formal disciplinary processes compared to White staff
WRES 4	Relative likelihood of ethnically diverse staff accessing non-mandatory training and CPD compared to White staff
WRES 5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public
WRES 6	Percentage of staff experiencing harassment, bullying or abuse from managers or colleagues
WRES 7	Percentage of staff believing the Trust provides equal opportunities for career progression or promotion
WRES 8	Percentage of staff experiencing discrimination from managers, colleagues or service users
WRES 9	Board representation compared to workforce ethnicity profile

Workforce Disability Equality Standards (WDES) Metrics

Metric	Definition
WDES 1	Percentage of disabled staff in workforce
WDES 2	Relative likelihood of disabled applicants being appointed from shortlisting compared to non-disabled applicants
WDES 3	Relative likelihood of disabled staff entering formal capability processes compared to non-disabled staff
WDES 4a-d	Experiences of bullying, harassment, abuse and discrimination
WDES 5	Percentage of disabled staff feeling pressure to attend work when unwell
WDES 6	Percentage of disabled staff satisfied with adjustments
WDES 7	Percentage of disabled staff believing organisation provides equal opportunities for career progression
WDES 8	Percentage of disabled staff experiencing discrimination
WDES 9a	Percentage of disabled staff suffering presenteeism
WDES 9b	Percentage of disabled staff feeling valued by their organisation
WDES 10	Board disability representation

NHS National Staff Survey Measures

The following questions will be used as key indicators of improvement:

Inclusion & Belonging

- "My organisation acts fairly with regard to career progression or promotion."
- "My organisation respects individual differences."
- "I feel valued by my organisation."
- "Senior managers are committed to creating a diverse and inclusive organisation."

Discrimination

- "In the last 12 months have you experienced discrimination at work?"
- "Did the discrimination come from managers?"
- "Did the discrimination come from colleagues?"
- "Did the discrimination come from patients, service users or members of the public?"

Bullying and Harassment

- "In the last 12 months have you experienced bullying, harassment or abuse from managers?"
- "In the last 12 months have you experienced bullying, harassment or abuse from colleagues?"
- "In the last 12 months have you experienced bullying, harassment or abuse from patients, service users or the public?"

Health & Wellbeing

- "My organisation takes positive action on health and wellbeing."
- "I am able to meet the conflicting demands on my time at work."
- "I would recommend my organisation as a place to work."

Leadership

- "Senior managers try to involve staff in important decisions." And "Communication between senior management and staff is effective."

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 10.11

Private/Public paper:	**Public**		
Title:	**Planning update**		
Lead Director:	**Dawn Lawson – Executive Director of Strategy, Inclusion and Change/ Deputy Chief Executive** **Adrian Snarr – Executive Director of Finance and Resources**		
Mission/values:	The development of our plan supports the effective use of resources and our wider strategic objectives to be the **Best we can Be**. By **living our values** we will ensure that we have the financial resources in place to deliver **our mission to support people to reach their potential and live well in their community**.		
Purpose:	The purpose of this paper is to provide Trust Board with an update on the development of the Trust operating plan.		
Strategic aims:	Live Our Values	✓	The Trust's planning process supports all of our strategic aims.
	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. 6.2 System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience. 6.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships.	The paper highlights the opportunities available to the Trust to work with other partners to tackle shared challenges through a system approach to planning, and developments and discussions in progress where relevant.		
Any background papers / previously considered by:	An update on progress with development of plans was shared with EMT time out on 15 October 2026, and with Finance, Investment and Performance Committee on 19 October 2026.		

With **all of us** in mind.

Executive summary:	In August 2025, NHSE shared the draft 'Planning Framework for the NHS in England'. The framework shifts the focus of planning towards a rolling five-year planning horizon and planning as a continuous, iterative process that supports transformational change, delivering the three shifts set out in the 10 Year Health Plan. On 24 October 2025, the Medium Term Planning Framework was published. This set out performance targets and requirements for NHS organisations over three and five years. The attached paper provides an update on our Trust approach to planning for, and our progress to date. Last year we co-designed our planning approach with colleagues to be an aligned, clear focus across the organisation so that we are intentionally planning to be the **Best we can be.** Our multi-year plan clearly defined our priorities and delivery plans so that we will use our collective energy to work towards common goals. This approach was designed to provide assurance that we will meet national and local planning requirements, whilst **living our values** and, **being ambitious for the communities we serve and our colleagues.** We have gained learning from our 2026/27 planning process and gained insights from leaders from across the organisation to support us to further refine our planning principles and approach for 2027/28. The 'all of us' planning conversation for 2027/28 will further engage with our leaders in the Operational Management Group, extended executive management group and executive management team, and they in turn engage with their teams, and draw upon feedback and insight from our service users and communities. The conversation is important to develop ideas on the 'art of the possible' as well as understanding our genuine limitations and difficult decisions that we need to make. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register.
Recommendation:	**Trust Board member are asked to:** • **NOTE** the update on the development of, and timescales for, the Trust operating plan.

South West Yorkshire Partnership Teaching
NHS Foundation Trust

Trust Board
28 October 2026
Annual Planning Update

1. Introduction

The purpose of this paper is to provide Trust Board with an update on the development of the Trust operational plan for 2027/28.

2. National context

In August 2025, NHSE shared the 'Planning Framework for the NHS in England'.

The framework shifted the focus of planning towards a rolling five-year planning Horizon, and planning as a continuous, iterative process that supports transformational change, delivering the three shifts set out in the 10 Year Health Plan.

The National planning framework has 5 areas of focus for plans:

- Outcome-focused- Planning should be anchored in delivering tangible and measurable improvements in outcomes for patients and the public, and improved value for taxpayers. Involving patients, carers, and communities is critical for ensuring that plans deliver better outcomes and services that are responsive to local needs.

- Accountable and transparent- Effective planning requires clarity on roles, responsibilities, and accountabilities. Governance structures must support transparent decision-making, provide regular oversight and constructive challenge, and ensure alignment with strategic objectives at organisation, place and system level.

- Evidence-based- The decisions made as part of planning should be underpinned by robust analytical foundations, including population health analysis, demand and capacity modelling, workforce analytics, and financial forecasts. This should be informed by best practice and benchmarking.

- Multi-disciplinary- Planning must bring together staff from across different functional areas (finance, workforce, clinical etc) to ensure that work is co-ordinated and that those responsible for delivery have shaped its content.

- Credible and deliverable- Plans must set ambitious yet achievable goals. They should clearly articulate the resources required, realistically reflect workforce and financial constraints, and include mitigation strategies for key risks. Robust triangulation between finance, performance, workforce and quality is critical.

On 24th October 2025, the national Medium Term Planning Framework was published. This set out performance targets and requirements for NHS organisations over three and five years.

We have not yet received any further national planning guidance for 2027/28 and continue to work towards the frameworks outlined above.

3. Our Trust approach to planning

In 2025/26, the Trust developed its Operational Plan for 2026-2031, our 'All of Us Plan'. Work has now commenced to undertake a full review of our plan, to ensure we develop the detailed operational and financial plans in line with the trajectories identified. We will develop the assurance that we are able to deliver the trajectories that we set out for the year ahead.

To ensure that we deliver a plan that: meets the areas of focus outlined in planning guidance; that is in line with our values and strategic plan; and is owned across the organisation, the Trust developed and agreed the following principles last year to underpin our planning approach following engagement with our OMG, Extended Executive Management Team (EMT), internal Planning Group and EMT. These principles will frame our approach to planning for 2026/27.

These are:

- Plan once, plan well; so that plan can be used for the range of purposes that we need.
- To use the annual planning process throughout the year as the 'one version of the truth' for performance discussions and planning within year and across years.
- Be very clear about what our priorities are for each team, service, directorate and iterate this throughout the planning process.
- Understand and connect the delivery of our priorities across the organisation, with support services enabling front line delivery.
- Provide as much certainty as possible about internally what we need to do, defining the difficult decisions such as service re-design.
- Link the relevant planning objectives to appraisals, so that all colleagues understand the contribution that they make, within year and across years.
- To align planning with our strategy, and our approach to governance so that they become an integral enablers that help us all to do our jobs better.
- Always living our values and, being ambitious for the communities we serve and our colleagues

We recognise that the year ahead will present significant challenges both operationally and financially. It is therefore very important that the organisation is prepared for this and that we are prepared to corporately lead and manage proactively. Providing as much certainty as possible internally regarding our approach and priorities is an important aspect of maintaining morale and hope.

4. Progress so far

Our planning process is overseen by the Executive Director of Strategy, Inclusion and Change/Deputy Chief Executive.

An internal Planning Group has been established for 2027/28 planning chaired by the Director of Strategy, Inclusion and Change with the Executive Director of Finance and Resources as deputy chair. The Group has commenced meeting weekly, reporting directly into EMT. The group is by design, a cross section of colleagues, clinical, operational and corporate to provide a breadth of input and expertise. In particular, we want to ensure a strong clinical and operational voice in our planning processes.

In line with our approach to continuous improvement and learning, in September 2026 EMT reflected on our planning approach and identified areas that went well and areas for improvement. In October 20206 the Annual Planning Group and have also undertaken this

exercise. The suggested improvements have been incorporated into the planning approach and amendments have been made to annual planning templates**.**

It is important to recognise that we are not planning from scratch and must take the opportunity to build on both the existing templates and the outputs of last year.

The Annual Planning Group are working to define the 'top down' mandates and must-dos, and requirements of all directorates and care groups. A planning timetable has been developed which includes opportunities for engagement and involvement across care groups/services, with key groups such as Operational Management Group (OMG), Extended Executive Management Team (EMT), and EMT. By working together, and building a shared understanding of the ask, we aim to ensure development of a plan that is intentional in our actions for co-ordinated effort.

We are following a similar process to that used last year as our learning indicates that this approach worked well. Having finalised our planning principles and approach, we are launching our planning process and gaining insights from leaders from across the organisation during October.

We have reviewed our internal planning templates and guidance, which will be shared with all Directorates and Care Groups to be completed during October/November in line with our timeline below. This process will recognise that multi- year plans were developed last year, and only request further detail where needed particularly in relation to transformation and productivity opportunities. Last year we launched our health inequalities toolkit to support the annual planning process Health inequalities toolkit - Home, along with dedicated support to Care Groups to consider how addressing health inequalities is embedded within plans. This was well received and services are encouraged to follow the same approach this year building on outputs from last year.

We will build on our Trust- wide communications relating to the 'all of us' planning conversation, carefully and consistently linked to the value for money work programs. Our communications plan includes dedicated intranet resources and regular updates on planning via The View, The Headlines and The Brief.

Plans will be developed by all Care Groups and Directorates throughout October and November. Since we already have a multiyear plan, these will build on last year's plans, outline current position and areas of focus for plans, identify key priorities going forward under key themes of best quality, best partner, best value, and best place to work and learn and ensure addressing health inequalities underpins all plans.

Our learning has led us to adopt a two-phased approach this year.

Phase 1:

- Care groups/corporate services immediately commence review of their plans.
- The organisation collectively develops an agreed set of planning assumptions and clear principles.
- The Planning Group collates a concise summary of the supporting data and intelligence, with links to the fuller analysis, dashboards, and engagement findings to support planning decisions.

Phase 2:

- Utilising the agreed set of planning assumptions and principles, and the supporting data and intelligence, Care groups/corporate services continue with their approach to planning and identification of priorities and actions to finalise plans.

An important aspect of planning in line with our values, is to ensure we empower our colleagues to proactively engage with their teams in the planning process, encouraging an 'all of us' planning conversation that will ensure we engage with our leaders in the Operational Management Group, extended executive management group and executive management team, and that they in turn engage with their teams, and drawn upon feedback and insight from our service users and communities. The conversation is important to develop ideas on the 'art of the possible' as well as understanding our genuine limitations and difficult decisions that we need to make. Development of plans at local level will also support ownership of plans.

There will be opportunity for Governors to contribute their thoughts to annual planning and specifically how they can support strong engagement in the communities they represent at the Members' Council meeting in November 2026.

Once this process is completed, the Trust will work to develop the national requirements for returns. These are expected to include specific workforce, finance and activity returns in addition to Board assurance statements.

5. Internal Trust Planning Timetable

Our internal planning timetable is shared below. This may change in light of national requirements, as final timescales for submission have not yet been shared.

Date	Key Milestones	Lead
September 2026	Reflection on 2026/27 planning process and refresh of purpose and approach completed	EMT and Planning Group
October 2026	Internal planning group established	Izzy Worswick
October 2026	Review of internal planning templates	Planning Group (coordinated by Sharon Kennedy)
19th October 2026- 13th November	Phase 1 planning- all corporate services/Care Groups commence review of their medium term plan and identify opportunity for transformation and efficiency in 2027/28.	All of us
October 2026	Further national planning guidance received	Izzy Worswick
October 2026	Planning discussions via OMG, Medics, Strategy Advisory Group, Corporate and Care Group Meetings	All of us
9th November 2026- 20th November 2026	Any additional planning templates for 2027/28 shared with all service areas and all Care Groups/Corporate Services for completion	All of us

27th November 2026	Completion of all Care Group/Directorate plans	All of us, led by Care Group Directors and Deputy Directors
3rd December 2026	Update on planning shared with Extended EMT	Dawn Lawson/Izzy Worswick
8th December 2026	Plan shared with FIP, and recommended for agreement by Board.	Dawn Lawson/Izzy Worswick
TBC	Draft planning assumptions- workforce, activity and finance shared with ICB	Mel Wood, Phil Speight and Jo Gawthorpe
15th December 2026	Final plan presented to Board and approved for submission	Dawn Lawson/Adrian Snarr/Izzy Worswick
TBC	Submission of plans	ICB

Key:

Complete	**On Target**	**In progress, some risks**	**Not on target**	**Not yet started**

6. Next steps

Planned next steps in the development of the operational plan are as follows:

- Commencement of phase 1 planning for Care Groups and Corporate Services to review existing plans, and identify opportunities for transformation and efficiency.
- Agreement of final planning principles.
- Communications in relation to planning to be shared across the organisation.

Recommendation

Board is asked to:

- **NOTE** the update on the development of, and timescales for, the Trust operating plan.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 11.1

Private/Public paper:	**Public**		
Title:	**Integrated Performance Report (IPR)**		
Lead Director:	**Adrian Snarr – Executive director of finance, estates, and resources**		
Mission/values:	The paper supports achievement of all Trust values: Person first and in the centre; Families and carers matter; respectful, honest, open and transparent; Improve and am to be outstanding, Relevant today and ready for tomorrow.		
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for September 2026.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	All BAF risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The Trust performance management framework and reporting provides the Integrated Care Boards (ICB) with assurance that the Trust has an effective performance management system to contribute to the delivery of both the South and West ICBs' strategic priorities and delivery plans.		
Any background papers / previously considered by:	The IPR is reviewed at Trust Board meetings held in public eight times a year. On months when meetings in public are not held, it is circulated to Board members and published on the Trust website. The IPR is reviewed monthly by the Executive Management Team (EMT) The IPR is reviewed monthly at the Operational Management Group (OMG) meeting.		
Executive summary:	**Quality and Safety**		

With **all of us** in mind.

Overall assurance position

The performance rates summary (page 5) shows 78.1% of Quality and Safety metrics with a target are being fully achieved, with 21.9% showing areas for improvement. The section provides assurance that services remain safe, while also identifying areas requiring continued improvement and oversight to maintain safety for staff, patients and carers.

Areas of positive assurance

- Complaints performance remains positive, however, there has been a dip in September performance this relates to 2 complaints exceeding the 6-month timescale for closure – 1 was closed 3 days outside threshold and the other was delayed due to complainant being unwell for several months.
- The overall number of reported incidents in August was 1,307 and remains within normal range. All incidents continue to be reviewed by the patient safety team, with relevant governance oversight and learning within care groups.
- The Trust's focus on reducing prone restraint continues to show sustained improvement, there have been zero prone restraints incidents reported in September.
- There has been a focussed piece of work to support estates maintenance to improve compliance of ligature jobs completed within timeframe, this has been successful over September with 100% of jobs being completed within timeframe.

Key areas requiring attention

- There were 11 information governance personal data breaches during September which is under the Trust target of less than 12 per month. A review of incidents has identified issues around incorrectly addressing correspondence, failure to verify recipient details before disclosure and admin errors, all of which are being address through communications and improvement work.
- Sadly, there were three patient safety incidents resulting in deaths during the month where the service users were known to the Trust's mental health services. These incidents are subject to review and any learning will be identified. Condolences and support have been offered to the families concerned in these tragic circumstances.
- Supervision remains an area of focus following the revised policy and new reporting method introduced from April 2026. Management and clinical supervision are now reported separately against a 60-day standard and include all clinical staff. Targeted work is underway to maintain a positive trajectory, with care groups addressing identified hotspot areas. Clinical supervision has exceeded the Trust target of 80% this month and a good improvement has been seen in the management supervision.
- Risk assessment and care planning performance continues to improve compared with last year; the focused work continues to meet the trajectory

	of compliance to achieve the Trust's 95% standard across all five metrics and all areas and improvement has been seen during the month. Any risk assessments or care plans not completed within timescale remain subject to care group oversight and scrutiny. • The Trust reported 6 RIDDOR incidents during quarter 2. 5 of those incidents related to violence and aggression on Mental health (4) and Forensic (1) wards. Staff have been supported through their recuperation supported by occupational health and their operational management team. **Patient safety, harm and clinical risk** • There were no red rated inpatient falls across our inpatient services. All patients that are at risk of falls have a risk assessment and care plans to manage falls. Falls on inpatient wards per 1,000 bed days remain notably lower than national averages. • There were no prone restraints for the second month in a row and the number of restraint incidents in September was within normal range. All incidents are reviewed and learning is shared through the relevant governance routes. **Staff and patient experience** • There were 24 incidents involving race against staff on mental health wards during September, across 18 wards. Recognising that this has an impact on staff, a robust process of personal and clinical support has been created to safeguard staff who experience racist abuse during their work in a clinical role and we are working to identity further wellbeing offers to increase the support to staff. • There were 12 sexual safety incidents against staff by patients and 5 sexual safety incidents against patients in September. The most common theme was inappropriate sexual behaviour. We are very aware of the personal impact this has on our colleagues and service users and as part of our We are safe and healthy we are launching a #allofustogether campaign aimed at preventing harm to staff and providing support when it does, which will also support the implementation of the national staff standards aimed at improving staff experience. • The Trust continues to improve the recording and collection of protected characteristics across services to support better understanding of service provision and experience. All data recording is within target, with ethnicity at 95.4% against a 90% target; disability recording is 58.2%, sexual orientation 58.6% and postcode 99.6%. Work continues to improve data capture across all services. **People** • Sickness absence performance for the month (at 5.8%) is slightly higher compared to our position at the same time last year (5.6%). At 5.3% our current year to date performance is above the level required to deliver the year-end target set out in the Workforce Plan (5.0%). As a result of the targeted interventions arising from the Trust's sickness reduction plans,

there has been a decrease in our long term sickness (4.5% to 4.2%) this month. As expected at this time of year, there has been an increase in seasonal illness, contributing to the increase in short term absence (now 1.6% from 1.2%). However, the increase in short term absence has also been driven by an increase in short term MSK and stress/ anxiety. This reiterates the need to strengthen early support and intervention, helping colleagues maintain their wellbeing, and minimise progression to long-term absence, which also reflects the approach outlined in the sickness reduction plan.

- In September 2026, appraisal compliance was 98.2%, achieving the Trust's KPI target of having an appraisal within a rolling 12-month period. The Trust is moving to a new appraisal window (April-September) and 2026 is a transition year. However, as at end September we achieved 98.2% and all care groups achieved compliance.
- At trust level, we are achieving overall compliance for mandatory training across all subject areas.

National Metrics

The Trust continues to perform well against most national metrics.

The performance rates summary (page 5 of the IPR) shows 72.3% of the metrics with a target are being fully achieved with 27.7% showing areas of improvement (13 metrics). The following should be noted:

- In paediatric audiology, 95% of children referred, received a diagnostic appointment within 6 weeks, this is now significantly above the revised national threshold and is a sustained position over the last 6 months.
- Children & younger people with an eating disorder – four routine referrals were not seen within the four-week target. In all cases, an appointment was offered within the timeframe, but the family declined and chose a later date.
- The Trust has set itself a target to reduce adult acute and psychiatric intensive care lengths of stay by 10% by the end of March 2027. In September, the Trust trajectory has been met overall, however, longer lengths of stay for people discharged in September for our West Yorkshire service users are below our forecast position. We have achieved our forecast for older people lengths of stay (72.5 days against a forecast of 76.1 days), however, have longer lengths of stay for South Yorkshire patients during the reporting period. Reported performance is affected by discharges of patients with particularly long lengths of stay, this is associated with the availability of external placements, particularly for older people and specialist mental health support. There are robust escalation processes in place to expedite those clinically ready for discharge.
- Waits for appointments across physical health and wellbeing services in Barnsley continue to see a reduction in overall waiting times. For the month of September, 97% of adults and 98% of children and young

	people waiting for a community health appointment were waiting 18 weeks or less, which exceeds the national year-end target of 78%. • Virtual ward occupancy during September was 74.7%%, below the 80% target. Acute consultant capacity continues to impact on Frailty pathway admissions. Respiratory virtual has seen improvements in occupancy levels over September but still below target trajectory and continues to be the least utilised pathway and there is still further work to ensure that colleagues across the partnership maximise use of this pathway for appropriate patients. **Care Groups** • The performance rates summary (page 5 of the IPR) shows some areas for improvement against Trust targets within mental health inpatients and forensic services. The specific detail and improvements taking place can be seen in the care group section of the report. • Child and adolescent mental health services (CAMHS) continue to prioritise children with high levels of need and if a child's/young person's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period. For service users waiting for treatment at the end of September, 81.8% had been waiting for a period of 18 weeks or less which represents a sustained improvement. All of these cases have had some form of screening, consultation, or initial assessment before being placed on a treatment waiting list. This service is experiencing an increase in demand, particularly in Kirklees. • Children's neurodevelopmental waits remain a significant issue given the exponential growth in demand in recent years, which has been further compounded by vacancies in the team. Neuro-development waits are part of a specific pathway review across places in line with commissioned models. There is an offer in place to support children and families whilst waiting. • Improvement work within community learning disability services has delivered a sustained improvement in waiting-time performance. In September, performance recovered from the reduction seen in previous months and is now just below the 95% threshold for people completing their assessment, having an agreed care package and commencing service delivery within 18 weeks. • The number of out of area bed placements remains at a lower level than previous years. At the end of September, the Trust had 3 service users placed in an inappropriate out of area bed with 78 bed days used over the month, which is a decrease on the previous three months. There is significant ongoing focus on patient flow and bed management to minimise out of area bed placements. • Focus on patients clinically ready for discharge continues to take place across all services. At the end of September, 30 people were clinically ready for discharge but remained in a bed, accounting for a total of 825 bed days over the month. The main challenges to discharge continue to

	be specialist placements and housing and we are continually in dialogue with partners to identify solutions. • Adult Attention Deficit Hyperactivity Disorder (ADHD) and autism referrals continue to be at levels significantly higher than commissioned – cases, where agreed with commissioners, are triaged and prioritised according to need. • The commissioned level for ADHD pathways in Barnsley, Wakefield and Kirklees is approximately 29 cases across all three areas per month. The average number of monthly referrals for ADHD received for these areas in the last three months was 321. As demand in all areas is significantly more than capacity, this leads to lengthy waits, and the care remains with the referrer until accepted by the service. • Mental health bed occupancy (excluding leave) increased to 99.2%. There are individual wards which have a much higher occupancy and increasing acuity of patients places further challenge on colleagues. The acuity of patients remains a challenge. Particularly with risk to self and others, therefore, requires enhanced observations to keep people safe, which has an impact on staffing and finance. • The temporary staffing group continues to have a focus on the use of temporary workforce, ensuring safe staffing whilst delivering a sustainable workforce to meet the patient needs. Bank and locum expenditure continues to fluctuate from month to month, and bank staffing remains higher than plan. Agency spend has continued to be maintained at an overall low level (£165k in September). The use of agency staff largely relates to very limited number of medical staff although some pressures are expected in the coming weeks due to pending staff retirements. Use of bank staff continues to have executive oversight of the reason for requirements. The recruitment of healthcare support workers continues to support the reduction of bank staff and improve continuity of care. • Single point of access for mental health (SPA) patients assessed within 14 days has been met within Barnsley and Wakefield. There have been challenges with vacancies in Calderdale & Kirklees SPA and an increased demand for urgent assessments. The service has implemented business continuity plans, with a focus on diverting increased resource towards triage. • Our bank fill rate for registered nurses has increased slightly from the reduced level we had reported in the previous 3 months. Redeployment across wards on a daily basis has occurred to ensure skill mix is safe. **Finance** • The financial performance in September 2026 is a surplus of £384k which is £32k worse than plan in month. The year-to-date position remains just ahead of plan (£3k). This movement, from deficit to surplus, was planned with the receipt, in month, of £644k income relating to national low value

	activity calculations. To deliver the financial target of breakeven will require a positive / surplus run rate for the remainder of the year. • The Trust value for money programme continues to report as ahead of the plan for the year to date due to reduction in corporate costs and maintained run rate reductions in temporary staffing and out of area placements. The forecast remains that the target will be delivered in full. To achieve this, schemes planned for the second half of the year need to have a positive impact on the Trust run rate. • The current cash position continues to be positive but, in line with national focus in this area, best practice continues to be reviewed to ensure that we have effective management of the Trust working capital position. • The Trust continues to progress with its capital programme. Pricing, and profiles, are expected to be agreed shortly for the main schemes. Mitigations to manage within the in-year allocation are being developed to ensure that this can be fully and appropriately utilised.
Recommendation:	**Trust Board members are asked to:** **NOTE** the Integrated Performance Report and **COMMENT** accordingly.

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

Integrated Performance Report
Strategic Overview



September 2026

With all of us in mind.

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

Table of Contents

Click on each section heading to navigate to that section

	Page No
Introduction	4
Headlines	5 - 8
Summary	9 - 11
Quality & Safety	12 - 17
People	18 - 19
National Metrics	20 - 27
Care Groups	28 - 42
Ward Detail	43 - 67
Finance	68
Appendix 1 - Finance Report	69 - 85
Appendix 2 - SPC Charts - Explained	86 - 87

Introduction

Welcome to the Trust's Integrated Performance Report (IPR) for September 2026.

The report format for 2026/27 aligns with the Trust board's focus and national priorities. In months where the report is not included on the Trust board agenda (Strategy focus) or has a shorter time allocation (Risk focus) a more data focussed report with key headlines will be produced. For Performance focus months, this will be a full report including supporting narrative and we will continue to develop more in-depth analysis over the year. Please note, data is correct at the time of reporting and will be refreshed each month. This can mean that historical months performance will change as records are updated.
Performance is reported through a number of key performance indicators (KPIs). KPIs provide a high-level view of actual performance against target. The report has been categorised into the following areas to enable performance to be discussed and assessed with respect to:

- Headlines
- Executive summary
- Quality and Safety
- People
- National metrics
- Care groups including ward level detail
- Finance

Our Integrated Performance Report (IPR) provides a comprehensive view of Trust performance against its targets. We have mapped this performance information against our strategic aims, values and best statements so that it is easy to see how the performance data links to the delivery of the strategy. A separate report will be provided to board with a specific focus on delivery of the Strategy. We have also mapped the metrics included in this report against the Care Quality Commission domains.

An exercise has been undertaken to review all metrics and thresholds to ensure they meet the requirements and priorities for 2026/27; the report has been updated to reflect this. In particular, the national metrics section includes those metrics contained within the NHS oversight framework, operational planning guidance for 2026/27 and NHS standard contract items.

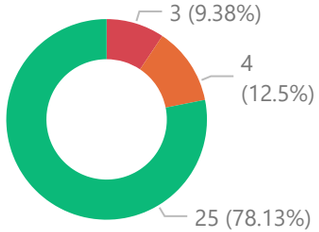
A review of the reducing inequalities section has been undertaken to ensure alignment with the Trust's equality, diversity and inclusion strategy which includes a number of metrics to evidence our progress towards delivering more responsive and equitable services for our communities. The strategy will guide us to being a more inclusive employer, where everyone can be themselves and feel valued for their contribution. This reporting will align to the deployment of the Trusts Equality, diversity, and inclusion strategy. This section will be updated over the next month.

Our Integrated Performance Report is publicly available on the internet.

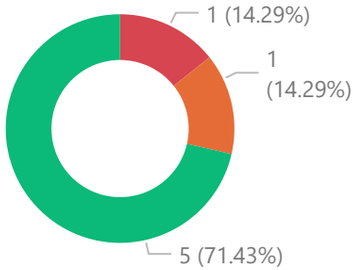
Headlines - Performance Rates Summary

This section of the IPR shows a very high-level overview of the performance rates for each area and Care Group based on the proportion of targeted metrics that have achieved threshold.

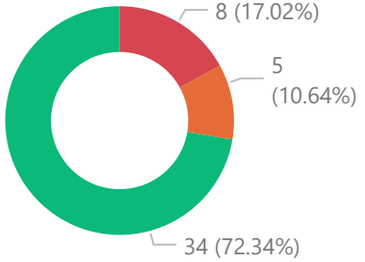
Quality & Safety Metrics Performance Rate



People Metrics Performance Rate



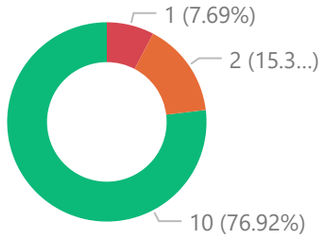
National Metrics Performance Rate



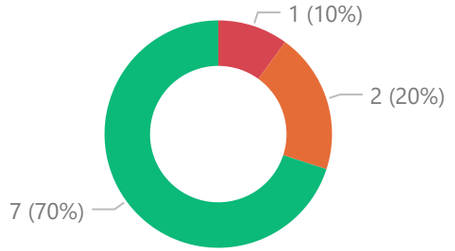
Finance Metrics Performance Rate



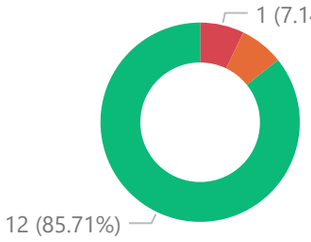
Barnsley Physical Health Metrics Performance Rate



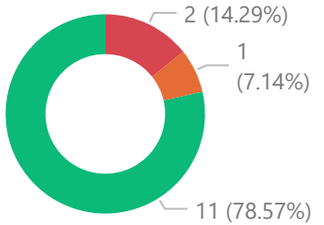
CAMHS Metrics Performance Rate



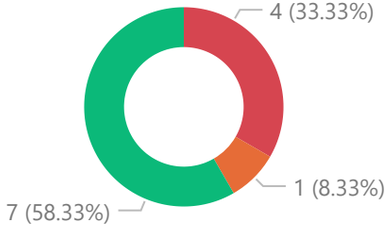
Mental Health Community Metrics Performance Rate



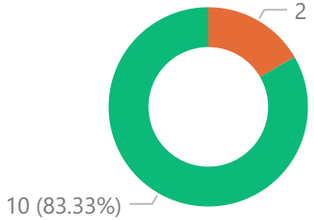
Mental Health Inpatient Metrics Performance Rate



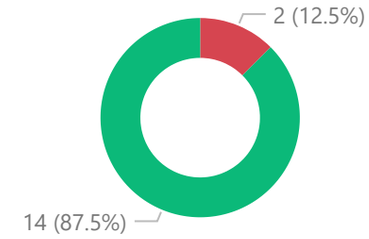
ASD/ADHD Metrics Performance Rate



Forensic SY Metrics Performance Rate



Forensic WY Metrics Performance Rate



Headlines

This section of the report identifies the metrics where there has been a change in performance from non achievement to achievement or where expected levels are not being achieved. Metrics that are routinely meeting thresholds will not appear on this page. Whilst the metrics included may have seen a change since last month, the assurance/variation icons, where available, show if data over time indicates that there is any action required.

A hyperlink has been added to each section so the reader can look at the detail relating to the metrics in that section in the main body of the report as required.

Quality and Safety

Metric	Change from last month	Variation/ Assurance
Complaints - Number of responses provided within six months of the date a complaint received	↓	
Friends and Family Test - Community	↓	
% of inpatients clinically ready for discharge	↑	
% of staff receiving supervision within policy guidance - Clinical	↑	
% of staff receiving supervision within policy guidance - Management	↑	
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	↑	
Estates Urgent Response Times - Service level agreement (SLA)	↑	
% of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened)	↑	
% on community active caseload at month end with a care plan which has been reviewed within the last year	↔	
% inpatient care plans commenced within 24hrs before or after admission	↑	
% inpatient risk assessment completed within 24hrs before or after admission	↑	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	↓	

National metrics

Metric	Change from last month	Variation/ Assurance
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - Trust	↑	
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - West Yorkshire	↑	
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - South Yorkshire	↓	
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - West Yorkshire	↑	
Access to Mental Health Support Teams Mental Teams in schools and colleges - Kirklees	↓	
Number of patients accessing Individual Placement Support services - rolling 12-month - Calderdale	↑	
Number of patients accessing Individual Placement Support services - rolling 12-month - Kirklees	↓	
Diagnostic test activity	↑	
Inappropriate out of area bed days	↑	
Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	↑	
Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	↓	
Virtual ward occupancy	↓	

Finance

Metric	Change from last month	Variation/ Assurance
Bank spend	↓	
Capital Spend	↑	

People

Metric	Change from last month	Variation/ Assurance
Sickness absence - Month	↓	
Sickness absence - Year to date	↔	

Headlines

Care Groups

LD, ADHD & ASD

Metrics	Change from last month	Variation/ Assurance
% of feedback with staff values and behaviours as an issue	↓	
% of staff receiving supervision within policy guidance - Clinical	↑	
% of staff receiving supervision within policy guidance - Management	↑	
% of clients clinically ready for discharge	↑	
Information Governance (IG) training compliance	↑	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	↓	

Children and Young Peoples Mental Health Services

Metric	Change from last month	Variation/ Assurance
% of staff receiving supervision within policy guidance - Management	↑	
Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	↑	
Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	↓	
Information Governance training compliance	↓	
Sickness rate (Monthly)	↓	

Mental Health Inpatient

Metrics	Change from last month	Variation/ Assurance
% Bed occupancy (excluding leave)	↓	
% of feedback with staff values and behaviours as an issue	↑	
% of staff receiving supervision within policy guidance - Management	↑	
% of clients clinically ready for discharge	↓	
% inpatient risk assessment completed within 24hrs before or after admission	↑	
Sickness rate (Monthly)	↓	

Forensic - West Yorkshire

Metrics	Change from last month	Variation/ Assurance
% of feedback with staff values and behaviours as an issue	↑	
% of staff receiving supervision within policy guidance - Clinical	↑	
% of staff receiving supervision within policy guidance - Management	↑	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	↓	
Information Governance (IG) training compliance	↓	
Sickness rate (Monthly)	↑	

Forensic - South Yorkshire

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% Bed occupancy (incl leave)	↑	
% of staff receiving supervision within policy guidance - Clinical	↑	
% of staff receiving supervision within policy guidance - Management	↑	
Information Governance (IG) training compliance	↑	

Mental Health Community

Metrics	Change from last month	Variation/ Assurance
% of staff receiving supervision within policy guidance - Management	↓	
Information Governance training compliance	↓	
Sickness rate (Monthly)	↓	

Barnsley Physical Health and Wellbeing

Metrics	Change from last month	Variation/ Assurance
Safer staffing (Overall)	↓	
% of staff receiving supervision within policy guidance - Clinical	↓	
% of staff receiving supervision within policy guidance - Management	↑	

Headlines

KEY

Improvement from last month but up to 5% below threshold	↑
No change from last month and up to 5% below threshold	↔
Deterioration from last month and up to 5% below threshold	↓
Improvement from last month and below threshold	↑
No change from last month and below threshold	↔
Deterioration from last month and below threshold	↓
Achievement of threshold and increased performance from last month.	↑
No change from last month and achieving threshold	↔
Achievement of threshold but decreased performance from last month.	↓

	Variation Icons The icon which represents the last data point on an SPC chart is displayed.						**Assurance Icons** If there is a target or expectation set, the icon displays on the chart based on the whole visible data range.		
ICON									
SIMPLE ICON	● ● ●	● ? H L ●	● H ●	● L ●	● H ●	● L ●	?	F	P
DEFINITION	Common Cause Variation	Special Cause Variation where neither High nor Low is good	Special Cause Concern where Low is good	Special Cause Concern where High is good	Special Cause Improvement where High is good	Special Cause Improvement where Low is good	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass
PLAIN ENGLISH	Nothing to see here!	Something's going on!	Your aim is low numbers but you have some high numbers.	Your aim is high numbers but you have some low numbers	Your aim is high numbers and you have some.	Your aim is low numbers and you have some.	The system will randomly meet and not meet the target/expectation due to common cause variation.	The system will consistently fail to meet the target/expectation.	The system will consistently achieve the target/expectation.
ACTION REQUIRED	Consider if the level/range of variation is acceptable.	Investigate to find out what is happening/ happened, what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened, what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened, what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened, what you can learn and celebrate the improvement or success.	Investigate to find out what is happening/ happened, what you can learn and celebrate the improvement or success.	Consider whether this is acceptable and if not, you will need to change something in the system or process.	Change something in the system or process if you want to meet the target.	Understand whether this is by design (!) and consider whether the target is still appropriate, should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

This section has been developed to give an overview of key headlines for each section of the report. More detail is included in the relevant sections of the Integrated Performance Report.

Quality & Safety

Overall assurance position

The performance rates summary (page 5) shows 78.1% of Quality and Safety metrics with a target are being fully achieved, with 21.9% showing areas for improvement. The section provides assurance that services remain safe, while also identifying areas requiring continued improvement and oversight to maintain safety for staff, patients and carers.

Areas of positive assurance

• Complaints performance remains positive, however, there has been a dip in September performance this relates to 2 complaints exceeding the 6-month timescale for closure – 1 was closed 3 days outside threshold and the other was delayed due to complainant being unwell for several months.

• The overall number of reported incidents in August was 1,307 and remains within normal range. All incidents continue to be reviewed by the patient safety team, with relevant governance oversight and learning within care groups.

• The Trust's focus on reducing prone restraint continues to show sustained improvement, there have been zero prone restraints incidents reported in September.

• There has been a focussed piece of work to support estates maintenance to improve compliance of ligature jobs completed within timeframe, this has been successful over September with 100% of jobs being completed within timeframe.

Key areas requiring attention

• There were 11 information governance personal data breaches during September which is under the Trust target of less than 12 per month. A review of incidents has identified issues around incorrectly addressing correspondence, failure to verify recipient details before disclosure and admin errors, all of which are being address through communications and improvement work.

• Sadly, there were three patient safety incidents resulting in deaths during the month where the service users were known to the Trust's mental health services. These incidents are subject to review and any learning will be identified. Condolences and support have been offered to the families concerned in these tragic circumstances.

• Supervision remains an area of focus following the revised policy and new reporting method introduced from April 2026. Management and clinical supervision are now reported separately against a 60-day standard and include all clinical staff. Targeted work is underway to maintain a positive trajectory, with care groups addressing identified hotspot areas. Clinical supervision has exceeded the Trust target of 80% this month and a good improvement has been seen in the management supervision.

• Risk assessment and care planning performance continues to improve compared with last year; the focused work continues to meet the trajectory of compliance to achieve the Trust's 95% standard across all five metrics and all areas and improvement has been seen during the month. Any risk assessments or care plans not completed within timescale remain subject to care group oversight and scrutiny.

• The Trust reported 6 RIDDOR incidents during quarter 2. 5 of those incidents related to violence and aggression on Mental health (4) and Forensic (1) wards. Staff have been supported through their recuperation supported by occupational health and their operational management team.

Patient safety, harm and clinical risk

• There were no red rated inpatient falls across our inpatient services. All patients that are at risk of falls have a risk assessment and care plans to manage falls. Falls on inpatient wards per 1,000 bed days remain notably lower than national averages.

• There were no prone restraints for the second month in a row and the number of restraint incidents in September was within normal range. All incidents are reviewed and learning is shared through the relevant governance routes.

Staff and patient experience

• There were 24 incidents involving race against staff on mental health wards during September, across 18 wards. Recognising that this has an impact on staff, a robust process of personal and clinical support has been created to safeguard staff who experience racist abuse during their work in a clinical role and we are working to identity further wellbeing offers to increase the support to staff.

• There were 12 sexual safety incidents against staff by patients and 5 sexual safety incidents against patients in September. The most common theme was inappropriate sexual behaviour. We are very aware of the personal impact this has on our colleagues and service users and as part of our We are safe and healthy we are launching a #allofustogether campaign aimed at preventing harm to staff and providing support when it does, which will also support the implementation of the national staff standards aimed at improving staff experience.

• The Trust continues to improve the recording and collection of protected characteristics across services to support better understanding of service provision and experience. All data recording is within target, with ethnicity at 95.4% against a 90% target; disability recording is 58.2%, sexual orientation 58.6% and postcode 99.6%. Work continues to improve data capture across all services.

People

• Sickness absence performance for the month (at 5.8%) is slightly higher compared to our position at the same time last year (5.6%). At 5.3% our current year to date performance is above the level required to deliver the year-end target set out in the Workforce Plan (5.0%). As a result of the targeted interventions arising from the Trust's sickness reduction plans, there has been a decrease in our long term sickness (4.5% to 4.2%) this month. As expected at this time of year, there has been an increase in seasonal illness, contributing to the increase in short term absence (now 1.6% from 1.2%). However, the increase in short term absence has also been driven by an increase in short term MSK and stress/ anxiety. This reiterates the need to strengthen early support and intervention, helping colleagues maintain their wellbeing, and minimise progression to long-term absence, which also reflects the approach outlined in the sickness reduction plan.
• In September 2026, appraisal compliance was 98.2%, achieving the Trust's KPI target of having an appraisal within a rolling 12-month period. The Trust is moving to a new appraisal window (April-September) and 2026 is a transition year. However, as at end September we achieved 98.2% and all care groups achieved compliance.
• At trust level, we are achieving overall compliance for mandatory training across all subject areas.

National Metrics

The Trust continues to perform well against most national metrics.
The performance rates summary (page 5 of the IPR), shows 72.3% of the metrics with a target are being fully achieved with 27.7% showing areas of improvement (13 metrics). The following should be noted:
• In paediatric audiology, 95% of children referred, received a diagnostic appointment within 6 weeks, this is now significantly above the revised national threshold and is a sustained position over the last 6 months.
• Children & younger people with an eating disorder – four routine referrals were not seen within the four week target. In all cases, an appointment was offered within the timeframe, but the family declined and chose a later date.
• The Trust has set itself a target to reduce adult acute and psychiatric intensive care lengths of stay by 10% by the end of March 2027. In September, the Trust trajectory has been met overall, however, longer lengths of stay for people discharged in September for our West Yorkshire service users are below our forecast position. We have achieved our forecast for older people lengths of stay (72.5 days against a forecast of 76.1 days), however, have longer lengths of stay for South Yorkshire patients during the reporting period. Reported performance is affected by discharges of patients with particularly long lengths of stay, this is associated with the availability of external placements, particularly for older people and specialist mental health support. There are robust escalation processes in place to expedite those clinically ready for discharge.
• Waits for appointments across physical health and wellbeing services in Barnsley continue to see a reduction in overall waiting times. For the month of September, 97% of adults and 98% of children and young people waiting for a community health appointment were waiting 18 weeks or less, which exceeds the national year-end target of 78%.
• Virtual ward occupancy during September was 74.7%%, below the 80% target. Acute consultant capacity continues to impact on Frailty pathway admissions. Respiratory virtual has seen improvements in occupancy levels over September but still below target trajectory and continues to be the least utilised pathway and there is still further work to ensure that colleagues across the partnership maximise use of this pathway for appropriate patients.

Care Groups

• The performance rates summary (page 5 of the IPR) shows some areas for improvement against Trust targets within mental health inpatients and forensic services. The specific detail and improvements taking place can be seen in the care group section of the report.
• Child and adolescent mental health services (CAMHS) continue to prioritise children with high levels of need and if a child's/young person's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period. For service users waiting for treatment at the end of September, 81.8% had been waiting for a period of 18 weeks or less which represents a sustained improvement. All of these cases have had some form of screening, consultation, or initial assessment before being placed on a treatment waiting list. This service is experiencing an increase in demand, particularly in Kirklees.
• Children's neurodevelopmental waits remain a significant issue given the exponential growth in demand in recent years, which has been further compounded by vacancies in the team. Neuro-development waits are part of a specific pathway review across places in line with commissioned models. There is an offer in place to support children and families whilst waiting.
• Improvement work within community learning disability services has delivered a sustained improvement in waiting-time performance. In September, performance recovered from the reduction seen in previous months and is now just below the 95% threshold for people completing their assessment, having an agreed care package and commencing service delivery within 18 weeks.
• The number of out of area bed placements remains at a lower level than previous years. At the end of September, the Trust had 3 service users placed in an inappropriate out of area bed with 78 bed days used over the month, which is a decrease on the previous three months. There is significant ongoing focus on patient flow and bed management to minimise out of area bed placements.
• Focus on patients clinically ready for discharge continues to take place across all services. At the end of September, 30 people were clinically ready for discharge but remained in a bed, accounting for a total of 825 bed days over the month. The main challenges to discharge continue to be specialist placements and housing and we are continually in dialogue with partners to identify solutions.
• Adult Attention Deficit Hyperactivity Disorder (ADHD) and autism referrals continue to be at levels significantly higher than commissioned – cases, where agreed with commissioners, are triaged and prioritised according to need.
• The commissioned level for ADHD pathways in Barnsley, Wakefield and Kirklees is approximately 29 cases across all three areas per month. The average number of monthly referrals for ADHD received for these areas in the last three months was 321. As demand in all areas is significantly more than capacity, this leads to lengthy waits, and the care remains with the referrer until accepted by the service.

Care Groups cont...

• Mental health bed occupancy (excluding leave) increased to 99.2%. There are individual wards which have a much higher occupancy and increasing acuity of patients places further challenge on colleagues. The acuity of patients remains a challenge. Particularly with risk to self and others, therefore, requires enhanced observations to keep people safe, which has an impact on staffing and finance.
• The temporary staffing group continues to have a focus on the use of temporary workforce, ensuring safe staffing whilst delivering a sustainable workforce to meet the patient needs. Bank and locum expenditure continues to fluctuate from month to month, and bank staffing remains higher than plan. Agency spend has continued to be maintained at an overall low level (£165k in September). The use of agency staff largely relates to very limited number of medical staff although some pressures are expected in the coming weeks due to pending staff retirements. Use of bank staff continues to have executive oversight of the reason for requirements. The recruitment of healthcare support workers continue to support the reduction of bank staff and improve continuity of care.
• Single point of access for mental health (SPA) patients assessed within 14 days has been met within Barnsley and Wakefield. There have been challenges with vacancies in Calderdale & Kirklees SPA and an increased demand for urgent assessments. The service has implemented business continuity plans, with a focus on diverting increased resource towards triage.
• Our bank fill rate for registered nurses has increased slightly from the reduced level we had reported in the previous 3 months. Redeployment across wards on a daily basis has occurred to ensure skill mix is safe.

Finance

• The financial performance in September 2026 is a surplus of £384k which is £32k worse than plan in month. The year to date position remains just ahead of plan (£3k). This movement, from deficit to surplus, was planned with the receipt, in month, of £644k income relating to national low value activity calculations. To deliver the financial target of breakeven will require a positive / surplus run rate for the remainder of the year.
• The Trust value for money programme continues to report as ahead of the plan for the year to date due to reduction in corporate costs and maintained run rate reductions in temporary staffing and out of area placements. The forecast remains that the target will be delivered in full. To achieve this schemes planned for the second half of the year need to have a positive impact on the Trust run rate.
• The current cash position continues to be positive but, in line with national focus in this area, best practice continues to be reviewed to ensure that we have effective management of the Trust working capital position.
• The Trust continues to progress with it's capital programme. Pricing, and profiles, are expected to be agreed shortly for the main schemes. Mitigations to manage within the in year allocation are being developed to ensure that this can be fully and appropriately utilised.

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Best Quality	Responsive	TBC	85.7%	87.9%	90.5%	86.9%	85.2%	81.8%	N/A
Complaints	% of feedback with staff values and behaviours as an issue [12]	Best Quality	Caring	< 20%	10% (3/30)	0% (0/33)	8% (3/38)	10% (4/39)	10% (4/40)	9% (3/35)	1
	Complaints - Average number of working days to sign off for closed complaints (in month)	Best Quality	Well led	Trend monitor	101.3	119.7	131.3	93.2	99.9	115.6	N/A
	Complaints - Number of responses provided within six months of the date a complaint received [16]	Best Quality	Well led	100%	100% (14/14)	91% (10/11)	92% (24/26)	100% (9/9)	100% (21/21)	91% (20/22)	
Service User Experience	Friends and Family Test - Mental Health	Best Quality	Caring	84%	86%	93%	87%	88%	86%	88%	1
	Friends and Family Test - Community	Best Quality	Caring	95%	91%	96%	94%	95%	97%	93%	1
	Number of compliments received	Best Quality	Caring	N/A	40	33	55	53	36	60	N/A
Quality	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Best Quality	Safe	Trend monitor	2	5	1	8	4	2	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Best Quality	Safe	Trend monitor	0	1	1	0	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4]	Best Quality	Safe	0	0	0	0	0	0	0	1
	Number of Information Governance breaches [3]	Best Quality	Well led	<12	12	5	6	16	10	11	2
	% of inpatients clinically ready for discharge	Person first and in the centre	Responsive	3.5%	6.1%	4.8%	4.0%	3.8%	5.2%	5.1%	3
	Total number of reported incidents	Best Quality	Safe	Trend monitor	1450	1385	1541	1386	1424	1307	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Best Quality	Safe	Trend monitor	33	29	40	44	28	25	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9]	Best Quality	Safe	Trend monitor	0	0	2	1	1	1	
	Total number of patient safety incidents resulting in death where the patient was under the care of the Trust at the time of death occurring (Degree of harm subject to change as more information becomes available) [9]	Best Quality	Safe	Trend monitor	1	1	1	1	0	3	
	Safer staff fill rates	Best Quality	Safe	90%	114.0%	115.1%	115.0%	112.8%	112.1%	113.8%	1
	Safer Staffing % Fill Rate Registered Nurses	Best Quality	Safe	80%	99.7%	98.6%	99.5%	98.7%	96.3%	99.6%	1
	% Bank Fill Rates - Registered Nurses	Best Quality	Safe	-	90.5%	86.7%	81.0%	81.2%	80.8%	86.2%	
	% Bank Fill Rates - Health Care Assistants	Best Quality	Safe	-	95.3%	93.0%	93.0%	92.4%	91.6%	91.6%	
	Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)	Best place to work and learn	Safe	-	94.3%	91.7%	86.4%	89.4%	88.8%	91.6%	
	Number of pressure ulcers which developed under SWYPFT care [1]	Best Quality	Safe	Trend monitor	55	57	55	84	57	54	
	Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement	Best Quality	Safe	0	0	0	3	1	1	1	0
	Eliminating Mixed Sex Accommodation Breaches	Best Quality	Safe	0	0	0	0	0	0	0	1
	Number of Falls (inpatients)	Best Quality	Safe	Trend monitor	53	65	55	48	69	49	
	Number of restraint incidents	Best Quality	Safe	Trend monitor	185	152	197	121	162	136	
	% of staff receiving supervision within policy guidance [15] - Clinical	Best place to work and learn	Well led	80%	74.7%	78.4%	78.6%	81.6%	78.7%	82.4%	
	% of staff receiving supervision within policy guidance [15] - Management	Best place to work and learn	Well led	80%	64.6%	69.2%	70.1%	74.1%	74.1%	78.9%	
	Potential under-reporting of patient safety incidents	Best Quality	Safe								
	% people dying in a place of their choosing [14]	Person first and in the centre	Responsive	80%	93.5%	100%	100%	90.3%	89.5%	89.3%	1
	Number of job start/work retention outcomes during month by individual placement and support service	Best Quality	Effective	Trend Monitor	10	19	24	15	11	15	N/A
	Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks), by ethnicity, disability, sexual orientation and deprivation	Best Quality	Effective	55%		71.3%		Due November 2026			
	Number of incidents against staff on mental health wards involving race	Best place to work and learn	Safe	Trend Monitor	34	27	18	45	19	24	N/A
	Number of sexual safety incidents against patients (source Datix)	Best Quality	Safe	Trend Monitor	6	5	7	9	9	5	
	Number of sexual safety incidents against staff - patient on staff (source Datix)	Best place to work and learn	Safe	Trend Monitor	16	10	11	13	6	12	

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Year End Forecast*
	Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Best Quality	Safe	0		7			6		
	Estates Urgent Response Times - Service level agreement (SLA)	Best Quality	Well led	95%	99.0%	95.9%	99.4%	96.0%	91.7%	97.0%	
	Compliance with statutory requirements (Water, Gas, Electricity, Refrigeration, Pressure, Loler and Asbestos)	Best Quality	Well led	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	% of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened)	Best Quality	Well led	100%	100.0%	87.1%*	96.0%	97.0%	88.2%	100.0%	
	Percentage of service users who have had their equality data recorded - ethnicity	Best Quality	Responsive	90%	96.5%	96.1%	95.2%	95.1%	95.3%	95.4%	
	Percentage of service users who have had their equality data recorded - disability	Best Quality	Responsive	50%	58.7%	58.0%	57.0%	56.5%	57.9%	58.2%	
	Percentage of service users who have had their equality data recorded - sexual orientation	Best Quality	Responsive	50%	58.7%	57.6%	56.7%	55.4%	58.7%	58.6%	
	Percentage of service users who have had their equality data recorded - deprivation (postcode)	Best Quality	Responsive	90%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	
	Timely completion of equality impact assessments (EIAs) in services and for policies (snapshot figure) EIA policy reporting refers to policies signed off by the Executive Management Team (EMT) with an up to date EIA in place	Best Quality	Responsive	Service timely completion - 75% Policy - 95%	95.2% Service 100% Policy	92.7% Service 100% Policy	92.7% Service 100% Policy	74.3% Service 100% Policy	*See reducing health inequalities section Nov26 100% Policy	100% Policy	
	% on community active caseload at month end with a care plan which has been reviewed within the last year	Person first and in the centre	Caring	95%	94.0%	94.5%	95.1%	95.0%	94.5%	94.5%	
	% with care plan that includes service user input/views	Person first and in the centre	Caring		95.6%	95.1%	95.2%	95.5%	95.5%	98.4%	
	% inpatient care plans commenced within 24hrs before or after admission	Person first and in the centre	Caring		97.3%	96.7%	94.9%	96.6%	94.9%	95.4%	
	% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe		91.3%	92.0%	89.3%	91.7%	92.8%	96.2%	
	% on community active caseload at month end with a risk assessment which has been reviewed within the	Best Quality	Safe		93.7%	93.6%	93.6%	93.4%	92.7%	92.3%	
	Number of prone restraint incidents during the month - (where we have purposefully placed the person in the prone position)	Best Quality	Safe	Dec & Jan - 4, Feb & Mar - 2, 26/27 stretch target to reduce to zero	3	2	6	3	0	0	
	No of times staff access Yorkshire & Humber care record / Interweave during month	Best Quality	Safe	Trend Monitor	73	144	54	117	64	56	N/A
	Number of Monthly Active Users (Patients accessing patient knows best system)	Best Quality	Safe	Trend Monitor	12,000	11,968	13,289	13,935	14,546	14,918	N/A
	Medical Devices compliance rate	Best Quality	Safe	Trend Monitor	75%	75%	82%	88%	89%	88%	
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Person first and in the centre	Safe	6	0	0	0	1	1	0	1
	C Diff avoidable cases	Person first and in the centre	Safe	0	0	0	0	0	0	0	1
	E. Coli bloodstream infection rate	Person first and in the centre	Safe	0	0	0	0	1	0	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Person first and in the centre	Safe	0	0	0	0	0	0	0	
Improving Resource	NHS Oversight Framework segmentation	All	Well led	1/2		1		Due December 2026			
	Overall CQC rating	All	Well led		Good						
	CQC well - led rating	All	Well led		Good						

Quality & Safety Dashboard Footnotes:

1 - Number of pressure ulcers which developed under South West Yorkshire Partnership Teaching NHS Foundation Trust (SWYPFT) care - A pressure ulcer (Category 2 and above) that has developed after the first face-to-face contact with the patient under the care of SWYPFT staff. There is evidence in care records of all interventions put in place to prevent patients developing pressure ulcers, including risk assessment, skin inspection, an equipment assessment and ordering if required, advice given and consequences of not following advice, repositioning if the patient cannot do this independently off-loading if necessary

2 – Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. Evidence is not available as above, one component may be missing, e.g. failure to perform a risk assessment or not ordering appropriate equipment to prevent pressure damage

3 - The Information Governance breach target is based on a year-on-year reduction of the number of confidentiality breaches across the Trust. The Trust is striving to achieve zero breaches in any one month. This metric specifically relates to confidentiality breaches

4 - Notifiable Safety Incidents are where Duty of Candour is applicable.

5 - CAMHS referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date. Excludes autistic spectrum disorder waits and neurodevelopmental teams.

9 - Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed. Trend reviewed in risk panel and clinical governance and clinical safety group. Initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report.

9 - Patient safety incidents resulting in death (subject to change as more information comes available). All incident data is reviewed using SPC charts to identify any special cause variation, if this occurs this will be reported by exception. Otherwise reporting rates remain within normal variation.

11 - Number of records with up to date risk assessment - 'Older people and working age adult inpatients' - we are counting how many staying safe care plans were completed within 24 hours and for 'community services for service users on care programme approach' - we are counting from first contact then 7 working days from this point.

12 - This is the count of written complaints/count of whole time equivalent staff as reported via the Trusts national complaints return. Please note, the wording of this metric has changed from the November 2024 report to align with wording used in the national reporting. This relates to complaints received during the month and until investigation process is complete, this may result in not all of those being upheld.

14 - This metric relates to the Macmillan service, end of life pathway.

15 - % of Band 4 and above clinical staff who have received supervision in the previous 90 days.

16 - Formal complaints should be responded to/closed within 6 months of the date received as is written into the NHS Complaints (England) Regulations 2009

* - 6 out of 30 jobs not completed in timescale, this was predominantly due to access issues and mitigations have been put in place to prevent such future issues occurring.

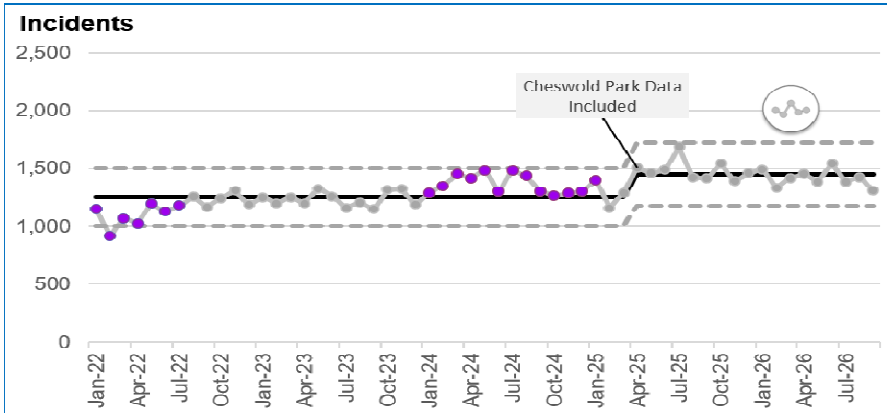
Quality & Safety Headlines

• Children and young people mental health services referral to treatment - September saw a dip in performance from previous month but an overall sustained position in the number of young people waiting less than 18 weeks for their treatment appointment. Following a period of focussed work on this metric since December 2025, performance has improved and has been above 80% for the last six months. Data for the metric will continue to be monitored to ensure we see a sustained improvement trend in the coming months.
• There were 11 information governance personal data breaches during September. Information disclosed in error continues to be the highest reported category. Work is taking place to review the incidents and ensure learning is embedded to prevent future occurrences. A review of incidents has identified three common themes of; incorrectly addressing correspondence; failure to verify recipient details before disclosure and administrative errors - these are being addressed through communications and improvement work.
• Focus on patients clinically ready for discharge continues to take place across mental health and learning disabilities, with support from colleagues within place with improvements recognised. The main challenges continue to be specialist placements and housing. At the end of September, 30 people were clinically ready for discharge but remained in a bed. Delays are spread across all our Places and services.
• The Trust has recently reviewed its supervision policy and as a result from 1st April, has moved to a new method of reporting splitting out management and clinical supervision and reporting against a 60 day standard. We also widened the scope to include all staff not just those who are registered as it was previously. This now shows some under performance against the 80% standard. Targeted work is taking place in care groups to address and ensure staff are fully supported.
• Our bank fill rate for registered nurses has increased slightly from the reduced level we had reported in the previous 3 months. Redeployment across wards on a daily basis has occurred to ensure skill mix is safe.
• The total number of reported incidents in August decreased slightly but remains within usual variance. A breakdown of this data can be seen in the care group dashboards. All incidents continue to be subject to review by the patient safety team with relevant governance within the care groups.
• Sadly, there were three patient safety incidents resulting in deaths during the month witihin 30 days of discharge from 3 mental health inpatient wards. Currently there are no immediate themes although these will be viewed through PSIRF processes alongside other deaths recently within this category to identify any themes or shared learning where the service users were known to the Trust's mental health services. These incidents are subject to review and any learning will be identified. Condolences and support have been offered to the families concerned in these tragic circumstances.
• The Trust had 24 incidents involving race in September - 11 incidents in the Forensics Care Group across eight wards/teams; 11 incidents in Mental Health inpatients across eight wards/teams; and two incidents in Cheswold Park Hospital across two wards/teams. We are working with the People Directorate colleagues to identity further wellbeing offers to increase the support. Recognising that this has an impact on staff, a robust process of personal and clinical support has been created to safeguard staff who experience racist abuse during their work in a clinical role.
• There were 12 sexual safety incidents against staff by patients and five sexual safety incidents against patient in September. The most common theme for these incidents was inappropriate sexual behaviour. We are very aware of the personal impact this has on our colleagues and service users. In the event of an incident, a sexual safety panel is convened which includes individuals who have undertaken specialist training. The reporting process for sexual safety incidents is currently being reviewed as part of the Trust's We are Safe and Healthy priority. The current position is Datix is used for any incidents involving patients and there is a separate reporting mechanism for staff-to-staff incidents in line with the Sexual Safety Charter Assurance Framework and NHSE reporting requirements. Internal governance is through care groups and HR business partners for individual cases and through QSC and PRC for anonymised data for triangulation of themes and assurance. In addition to this all incidents reported through Datix are now reviewed at the daily NQP safety huddle and actioned as appropriate on an individual basis.
• Estates urgent Response times – two jobs did not achieve response time target during the month, this was due to availability of staff required to accompany contractors for water cooler install works. These works are due to finish at the end of October 2026.
• All ligature job calls were logged and completed within timescale.
• The number of restraint incidents in September was 136. The highest number of incidents was on Elmdale ward (19). Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remain within expected range – all incidents are reviewed, and learning is shared.
• In September, there was 1 instance of a pressure ulcer that developed under SWYPFT care where there was an area for improvement identified. This was in relation to the scheduling of visits following the initial visit. A debrief has been completed with staff involved.
• There were 49 inpatient falls reported during September 2026, which is within acceptable range.
• Our focus on reducing the use of prone restraint has shown significant improvement over the last few months; there were zero staff led prone restraints on our mental health wards for the second consecutive month.
• For risk assessments and care plans, the Trust's aim is to work towards achievement of 95% against each of these standards. The metrics do show an improving position, however 95% has not been achieved across all 5 metrics in all areas – detail can be seen in the care group and ward level sections of the report. All risk assessments and care plans that have not been completed within the timescale have oversight and scrutiny from the Care Groups.
• Forensic risk assessments are completed prior to admission as part of the admission assessment and planning process. In line with good clinical practice these are then reviewed at the point of admission to ensure they are still clinically accurate, the admitting clinician will record this review within the risk assessment going forwards, which will enable capture of risk assessment. This is alongside the required Historical, Clinical Risk Management 20 tool (HCR20) required for a patient in forensics.
• All services are focusing on continuing to improve performance for risk assessments. Staying Safe plans are now captured as part of the My Care and Safety Plan, rather than the FIRM risk assessment. There is a high level of scrutiny when a staying safe care plan is not completed within 24 hours. At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed and communicated to the service user and ward staff. There is development work occurring with community teams to ensure they update the risk assessment before admission to support inpatient staff to understand the change in risk and reason for admission.
• There were six RIDDOR notifications in quarter two. The majority of these related to violence and aggression. In each violence and aggression case, staff have been supported through their recuperation and follow ups made with occupational health and welcome back meetings with the Department Managers if they have returned. Violence and aggression incidents including RIDDOR reportable ones will be reviewed, monitored and scrutinised at the newly formed Violence Prevention & Reduction Steering Group (VPRSG). Any learnings from incidents will be shared with colleagues in departments.
• *We have undertaken significant work to develop a series of health inequalities metrics which provide a more holistic and comprehensive view of our performance. These metrics are reported for the first time this month on page 27. It is therefore proposed to no longer report on this metric.

Patient Safety Incident Response Framework (PSIRF)
The review of the Trust's PSIRF plan has been approved and published on Trust website. The PSIRF policy which supports this is currently under review.

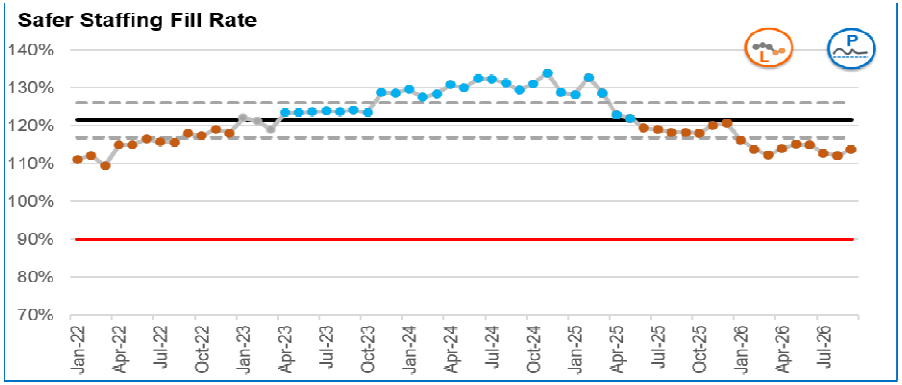
Statistical process control charts

Incidents

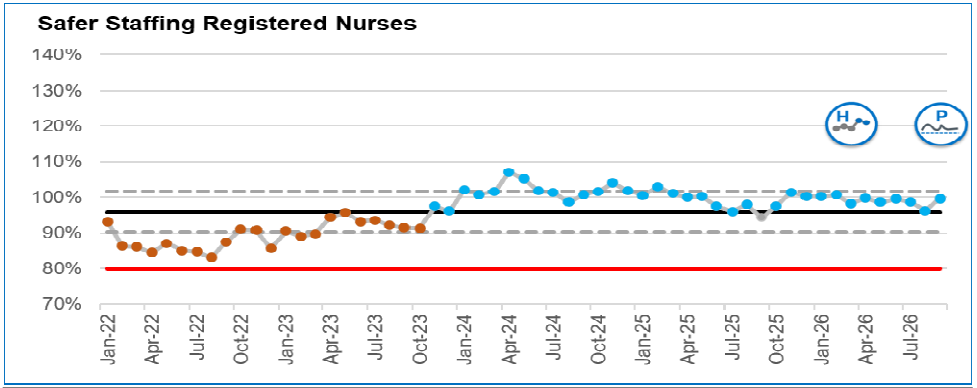


We have recalculated the chart from April 2025 due to the inclusion of Cheswold Park Hospital data. The chart shows that we are in a period of common cause variation (no concern).
It should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. We encourage reporting of incidents and near misses. An increase in reporting is a positive where the percentage of no/low harm incidents remains high as it does. All incidents are reviewed by the care group management team and then by the Patient Safety Datix team to review the actual degree of harm to ensure consistency with national reporting. All amber and red incidents are monitored through the weekly Trust Clinical Risk Panel and all serious incidents are investigated using systems analysis techniques. Learning is shared via a number of routes; care group learning events following a serious incident, specialist advisor forums, quarterly Trustwide learning events, briefing papers and the production of Situation Background Assessment Recommendation (SBARs).

Safer Staffing Inpatients



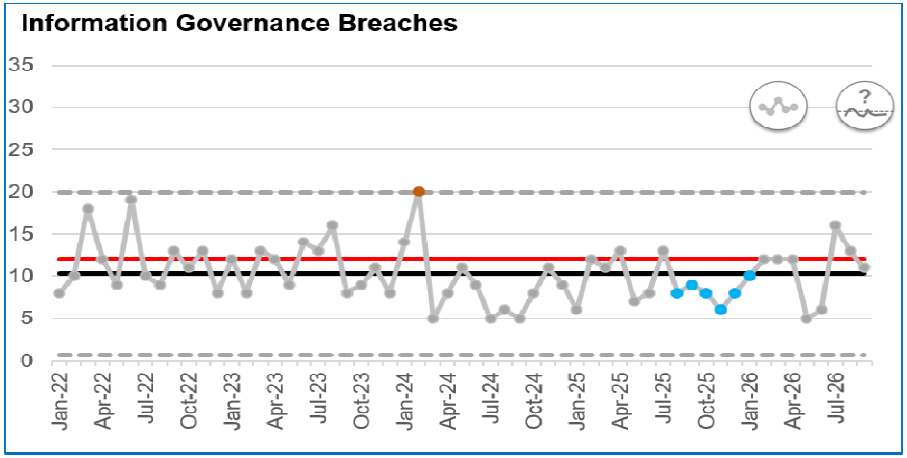
The chart above shows that in September 2026 we remain in a period of special cause concerning variation (something is happening and should be investigated).



The chart above shows that in September 2026 we remain in a period of special cause improving variation (something is happening and this should be investigated) and we are expected to meet the target.

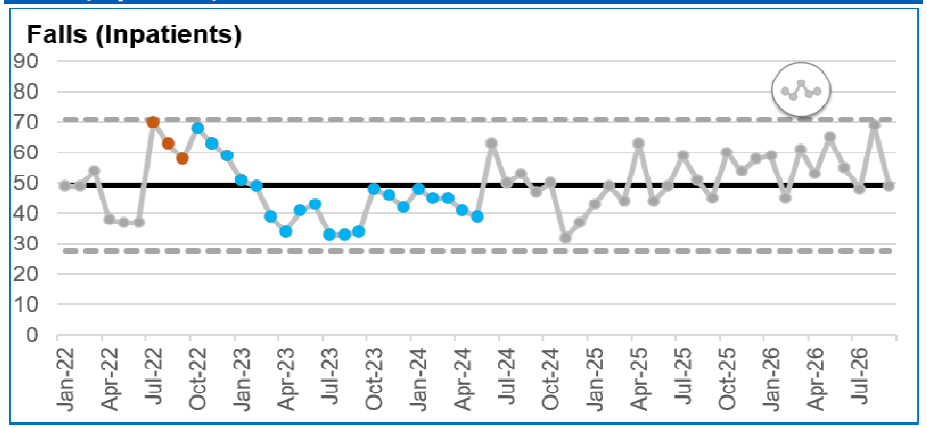
Statistical process control charts

Information Governance (IG)



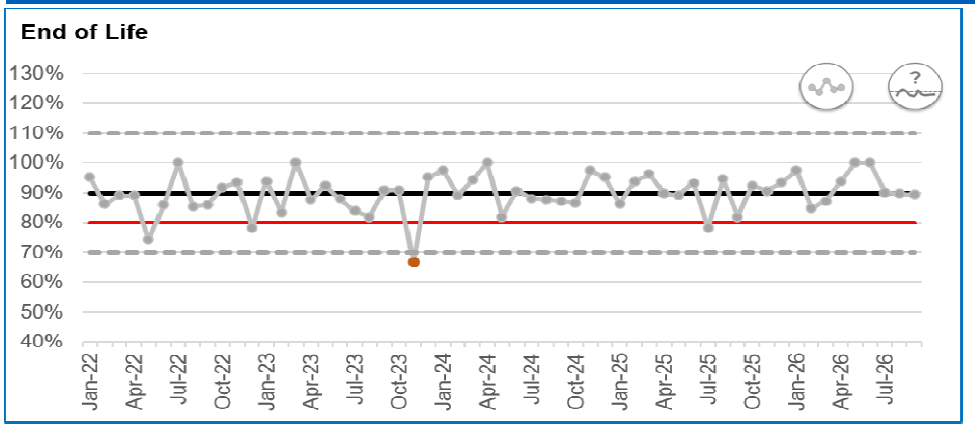
This SPC chart shows that as at September 2026 we remain in a period of common cause variation (no concern).

Falls (Inpatient)



The SPC chart above shows that in September 2026 we remain in a period of common cause variation (no concern). All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation.

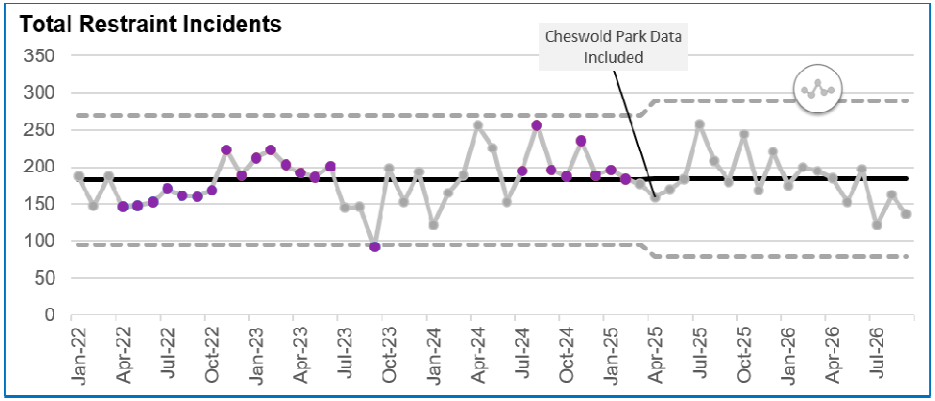
End of Life



The chart above shows that in September 2026 the performance against this metric remains in common cause variation (no concern). The performance for the month remains above the target.

Statistical process control charts

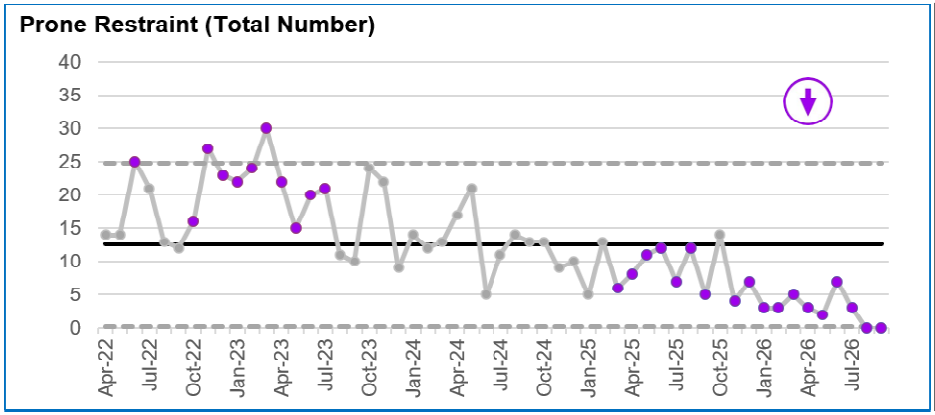
Restraints



This SPC chart shows that in September 2026 we remain in a period of common cause variation (no concern).

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

We have recalculated the chart from April 2025 due to the inclusion of Cheswold Park Hospital data.



The total number of prone restraints continues to show special cause reducing variation in line with the continued work to reduce prone restraints. There were no prone restraints in August or September 2026.

People - Performance Wall

Trust Performance Wall

	Strategic Objective	CQC Domain	Threshold	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Vacancy Rate	Best place to work and learn	Well led	8%	6.4%	6.6%	6.2%	5.9%	6.1%	6.0%
Turnover external (12 months rolling)	Best place to work and learn	Well led	10%	8.4%	9.3%	9.0%	8.7%	8.3%	8.5%
Starters	Best place to work and learn	Well led	-	37.3	14.8	39.6	38.9	50.8	35.1
Leavers	Best place to work and learn	Well led	-	28.9	39.3	25.7	36.2	55.9	36.7
Proportion of staff in senior leadership roles who are from ethnic minority background (relates to staff in post band 7 and above, excludes bank staff and medics) *	Best place to work and learn	Well led	-	132 (11.2%)	134 (11.4%)	132 (11.2%)	133 (11.3%)	130 (11.1%)	132 (11.2%)
Proportion of staff in senior leadership roles who were women (relates to staff in posts band 7 and above, excludes bank staff)	Best place to work and learn	Well led	-	985 (72.3%)	985 (72.3%)	985 (72.4%)	987 (72.5%)	992 (72.8%)	994 (72.4%)
Sickness absence - Year-to-Date (YTD)	Best place to work and learn	Well led	<=5%	4.9%	4.9%	5.0%	5.1%	5.3%	5.3%
Sickness absence - Month	Best place to work and learn	Well led		4.9%	4.8%	5.2%	5.6%	5.7%	5.8%
Appraisals - rolling 12 months	Best place to work and learn	Well led	90%	92.2%	92.8%	93.5%	93.3%	94.5%	98.2%
Appraisals completed within timeline (end of September 2026)	Best place to work and learn	Well led						80.3%	93.4%
Carbon Impact (tonnes CO2e) - business miles	Best use of resources	Well led	<76	64	65	64	68	69	62
Number of sexual safety incidents against staff - staff on staff (source People directorate)	Best place to work and learn	Safe	Trend Monitor	0	0	0	1	0	0
Mandatory Training - TOTAL	Best place to work and learn	Well led	>=80%	95.2%	95.4%	95.0%	95.4%	95.3%	95.6%

Our workforce supply

Turnover

September 2026 turnover was 8.5%, which is below the KPI target. Although our Forensics Care group is still above our KPI target (10.0%) this has reduced again since last month (10.1%)

Vacancy Rate

The vacancy rate has decreased slightly in September 2026 (6.0%). We have refreshed our recruitment plan to fill our Clinical Support Worker vacancies up to the remainder of the financial year.

We are safe and healthy

Sickness Absence

Sickness absence performance for the month (at 5.8%) is slightly higher compared to our position at the same time last year (5.6%). At 5.3% our current YTD performance is above the level required to deliver the year-end target set out in the Workforce Plan (5.0%). As a result of the targeted interventions arising from the Trust's sickness reduction plans, there has been a decrease in our long term sickness (4.5% to 4.2%) this month. As expected at this time of year, there has been an increase in seasonal illness, contributing to the increase in short term absence (now 1.6% from 1.2%). However, the increase in short term absence has also been driven by an increase in short term MSK and stress/ anxiety. This reiterates the need to strengthen early support and intervention, helping colleagues maintain their wellbeing, and minimise progression to long-term absence, which also reflects the approach outlined in the sickness reduction plan.

Employee Relations

Although there is currently one suspension exceeding 90 days, this is actively reviewed by the Deputy Chief People Officer in collaboration with the People Relations team to ensure appropriate oversight and progress.

We are compassionate and inclusive

Appraisal Compliance

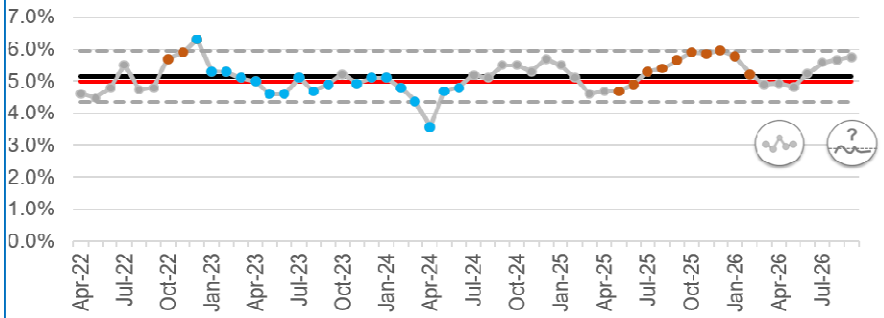
In September 2026, overall appraisal compliance was 98.2%, exceeding the Trust's KPI target. All Care Groups and Support Services have achieved their compliance. 93.4% of appraisals were completed within the appropriate appraisal window.

Training Compliance

At trust level, we are achieving overall compliance (95.6%).

Statistical process control charts

Trust Sickness Absence - In Month

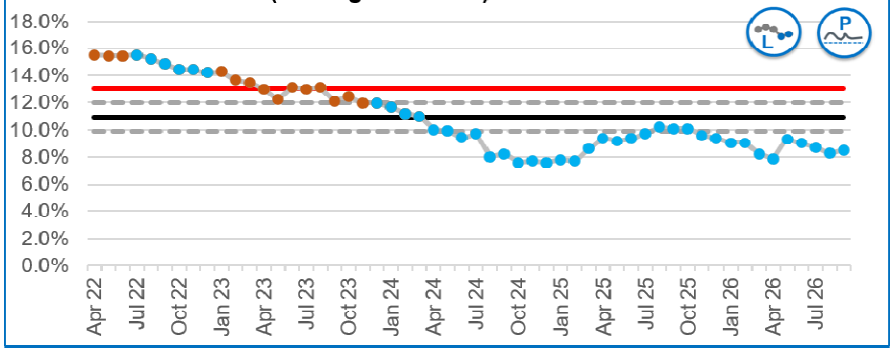


Sickness absence performance for the month (at 5.8%) is slightly higher compared to our position at the same time last year (5.6%). At 5.3% our current YTD performance is above the level required to deliver the year-end target set out in the Workforce Plan (5.0%). Please see previous page for detail and actions being undertaken.

The SPC chart shows that we remain a period of common cause variation.

From April 2025 this data includes Cheswold Park Hospital.

Trust Staff Turnover (Rolling 12 month)

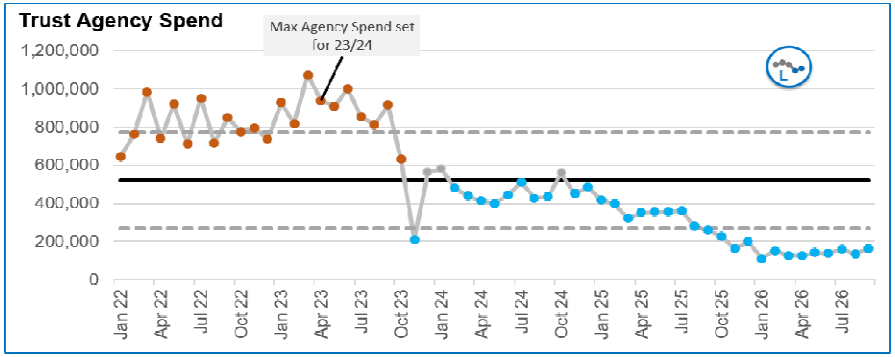


September 2026 turnover was 8.5%, which is below the KPI target. Although our Forensics Care group is still above our KPI target (10.0%) this has reduced again since last month (10.1%)

The SPC chart shows that we remain a period of special cause improving variation.

From April 2025 this data includes Cheswold Park Hospital.

Trust Agency Spend



Agency spend, which continues to be limited to a small number of medical posts, has an average run rate of £144k per month. There are slightly variations each month. Recruitment plans continue to be implemented. As monitored within the National Oversight Framework this is 0.6% of the Trust year to date total pay bill.

The SPC chart shows that due to the sustained overall reduction in spend, in September 2026 we remain in a period of special cause improving variation.

From April 2025 this data includes Cheswold Park Hospital.

Please see the Finance Report for further information.

National Metrics

Data as of : 21/10/2026 12:00:43

NHS South West Yorkshire Partnership NHS Foundation Trust

This section of the report includes the Trust performance against a range of national operational metrics including national priorities, operational planning and NHS Oversight Framework performance.

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26
M1	Incomplete Referral to Treatment (RTT) pathways of 52 weeks or more	Best Quality	Responsive		0	P		0	0	0	0	0	0	0	0	0	0	0	0
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive		92%	P		97.1%	97.8%	97.5%	96%	95.6%	96.4%	97.5%	97.5%	97.1%	97.1%	97.8%	96.7%
M204	RTT waiting list within 18 weeks (monthly RTT data)	Best Quality	Responsive		3680	?	H	4641	4514	4287	3868	3946	4162						
					4043	?	H							4273	4354	4454	4513	4602	4925
M206	Diagnostic test activity	Best Quality	Responsive		190	?		273	247	263	294	235	265						
					193	?								249	205	277	218	173	206
M171	% Admissions gate kept by crisis resolution teams	Best Quality	Safe		95%	P		98.9%	100%	100%	100%	100%	99.1%	100%	100%	98.2%	99.0%	99.0%	100%
M2	Inappropriate out of area bed days	Best Quality	Responsive		0	F	L	155	97	76	52	28	73	90	82	137	116	87	97
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	Best Quality	Responsive		5	?	L	3	4	2	1	1	2	2	2	6	3	2	4
M7	72 hour follow-up from psychiatric in-patient care	Best Quality	Safe		80%	?	H	89.0%	87.8%	87.6%	91.1%	87.7%	87.3%	86.5%	87.2%	86.8%	90%	92.0%	92.6%
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Best Quality	Effective		60%	P		94.6%	96.4%	96.9%	89.7%	96.4%	96.2%	85.3%	89.5%	90%	90.3%	100%	88.5%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months	Best Quality	Effective		95%	?	H	96.8%	96.6%	97.3%	96.9%	96.4%	96.4%	95.8%	96.5%	97.2%	96.7%	96.2%	96.4%
M34	% Clients in settled accommodation	Best Value	Effective	⚠	60%	P	L	82.9%	83.3%	83.0%	83.0%	83.2%	83.2%	82.9%	83.4%	82.7%	83.0%	83.3%	83.9%
M35	% Clients in employment	Best Value	Effective	⚠	10%	P	H	13.6%	14.0%	13.7%	14.0%	14.1%	14.2%	14.1%	14.2%	13.6%	13.7%	13.4%	13.6%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0	?		16	2	4	0	2	4	12	25	1	1	0	0
M9	Total number of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0	?		1	1	1	0	1	1	1	2	1	1	0	0

National Metrics

Data as of : 21/10/2026 12:00:43

NHS South West Yorkshire Partnership NHS Foundation Trust

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	Best Quality	Effective		95%	?	H	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	85.7%	100%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	Best Quality	Effective		95%	?	H	94.4%	94.4%	92.9%	91.2%	100%	89.7%	95%	100%	92.3%	93.0%	97.7%	90.9%
M47	Virtual ward occupancy	Best Quality	Responsive		80%	?		74.7%	70.7%	72%	70.7%	85.3%	62.7%	108%	78.7%	86.7%	88%	77.3%	74.7%
M188	Community services waiting list, over 52 weeks	Best Quality	Responsive		0	F	L	0	0	0	0	0	0	0	0	0	0	0	0
M30	Number of detentions under the Mental Health Act (MHA)	Best Quality	Safe					102	84	108	98	101	115	114	125	132	100	92	102
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin	Best Quality	Responsive					21.6%	19.0%	18.5%	23.5%	13.9%	22.6%	25.4%	24.8%	22.0%	14%	20.7%	15.7%
M10	Talking Therapies - Treatment within 6 Weeks of referral	Best Quality	Effective		75%	P		99.3%	99.4%	98.9%	97.7%	98.9%	98.6%	99.8%	99.6%	98.1%	99.0%	98.9%	97.8%
M11	Talking Therapies - Treatment within 18 weeks of referral	Best Quality	Effective		95%	P	H	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
M23	Talking Therapies - Completion of outcome data for appropriate Service Users	Best Quality	Well Led		90%	P		99.5%	99.4%	98.1%	99.1%	99.3%	99.5%	99.3%	99.0%	99.1%	98.6%	99.8%	98.7%
M178	Talking Therapies - Reliable Recovery	Best Quality	Effective		48%	?	H	52.9%	48.7%	50.2%	49.9%	50.6%	54.0%	56.8%	54.2%	52.4%	54.7%	50.7%	55.6%
M179	Talking Therapies - Reliable Improvement	Best Quality	Effective		67%	?	H	70.5%	72.2%	68.5%	68.9%	69.8%	71.7%	73.2%	72.8%	70.2%	72.1%	69.6%	72.6%
M43	Community health services two hour urgent response standard	Best Quality			70%	P	H	87.2%	89.5%	88.3%	88.2%	88.5%	91.1%	89.9%	90.6%	88.4%	88.5%	87.4%	88.5%

National Metrics

Data as of : 21/10/2026 12:00:43

NHS South West Yorkshire Partnership NHS Foundation Trust

The following metrics have Place based targets which have been updated for the 2026/2027 financial year. Data for the previous financial year therefore is no longer shown.

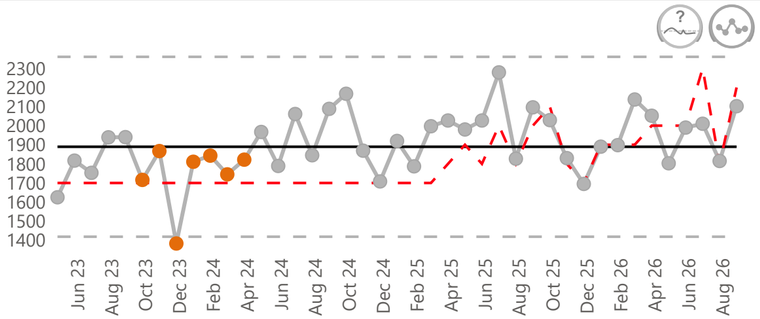
MetricID	Metric	Strategic Objective	CQC Domain	GroupCategory	GroupName	Target	Assurance	Variation	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26
M4	Talking Therapies - proportion of people completing treatment who move to recovery	Best Quality	Effective	Trust	Trust	50%			59.9%	55.4%	54.9%	55.9%	53.1%	57.5%
				Place	Barnsley	50%			59.4%	50.5%	52.8%	59.9%	49.4%	51.7%
					Kirklees	50%			60.1%	58.9%	56.3%	53.3%	55.5%	60.6%
M185	NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment	Best Quality	Effective	Trust	Trust				571	514	580	631	473	602
				Place	Barnsley				219	206	218	236	177	210
					Kirklees				352	308	362	395	296	392
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months	Best Quality	Responsive	Trust	Trust	13400			15103	15085	15083	14935	14843	14701
				Place	Barnsley	2900			2746	2688	2614	2561	2519	2507
					Calderdale	1400			1503	1470	1483	1472	1476	1498
					Kirklees	4800			5252	5304	5387	5381	5368	5266
					Wakefield	4300			4774	4797	4765	4687	4655	4625
M181	Women Accessing Specialist Community Perinatal Mental Health Services	Best Quality	Responsive	Trust	Trust				2100	2033	1970	1912	1882	1857
				Place	Barnsley	283			344	333	334	322	314	296
					Calderdale	247			311	287	282	280	272	269
					Kirklees	541			760	739	711	684	679	677
					Wakefield	406			575	562	537	514	502	496

National Metrics

Data as of : 21/10/2026 12:00:43

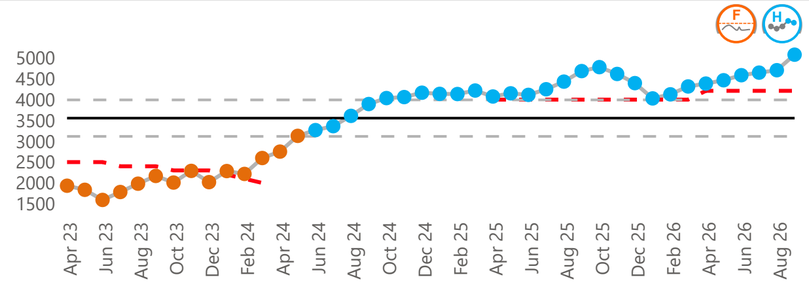
NHS South West Yorkshire Partnership NHS Foundation Trust

M184 - New RTT pathways (clock starts)



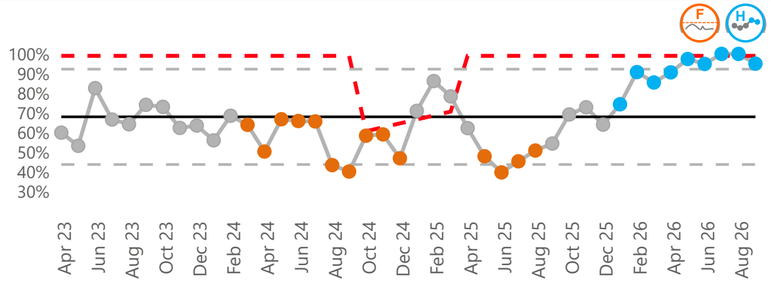
The Statistical Process Control (SPC) chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers. A new moving target is in place from 2025/26.

M45 - The number of incomplete Referral to Treatment (RTT) pathways



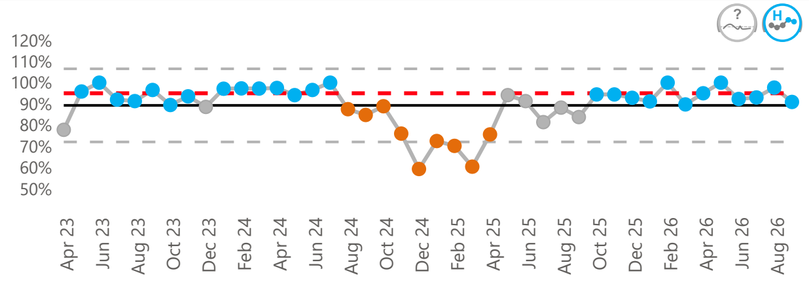
The SPC chart shows that we remain in a period of special cause concerning variation (something is happening and should be investigated) following a sustained increase in numbers of incomplete pathways over the past 12 months. We are not currently forecast to meet the target though current performance is above the target.

M6 - Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)



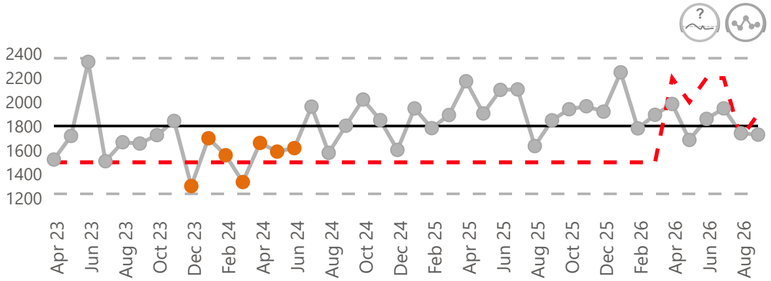
The SPC chart shows that we have entered a period of special cause improving variation (something is happening and should be investigated). Though we are not expected the meet the target of 99%.

M14 - Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks



The SPC chart shows that we have entered a period of special cause improving variation (something is happening and should be investigated) following a continued increase in performance.

M44 - The number of completed non-admitted RTT pathways in the reporting period



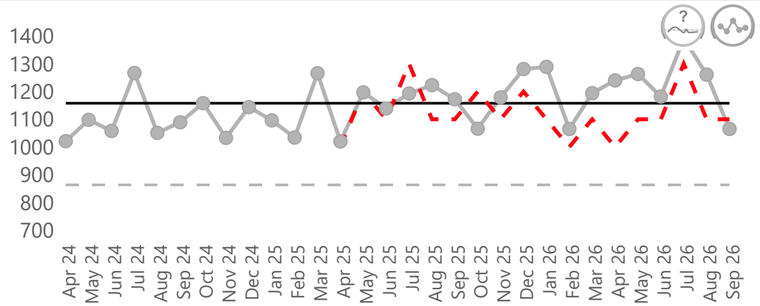
The SPC chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers this time last year.

National Metrics

Data as of : 21/10/2026 12:00:43

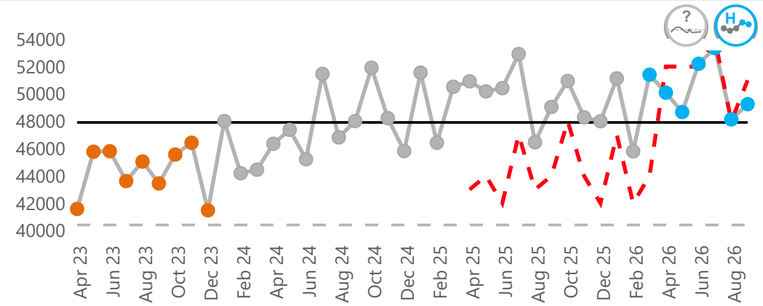
NHS South West Yorkshire Partnership NHS Foundation Trust

M187 - Urgent Community Response (UCR) referrals



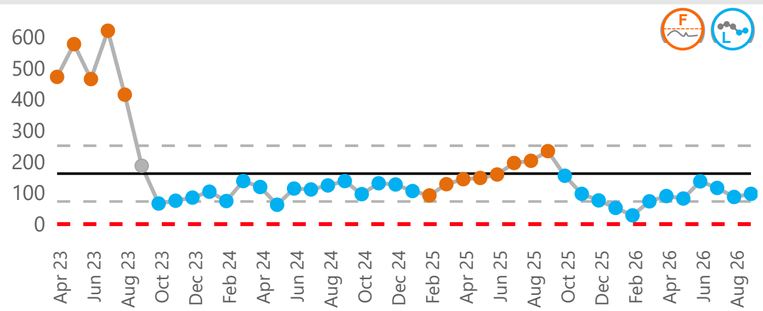
The SPC chart shows that we remain in a period of common cause variation (no concern).

M207 - Attended Community Care Contacts



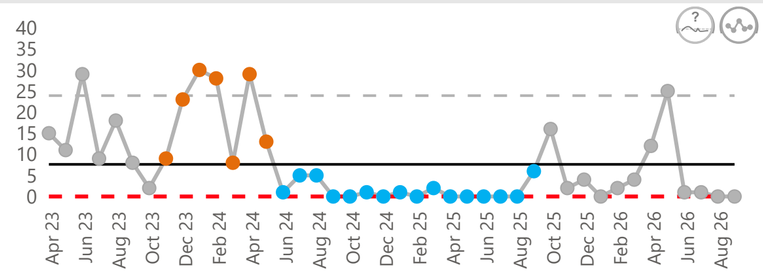
The SPC chart shows that we remain in a period of common cause variation (no concern).

M2 - Inappropriate out of area bed days



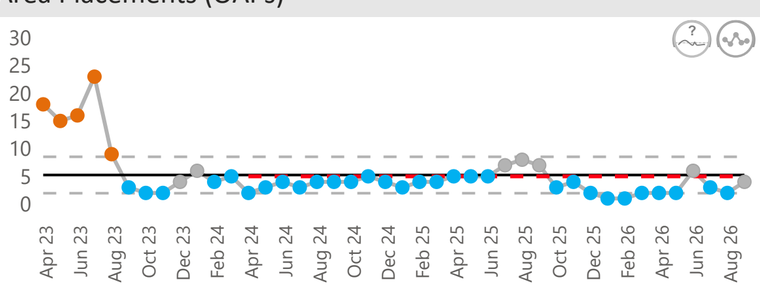
The SPC chart shows that due to the continued improvement in the number of out of area bed days we remain in a period of special cause improving variation (something is happening and should be investigated). Though we are still not anticipated to achieve the target of zero.

M8 - Total bed days of Children and Younger People under 18 in adult inpatient wards



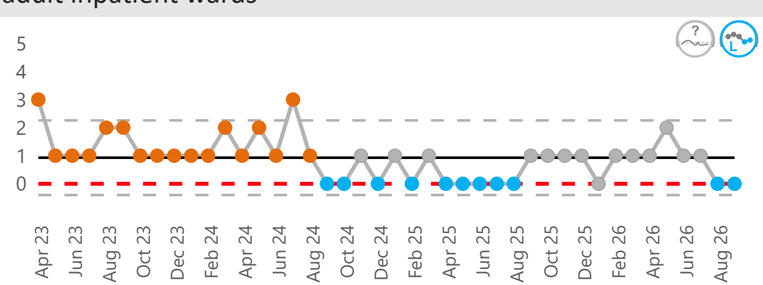
The SPC chart shows we remain in common cause variation (no concern).

M182 - Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)



The SPC chart shows that due to the continued improvement in the number of out of area placements we have entered a period of special cause improving variation (something is happening and should be investigated).

M9 - Total number of Children and Younger People under 18 in adult inpatient wards



There were no admission of an under 18 year old to an adult mental health ward in August.

Whilst the SPC chart shows us that this is an improving position when we compare it to the range of admissions we have had in the past, it is recognised that any admission of an individual under 18 is due to the national unavailability of a bed for young people to meet their specific needs. The Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care, and treatment reviews.

National Metrics

Data as of : 21/10/2026 12:00:43

NHS South West Yorkshire Partnership NHS Foundation Trust

The Trust continues to perform well against national metrics with performance against the majority within acceptable variance.

• M8 & M9 - There were no admissions of an under 18 year old to an adult mental health ward in September. It is recognised that any admission of an individual under 18 is due to the national unavailability of an appropriate bed for young people to meet their specific needs. The Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care, and treatment reviews.

• M2 - The number of out of area bed placements remains amongst the lowest in the North-East, Yorkshire and Humber region. At the end of September, the Trust had three service users placed in an inappropriate out of area bed with 78 bed days used over the month. Work to maintain effective patient flow continues, with the use of out of area beds being closely managed. The situation remains challenging in September and the pressure to meet the demand for admissions in a timely way has intensified. The impact of reduced usage of out of area beds on inpatient wards, Intensive Home-Based Treatment Teams, and community teams is triangulated and monitored.

• M13 & M14 - The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within four weeks was 90.9% in September. Four urgent referrals were not seen within the one-week target. In all cases, an appointment was offered within the timeframe, but the family declined and chose a later date. The routine access to treatment measure achieved 100%.

• M47 - Virtual ward occupancy during September was 74.7%%, below the 80% target. Acute consultant capacity continues to impact on Frailty pathway admissions. Respiratory virtual has seen improvements in occupancy levels over September but still below target trajectory and continues to be the least utilised pathway and there is still further work to ensure that colleagues across the partnership maximise use of this pathway for appropriate patients

• M6 - The percentage of service users waiting for a diagnostic appointment (Paediatric Audiology service only) within 6 weeks has achieved 95% in September. The continued increased in performance has meant that we remain in a period of special cause improving variation (something is happening and should be investigated).

• Reduction in our mental health length of stays are now split between adult acute and psychiatric intensive care unit (PICU), and older people. The Trust has set itself a target to reduce adult acute lengths of stay by 10% by the end of March 2027 from an August 2025 baseline. At Trust level, we are achieving our forecast position in September for adult and PICU lengths of stay (45.6 days against a forecast of 45.8 days) and for older peoples' lengths of stay (72.5 days against a forecast of 76.1 days). It is important to note that the performance will be affected by discharges of patients with particularly long lengths of stay and this may be impacted by the availability of external factors as identified when we highlight our performance against the clinically ready for discharge metric.

• Performance against number of patients accessing Individual Placement Support services is monitored at Place level and is an operational planning activity metric. IPS services help people with severe mental illness gain and maintain paid employment. This metric counts the number of people who have accessed the service over a rolling 12 month period. Calderdale - performance is impacted by primary care activity not currently being captured in reporting, resulting in under-representation of actual activity – work is taking place to try and resolve this to ensure we can include the data in our reporting. Service growth has also been affected by workforce challenges including sickness absence and vacancies. Kirklees - primary care IPS provision has been delayed due to unresolved governance requirements, including data sharing and MoU, impacting on activity. Service growth is also affected by vacancies, again impacting on reported activity.

• Waits for appointments across physical health and well being services in Barnsley continue to see a reduction in overall waiting times. For the month of September, 97.3% of adults and 98% of children and young people waiting for a community health appointment were waiting 18 weeks or less, which exceeds the national year-end target of 78%.

KPI	Strategic Objective	CQC Domain	Target	Jul-26	Aug-26	Sep-26
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Trust	Best Quality	Responsive	Jul - 443 Aug - 439 Sep - 435	450 (17%)	440 (18%)	Due November 2026
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Barnsley	Best Quality	Responsive	Jul - 81 Aug - 81 Sep - 80	78	71	
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Calderdale	Best Quality	Responsive	Jul - 43 Aug - 43 Sep - 43	73	77	
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Kirklees	Best Quality	Responsive	Jul - 213 Aug - 202 Sep - 191	244	252	
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Wakefield	Best Quality	Responsive	Jul - 34 Aug - 34 Sep - 34	20	17	
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - Trust	Best Quality	Responsive	Jul - 48.3 Aug - 47.6 Sep - 45.8	47.6	49.9	45.6
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - South Yorkshire	Best Quality	Responsive	Jul - 56.7 Aug - 58.6 Sep - 55.4	37.5	38.6	39.1
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - West Yorkshire	Best Quality	Responsive	Jul - 44.7 Aug - 44.3 Sep - 42.3	47.9	49.3	45.6
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - Trust	Best Quality	Responsive	Jul - 80.1 Aug - 79.6 Sep - 76.1	82.5	77.4	72.5
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - South Yorkshire	Best Quality	Responsive	Jul - 70.8 Aug - 73.2 Sep - 70.9	62.1	64.6	81.4
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - West Yorkshire	Best Quality	Responsive	Jul - 77.5 Aug - 77.5 Sep - 73.9	86.7	81.4	69.7
Access to Mental Health Support Teams Mental Teams in schools and colleges - Kirklees	Best Quality	Responsive	Jul - 890 Aug - 890 Sep - 920	1017	1001	856
Access to Mental Health Support Teams Mental Teams in schools and colleges - Wakefield	Best Quality	Responsive	1300	1801	1783	1727
Number of patients accessing Individual Placement Support services - rolling 12-month - Calderdale	Best Quality	Responsive	Jul - 174 Aug - 182 Sep - 189	121	116	120
Number of patients accessing Individual Placement Support services - rolling 12-month - Kirklees	Best Quality	Responsive	Jul - 318 Aug - 324 Sep - 330	253	257	250
Number of patients accessing Individual Placement Support services - rolling 12-month - Wakefield	Best Quality	Responsive	Jul - 304 Aug - 314 Sep - 324	414	411	414

KPI	Strategic Objective	CQC Domain	Target	Jul-26	Aug-26	Sep-26
Percentage of people on entire waiting lists who are waiting 18 weeks or less	Best Quality	Responsive	78% by March 27	92.7%	95.1%	97.3%
Percentage of people on waiting lists for Adult Community Services per system who are waiting 18 weeks or less as proportion of entire Adult waiting list	Best Quality	Responsive	78% by March 27	97.4%	97.7%	97.2%
Percentage of people on waiting lists for CYP Community Services per system who are waiting 18 weeks or less as proportion of entire CYP waiting list	Best Quality	Responsive	78% by March 27	71.1%	80.3%	98.0%
Percentage of people accessing mental health services with at least 2 contacts and a paired patient reported outcome score (CYP)	Best Quality	Effective	Monitored through NOF	22.6%	16.2%	*16.6%*
Percentage of people accessing mental health services with at least 2 contacts and a paired patient reported outcome score (Adult / OPS)	Best Quality	Effective	Monitored through NOF	3.9%	3.8%	*4.2%*
Percentage of intermediate care beds occupied by patients without criteria to reside	Best Quality	Responsive	Monitored through NOF	0%		
14 day readmission rate	Best Quality	Safe	Monitored through NOF	6.0%	5.0%	*3.7%*
% of mental health inpatients making a supported quit attempt with an in-house tobacco dependence treatment service (Rolling 12 month)	Best Quality	Effective	Monitored through NOF	*71.4%*		
Proportion of urgent referrals to Crisis Care teams with first face to face contact within 24 hours	Best Quality	Responsive	Monitored through NOF	80.9%	85.7%	95.6%
Data Quality Maturity Index score	Best Quality	Responsive	Monitored through NOF	*97.8%*		

Data quality
An additional column has been added to the national metrics dashboards to identify where there are any known data quality issues that may be impacting on the reported performance. This is identified by a warning triangle and where this occurs, further detail is included. For the month of August the following data quality issue has been identified in the reporting:
• The reporting for employment and accommodation shows 14.8% of records have missing employment and/or accommodation status with a further 1.6% that have an unknown employment status and 1.0% with an unknown accommodation status. This has been flagged as a data quality issue and work is taking place within care groups as part of their data quality action plans to review this data and improve completeness.

Operational Planning
Monthly performance against the national activity metrics for operational services can be seen in the dashboard. Where metrics have carried forward into 2026/27, there may have been a change in threshold, this is reflected in the dashboard. There are a number of new metrics related to operational planning for 2026/27 and these can also be seen in this section.

The following section of the report has been created to give assurance regarding the quality and safety of the care we provide. A number of key metrics have been identified for each care group, and performance for the reporting month is stated along with variation/assurance for each metric where applicable.

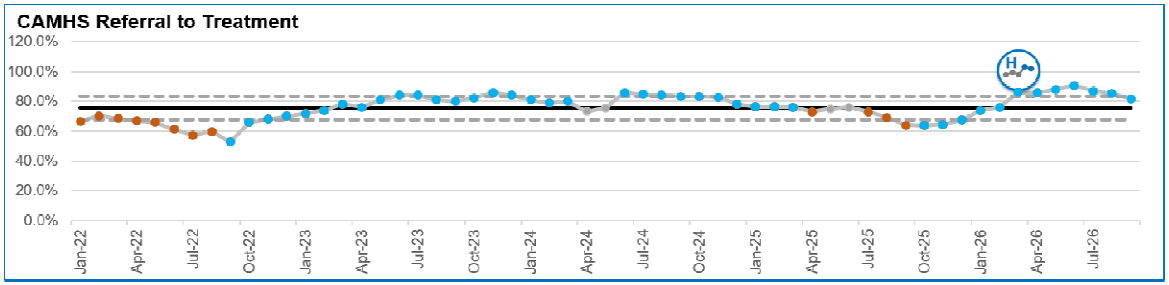
NB: data in *italics* is provisional, this will be refreshed in the next report once final.

Child and Adolescent Mental Health Services (CAMHS)

Headlines

Neurodevelopment waits remain a concern and discussions are underway with commissioners about how we can further strengthen the offer to reduce any impact on those who require assessment or support.

Metrics	Strategic Objective	CQC Domain	Threshold	Jul-26	Aug-26	Sep-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	91.0%	92.7%	99.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/4)	0% (0/5)	0% (0/8)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	85.2%	80.4%	83.7%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	80.1%	72.7%	77.1%	
CAMHS - Crisis Response 4 hours	Best Quality	Responsive	N/A	100.0%	100.0%	95.7%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	83.7%	84.5%	81.6%	
Eating Disorder - Routine clock stops	Best Quality	Effective	95%	92.9%	95.3%	90.9%	
Eating Disorder - Urgent/Emergency clock stops	Best Quality	Effective	95%	100.0%	85.7%	100.0%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.0%	94.1%	95.6%	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	94.6%	91.7%	92.5%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	5.5%	5.2%	6.0%	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	Best Quality	Responsive	126 days	711	700	771	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	Best Quality	Responsive	126 days	1,208	1,201	1,218	
Total number of reported incidents	Best Quality	Safe	Trend monitor	58	55	63	



In September 2026, the SPC chart indicates that we remain in a period of special cause improving variation (something is happening and this should be investigated). See narrative below for further information.

Alert/Action

• There are system-wide barriers within the ADHD medication pathways across Barnsley, Calderdale and Kirklees which are preventing timely transition and discharge of young people from CAMHS to adult services includes, including transition and prescribing risk, patients remaining in CAMHS beyond commissioned age range is impacting on caseload capacity, medication licensing concerns and on the wider ADHD pathway including extended waits for children and young people. This has been escalated and discussed with partners & commissioners regarding transition and Shared Care challenges.
• Kirklees CAMHS ADHD waiting list continues to rise due to increased referrals, Kirklees ICB 'Right to Choose' decision making, medical staffing vacancies and limited NMP support (0.6wte). Current longest wait (non-allocated appointment) is 92 weeks. Escalated to DoS and contracting colleagues.
• Wakefield CAMHS ReACH Team and Primary Intervention Team (SPA), continues to experience challenges recruiting to posts. Both pathways remain red on the risk register due to long term sickness and vacancies awaiting recruitment. The Psychotherapy offer remains closed to internal referrals. The action plan remains in place and is monitored in the wait's improvement group. Waits are increasing but all long waiters have been allocated and all cases are risk assessed and care plans are in place.

Advise

• Wakefield CAMHS have implemented the business continuity plan for the REACH Team which is affecting capacity across services in Wakefield. Recruitment is in place alongside robust management of sickness absence to ensure improvement.
• Kirklees Keeping in Mind (KKiM) MHST (Mental Health Support into Schools) have recruitment processes underway with positive application numbers to Trainee Education Mental Health Practitioners and are recruiting to existing vacancies within the team. September saw the mobilisation of NHSE MHST model realignment and successful application for Wave 16 funding. However, this remains a challenging time for the service.
• Kirklees & Calderdale medical workforce is currently running at 57% of establishment due to vacancies. Working with DoS and AMD Workforce to focus on recruitment of both substantive vacancies and temporary staffing to increase capacity for routine & emergency appointment and to cover medical on call. Recent positive recruitment and reduction in long term sickness will improve capacity.
• Calderdale & Kirklees CAMHS waiting numbers for autistic spectrum condition (ASC) / attention deficit hyperactivity disorder (ADHD) and neuro-developmental (ND) diagnostic assessment in Calderdale/Kirklees continue to remain challenging. This is further impacted by staff vacancies. This has been recorded on the risk register. Commissioners are sighted on these challenges. Recent recruitment in Calderdale will enable the service to meet commissioned assessment activity.
• The percentage of clinical staff in C&YP MH who met the 60-day target in September was 84% for clinical supervision and 77.4% for management supervision. There is an action plan in place and an expectation of improvement to above target at the end of September.
• Medicines Management Training Compliance is an area of focus in C&YP MH. Services are working with NQ&P to identify compliance required and accurate recording.

Assure

• C&YP MH achieved the appraisal target of over 90% of appraisals completed in window at 91.3%.
• Mandatory training – overall training compliance across all mandatory training requirements for C&YP Services was 94%

Mental Health Care Group

Headlines

Acute wards have continued to manage high levels of acuity.

General managers have a firm grip on sickness absence with staff being supported and managed in line with Trust policies. Community services sickness has been maintained under local threshold but there has been an increase across Mental Health inpatient services.

Mental Health Community

Metrics	Strategic Objective	CQC Domain	Threshold	Jul-26	Aug-26	Sep-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	95.1%	96.2%	99.1%	
% Assessed within 14 days of referral (Routine)	Best Quality	Responsive	75%	70.3%	75.2%	78.9%	
% Assessed within 4 hours (Crisis)	Best Quality	Responsive	90%	97.8%	97.5%	91.9%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	17% (3/18)	5% (1/21)	13% (2/16)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	87.6%	82.5%	82.6%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	84.8%	80.6%	79.6%	
% service users followed up within 72 hours of discharge from inpatient care	Best Quality	Safe	80%	90.0%	92.0%	92.7%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	96.7%	95.3%	96.0%	
% Treated within 6 weeks of assessment (routine)	Best Quality	Responsive	70%	97.5%	94.9%	96.4%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	86.4%	81.6%	84.5%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95%	97.4%	97.1%	97.2%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.3%	95.3%	97.7%	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	94.4%	89.5%	91.6%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	5.2%	5.7%	6.2%	
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses - Trust	Best Quality	Responsive	Trend Monitor	13,147	13,150	12,538	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	144	151	126	

Mental Health Inpatient

Metrics	Strategic Objective	CQC Domain	Threshold	Jul-26	Aug-26	Sep-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	95.0%	95.2%	99.2%	
% Bed occupancy (excluding leave)	Best Quality	Safe	85%	89.9%	91.6%	90.4%	
% Bed occupancy (including leave)	Best Quality	Safe		95.0%	98.2%	95.5%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/7)	50% (2/4)	0% (0/1)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	86.5%	80.6%	88.6%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	85.0%	78.8%	86.0%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.3%	88.8%	85.4%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	5.9%	8.0%	8.5%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	93.4%	94.0%	96.8%	
Inappropriate Out of Area Bed days	Best Quality	Responsive	150 (September)	116	87	78	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	98.4%	98.1%	97.1%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	19	24	14	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	45	48	31	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	91.3%	89.7%	86.5%	
Restraint incidents	Best Quality	Safe	Trend Monitor	76	115	*45*	
Safer staffing (Overall)	Best Quality	Safe	90%	118.1%	118.0%	118.7%	
Safer staffing (Registered)	Best Quality	Safe	80%	100.0%	97.3%	98.6%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5%	6.5%	7.4%	7.5%	
Readmissions within 28 days	Best Quality	Safe	Trend Monitor	11	2	*6*	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	540	595	523	

Alert/Action

• Acute wards have continued to manage high levels of acuity.
• High occupancy levels across wards and capacity to meet demand for beds remains a challenge. Plans are in place to mitigate any impact on safety of high occupancy such as increased staffing levels.
• Occupancy levels in rehabilitation units are affected by the fact that within the overall commissioned bed base the service model offers a flexible usage of beds and community packages of care at any one time depending on service user need. Occupancy calculations are based on the full commissioned bed base, not accounting for the agreed flexible usage.
• There continues to be people who are clinically ready for discharge but are delayed. This is an area of focus as part of the priority programme work and is being addressed with the ICB's through the MADE meetings as well as a weekly Director of Services led challenge meeting with general managers.
• Workforce challenges have led to continued use of temporary staffing, primarily bank. Throughout September some acute wards have worked above establishment. This is closely monitored by senior managers.
• Work to maintain effective patient flow continues, with the use of out of area beds being closely managed. The situation remains challenging in September and the pressure to meet the demand for admissions in a timely way has intensified. The impact of reduced usage of out of area beds on inpatient wards, Intensive Home-Based Treatment Teams, and community teams is triangulated and monitored.
• Intensive Home-Based Treatment (IHBT) teams in Calderdale and Kirklees are experiencing ongoing workforce challenges, recruitment is underway.
• All areas are focussing on continuing to improve performance for FIRM risk assessments. FIRM percentage compliance for inpatient services is significantly impacted due to the relatively small number of admissions. There were 4 wards that had 1 breach each in September. There is a high level of scrutiny when a FIRM risk assessment is not completed or reviewed and updated within 24 hours pre or post admission. At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed. A Staying Safe risk management care plan is also implemented within 24hrs of admission. The care group are reviewing the locally agreed standards for documenting the review of FIRM risk assessments on admission, and this work will be shared into the trust wide risk assessment quality improvement work.
• Care plan metrics for community capture the whole community caseload rather than only individuals on CPA. The care group are working with P&BI to ensure the metric reflects practice. Positive performance in September for Barnsley and Wakefield. Calderdale and Kirklees dipped slightly under target in September at 94.68% and 94.3% respectively, which is being addressed in weekly community performance meetings.
• Care Programme Approach (CPA) review performance is above target in Barnsley, Kirklees and Wakefield. Calderdale are slightly under the 95% target this month at 94.64%. Action plans and support from Quality and Governance Leads remain in place and all areas are expected to be above threshold in October.
• The sickness rate is above the Trust threshold on some wards and community service lines. Wards and teams with high sickness are where there are a number of people with long term sickness in addition to short term sickness. General Managers have a firm grip on absence with staff being supported and managed in line with Trust policies.
• The service is actively engaged in the trust wide improvement work with regards to minimising prone restraints during seclusion exit and when administrating intra-muscular medication. Matrons attend the monthly restraint oversight meeting chaired by RRPI specialist advisors and includes an in-depth review of all prone restraint incidents for learning.
• SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment remains at risk of being delayed in all areas. The access standard for assessed within 14 days of referral has been met in Barnsley and Wakefield. There have been challenges with vacancies in Calderdale & Kirklees SPA and an increased demand for urgent assessments. The service has implemented business continuity plans, with a focus on diverting increased resource towards triage.

Advise

• Improvement work is underway to understand the capacity and demand pressures on inpatient services and is monitored via the Inpatient Priority Programme. In addition, there is a focus on implementing the culture of care standards to improve the therapeutic nature of inpatient care for both service users and staff.
• Work continues in front line community services to adopt collaborative approaches to care planning, build community resilience, and to offer care at home including provision of robust gatekeeping and crisis alternatives, trauma informed care and effective intensive home treatment.
• The Talking Therapies recovery rate for September is 51.69% for Barnsley and 60.64% for Kirklees, both achieving the national standard of 50%.
• The care group holds monthly meetings to track and review progress of Equality Impact Assessments (EIAs). Performance remains strong. Delay in completion of EIAs in some areas have been due to manager changes/sickness and the service line Trios are supporting the teams in their completion.
• Equality data – we are working with a trust wide quality improvement group to enhance how equality information is captured on System One. Completeness of equality data is on our data quality improvement action plan.
• There were zero incidences of prone restraint in September. The care group continue to work collaboratively with colleagues in Nursing, Quality, and Professions to support the Trusts ambition for zero staff led prone restraint.

Assure

• Both Inpatient and Community MH services have achieved the 60 day supervision target for both clinical and management supervision.
• IHBT teams continue to perform well in gatekeeping admissions to our inpatient beds.
• Mandatory training compliance for the care group is 92.1%.
• The care group achieved 95.1% of appraisals completed within the appraisal window.

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) / Learning Disability (LD) Care Group

Headlines
Attention Deficit Hyperactivity Disorder (ADHD) / Autistic Spectrum disorder (ASD) services:
In line with the national picture, ADHD demand continues to exceed commissioned capacity.
Referral rates remain high across both pathways and the service try to minimise waiting times as far as possible.

Learning disability services:
Performance against the % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks remains just below target during September, the Learning Disability team continue to have robust oversight of all waits and are carrying out profession specific actions to address waits within individual disciplines.

LD, ADHD & ASD

Metrics	Strategic Objective	CQC Domain	Threshold	Jul-26	Aug-26	Sep-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	89.1%	90.8%	94.5%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/4)	0% (0/5)	25% (1/4)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	70.7%	73.4%	73.8%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	63.6%	63.0%	70.1%	
Bed occupancy (excluding leave) - Commissioned Beds	Best Quality	Safe	N/A	44.0%	40.7%	60.4%	
Bed occupancy (including leave) - Commissioned Beds	Best Quality	Safe	N/A	44.0%	40.7%	60.4%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	86.2%	86.2%	85.8%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	85.3%	92.1%	51.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	96.3%	94.6%	95.9%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	Best Quality	Responsive	90%	85.2%	89.5%	87.3%	
Physical Violence - Against Patient by Patient	Best Quality	Safe	Trend Monitor	0	0	0	
Physical Violence - Against Staff by Patient	Best Quality	Safe	Trend Monitor	3	0	3	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.1%	91.3%	93.7%	
Safer staffing (Overall)	Best Quality	Safe	90%	115.7%	108.8%	144.1%	
Safer staffing (Registered)	Best Quality	Safe	80%	151.5%	125.6%	161.7%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	3.5%	4.6%	4.4%	
Restraint incidents	Best Quality	Safe	Trend Monitor	3	1	*0*	
Average length of stay	Best Quality	Safe	Trend Monitor	20	10	322	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	33	27	29	

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) services:

Alert/Action

Transfer of Waiting List Patients
Discussions continue with West Yorkshire ICB regarding opportunities to utilise additional assessment capacity within the independent sector to support neurodevelopmental pathways.
Learning from arrangements implemented elsewhere across West Yorkshire has highlighted the importance of robust clinical review processes to ensure any transfers are appropriate, safe and aligned to individual patient need. Further work is underway to understand the operational requirements, resource implications and potential benefits of transfer arrangements.
Engagement with commissioners continues to develop an approach that supports patient choice, maintains clinical oversight and contributes to reducing waiting times where appropriate.

Risk Assessment Reporting
Reported compliance with risk assessments continues to be influenced by limitations within the current reporting methodology. Detailed review has identified a number of factors affecting performance reporting, including pathway design, triage activity and the recording of contacts within the ADHD and Autism pathways.
Work is underway with Business Intelligence colleagues to develop reporting arrangements that more accurately reflect the service model and provide meaningful oversight of compliance. Any proposed revisions will be subject to the Trust's governance and approval processes.

Demand/Capacity
Demand for neurodevelopmental assessments continues to present a significant challenge across the wider health system. However, the service is working collaboratively with commissioners and system partners to implement a range of measures aimed at improving pathway management, supporting clinical prioritisation and making best use of available capacity. Early indications suggest these interventions are beginning to have a positive impact on referral management and the rate of waiting list growth, although sustained system-wide action will be required to address the historic backlog of demand.

Advise

Waiting Lists
ADHD
Demand for ADHD assessments continues to exceed commissioned assessment capacity across all localities.
There are currently more than 7,200 people awaiting assessment, with extended waiting times reflecting sustained growth in referrals over recent years. Whilst demand remains high, the rate of waiting list growth has reduced across all areas. This reflects the impact of commissioned triage services, alternative assessment routes commissioned by the ICB and ongoing work to support people to access the most appropriate pathway.
All referrals continue to be subject to clinical review, with prioritisation processes in place to ensure individuals presenting with higher levels of need or risk receive appropriate consideration.

Autism
Calderdale remains the only locality with a significant Autism waiting list. There are currently 245 people awaiting assessment, with the longest waits approaching 800 days.
The Calderdale Neurodevelopmental Triage Project is expected to support improved pathway management and waiting list reduction once operational.
Across all other localities, Autism waiting times remain comparatively low, with 24 people awaiting assessment and most having waited less than 12 weeks.

Barnsley ADHD Triage Proposal
A proposal has been submitted to Barnsley commissioners outlining the benefits of introducing an ADHD triage service.
The proposed investment of approximately £125k per annum is expected to support improved pathway management, reduce avoidable demand within the wider system and contribute to shorter waiting times. A commissioning decision remains awaited.

Calderdale ADHD and Autism Triage Project
Calderdale commissioners have approved £432k of non-recurrent funding to support an 18-month programme focused on the management of neurodevelopmental waiting lists.
The project will provide triage for approximately 1,100 people awaiting ADHD assessment and 250 people awaiting Autism assessment, alongside the management of new referrals received during the life of the programme.
Recruitment processes are underway for four fixed-term posts required to deliver the project, with implementation planned following successful appointment and induction.

Wakefield ADHD Triage Funding
Wakefield commissioners have agreed recurrent funding of £203k to continue the ADHD triage service.
Service delivery has continued in line with agreed arrangements from April 2026. Work is ongoing with commissioners to ensure the funding is reflected within the Trust's contractual arrangements.

Assure

• The service remains on track to deliver commissioned activity levels for 2026/27 despite continued demand pressures across neurodevelopmental pathways.
• Progress against planned ADHD activity remains positive. Of the 440 assessment and treatment pathways commissioned for the year, 187 people (43%) have received an initial appointment, 49 are awaiting allocation and a further 18 have been invited to commence the assessment process.
• Recruitment activity is progressing well, with four substantive clinical appointments offered and pre-employment checks underway.
• Recruitment to four additional fixed-term posts is progressing to support delivery of the Calderdale ADHD and Autism Triage Project.
• Workforce performance indicators remain strong, with appraisal compliance meeting target, supervision compliance meeting target and mandatory training compliance remaining above target.
• Sickness absence levels remain within expected parameters, with no significant workforce wellbeing concerns identified.

Learning disability services:

Alert/Action

• Waiting time performance remains below target in Calderdale (72.2%) and Barnsley (89.4%), although the position is understood and individuals are being appropriately monitored and prioritised according to risk.
• Vacancy rates have increased to 14.7%. Whilst this is not currently impacting service delivery, the position will require ongoing monitoring until recruitment is completed.
• Risk Assessments A small number of community service users have risk assessments that have not been reviewed within the required 12-month timeframe, which remains an area of focus for teams and managers.
• Care Plan One service user was admitted without a care plan being completed within 24 hours of admission. This has been picked up locally.
• Supervision Compliance with management supervision has increased to 66.5%, with clinical supervision at 70.2%, which also represents an increase. An improvement plan is in place, including protected supervision sessions, increased oversight by managers, and routine monitoring of compliance to support sustained improvement.

Advise

Community
• Dysphagia Referrals - Dysphagia referrals have increased during the reporting period, creating additional pressure on SaLT capacity. This presents a risk to waiting list performance and may lead to longer waiting times for assessment and intervention.
• ICONIC - Research Project: Participation in the ICONIC research programme has commenced, supporting the service's commitment to research, innovation, and evidence-based practice within Community Services. Involvement in the programme will contribute to the development of knowledge and understanding to inform future service delivery and outcomes.
• STOMP: STOMP - remains well embedded across all localities and continues to promote the safe and appropriate use of psychotropic medication. Local teams have reported positive outcomes, including reductions in medication where clinically appropriate and, in some cases, successful discharge from specialist services when individuals' needs can be effectively met through mainstream or community-based support. This demonstrates the ongoing impact of person-centred approaches to medication optimisation and least restrictive practice.

Horizon – Assessment and Treatment Unit (ATU
• Bed Occupancy: Current bed occupancy is 60.4% (5 of 8 beds occupied). The service continues to monitor occupancy levels closely to ensure available capacity is utilised effectively, while maintaining sufficient flexibility to respond to changes in demand and support timely admissions where required.
• Assessment and Treatment Unit (ATU): Work continues to strengthen Assessment and Treatment Review pathways and associated processes. A programme of service improvement is underway to enhance care coordination, support timely progression through care pathways, and improve outcomes for individuals accessing the service. Further developments are planned as part of a longer-term approach to embedding sustainable improvements across the pathway.

Assure

• \Annual health checks in all four localities have exceeded the 75% threshold.
• Friends and family test positive response rate – 100%
• Prone Restraints – Horizon had no prone restraints.
• Quality Network for Community Learning Disability Services (QNLD) All community LD staff are actively engaged in QNLD improvement work, supporting ongoing quality improvement and service development.
• Waiting lists continue to be actively managed, with known pressure points understood and mitigated where possible. The service remains assured that individuals awaiting assessment are "waiting well".
• Vacancy Rates The increased vacancy rate is not currently causing operational concern, and managers remain confident that vacant posts can be successfully recruited to.
• Care Plan and Risk Assessments Work to improve care plan and risk assessment compliance continues to show overall progress across the service.

Forensic Care Group

Headlines

The monthly sickness rate continues to be an issue for our West Yorkshire services, hotspot areas can be seen in the ward level breakdown of the report. The people directorate business partner continues to work closely with the care group regarding sickness and actions are underway in line with the policy. Individual ward sickness performance is also impacted by the allocation of staff with long term conditions into less acute areas.

Focus remains on ensuring staff have a timely and comprehensive appraisal - good progress has been during the month with 96% being achieved across the board for our services.

Liaison with the collaborative is underway to find appropriate solutions for the patients waiting for high secure placements.

Forensic - West Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Jul-26	Aug-26	Sep-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	84.8%	92.2%	96.7%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	89.5%	90.2%	91.9%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/1)	100% (1/1)	0% (0/1)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	72.7%	74.9%	81.6%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	65.5%	76.6%	82.9%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	96.4%	97.3%	99.1%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	83.4%	84.0%	82.1%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	100.0%	100.0%	100.0%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95.0%	91.3%	93.3%	89.8%	
% with care plan that includes service user input/views	Best Quality	Safe	95.0%	97.6%	97.6%	98.1%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	94.7%	94.7%	95.4%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	5	3	1	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	10	6	4	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	95.8%	91.0%	92.6%	
Restraint incidents	Best Quality	Safe	Trend Monitor	9	12	*5*	
Safer staffing (Overall)	Best Quality	Safe	90%	110.1%	110.9%	110.7%	
Safer staffing (Registered)	Best Quality	Safe	80%	99.7%	96.0%	98.7%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	7.6%	7.1%	6.9%	
Average length of stay	Best Quality	Safe	Trend Monitor	1278	N/A	N/A	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	138	158	156	

Forensic - West Yorkshire:

Alert/Action

Rapid Improvement Programme
The service has commenced a Rapid Improvement Programme, overseen by the Chief Operating Officer. The programme is focused on strengthening the service by fostering a positive culture where staff feel valued, supported and empowered to deliver high-quality care and achieve key priorities. Through collaboration, engagement and continuous improvement, the programme aims to build on existing strengths while addressing areas for development.

Future Capacity & Demand
Work is continuing through the West Yorkshire Provider Collaborative, alongside regional partners, to understand future demand and support longer-term service planning. This includes analysis of activity, patient flow, length of stay, bed occupancy and emerging demand trends to inform decisions around service capacity, workforce requirements and future service development.
The Trust has also established its first internal programme board to coordinate and oversee SWYPFT actions arising from this work. The programme board will ensure local planning is aligned with the regional workstream, support delivery of agreed actions, and provide a mechanism for informing and influencing the wider collaborative programme.
This work will help ensure specialised services are able to respond effectively to future population need and system pressures while supporting sustainable service and workforce planning across the region.

Supervision
Improving supervision compliance remains a key priority across the service, with targeted actions in place to support further progress.
• Newton Lodge: Clinical Supervision 88.7%, Management Supervision 83.9%
• Bretton Centre: Clinical Supervision 59.5% (↑), Management Supervision 75.9% (↑)
• Newhaven: Clinical Supervision 96%, Management Supervision 92%
Performance at the Bretton Centre continues to present challenges, reflecting the sustained pressures associated with increased patient acuity and the operational difficulties of releasing staff from clinical duties to attend supervision. Despite these pressures, there has been a positive improvement in compliance during the month, particularly in relation to management supervision. Improvement activity remains ongoing, with continued focus on increasing supervision opportunities and supporting compliance across all staff groups.

Advise

Bed Occupancy
Bed occupancy remains stable across secure services:
• Newton Lodge: 92.48%
• Bretton Centre: 95.61%
• Newhaven: 79.79%
Occupancy within medium and low secure services remains generally strong. Lower occupancy levels continue to be seen within the Learning Disability pathway, reflecting ongoing challenges in demand across the wider system. As a result, Appleton Ward is currently operating below full capacity. However, there are positive indications of increased activity, with one recent admission completed and a further admission anticipated in the near future.
Demand for the women's pathway remains improved, with the service currently operating at full occupancy. The service continues to work closely with commissioners and system partners to monitor demand, optimise patient flow and ensure available capacity is utilised effectively across all pathways.

Recruitment and Turnover
Recruitment activity continues to focus on reducing unregistered nursing vacancies and improving workforce resilience.
Staff turnover across inpatient services remains positive and is below 10% across all pathways. Turnover rates are higher within Forensic Community Services and will continue to be monitored.

Sickness Absence
Year-to-date sickness absence remains above the Trust target of 4% across all service areas:
• Newton Lodge: 6.8% ↑
• Bretton Centre: 8.3% ↓
• Newhaven: 6.0% ↑
Sickness absence continues to be closely monitored across all services. While the Bretton Centre continues to report the highest level of absence, there has been a reduction in sickness rates during the reporting period. In contrast, sickness levels at Newton Lodge and Newhaven have increased and will remain a focus of management attention.
Managers are working closely with the People Business Partner and People Relations Team to support attendance management, understand the underlying causes of absence, and plan targeted interventions with staff.

Mandatory Training
Mandatory training compliance remains under close review across the service. Particular areas of underachievement have been identified in NEWS2 training at both Newton Lodge and the Bretton Centre, with Hand Hygiene and CPR training also identified as areas of concern at the Bretton Centre.
Targeted recovery plans have been developed and are being actively monitored, with actions focused on increasing training completion rates, improving oversight and ensuring compliance returns to expected standards. Progress against these plans will continue to be reviewed through local governance and performance arrangements.

Assure

• High levels of data quality continue across the Care Group.
• 100% compliance with completion of HCR-20 assessments within three months of admission.
• Positive relationships continue to be maintained with West Yorkshire Provider Collaborative partners.
• Robust mitigating arrangements remain in place to maintain safe staffing levels and support service delivery while improvement actions are implemented.
• 25 hours meaningful activity achieved in all areas.
• Appraisal compliance achieved.

Forensic - South Yorkshire							
Metrics	**Strategic Objective**	**CQC Domain**	**Threshold**	**Jul-26**	**Aug-26**	**Sep-26**	**Variation/ Assurance**
% Appraisal rate	Best place to work and learn	Well led	90%	83.3%	87.3%	96.5%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	84.0%	85.3%	86.7%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	50% (1/2)	0% (0/3)	0% (0/4)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	68.4%	71.4%	87.6%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	61.2%	69.4%	86.1%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	92.3%	89.4%	89.2%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	97.3%	93.7%	94.9%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	2	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	8	11	5	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.6%	88.8%	87.5%	
Restraint incidents	Best Quality	Safe	Trend Monitor	16	14	*10*	
Safer staffing (Overall)	Best Quality	Safe	90%	105.3%	107.8%	109.0%	
Safer staffing (Registered)	Best Quality	Safe	80%	87.7%	84.7%	93.5%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	3.9%	5.0%	4.5%	
Average length of stay	Best Quality	Safe	Trend Monitor	464	5,508	N/A	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	170	157	147	

Forensic - South Yorkshire:

Alert/Action

Vacancy & Turnover Rates

Workforce indicators continue to present a challenge for the service, with the turnover rate increasing to 14.8% and the vacancy rate reported at 21.7%. These staffing pressures increase reliance on temporary staffing arrangements to maintain safe staffing levels and support the delivery of high-quality care.

The impact is being felt most acutely in areas experiencing acuity where sustaining an experienced and stable workforce is crucial. Whilst temporary staffing provides essential resilience, reducing vacancy levels and improving retention remains a key priority in order to strengthen continuity of care, team stability and productivity.

A range of actions are being progressed to address these challenges, including focused recruitment campaigns which have been most successful with the recruitment of registered nurses and Psychologists. Managers are working closely with People colleagues to better understand turnover trends and identify themes arising from staff exit feedback.

Risk Assessment & Care Plans

Risk assessment and care planning compliance continues to be monitored through established governance processes. Performance has remained variable during the reporting period, with some areas demonstrating stronger compliance than others.

Whilst a number of actions are in place to support improvement, further focused work is required to achieve consistent performance and ensure standards are maintained across all services. Progress will continue to be monitored through routine assurance and performance processes.

Advise

Policy Integration
Integration of SWYPFT policies and procedures continues, supporting consistent practice, governance and assurance across Cheswold Park services. Progress remains on track, with ongoing work to align local processes and embed Trust standards.

Bed Occupancy
86.7% - Bed occupancy remains stable and continues to be monitored to ensure capacity is used effectively whilst maintaining flexibility to respond to changes in demand.

Appraisals
96.5% - Appraisal compliance remains strong and above target, demonstrating continued commitment to staff development, personal objectives and workforce wellbeing.

25 Hours Meaningful Activity
Compliance with the 25 Hours Meaningful Activity standard is currently 75.3%. While this demonstrates that a significant proportion of patients are accessing therapeutic and recovery-focused activity, further work is required to achieve the expected standard and ensure a consistent offer across the service.

Mandatory Training
Mandatory training compliance remains strong, with the service achieving compliance across all mandatory training requirements. This reflects the continued commitment of staff and managers to maintaining essential skills, knowledge and competence, supporting the delivery of safe and effective care. Ongoing oversight arrangements remain in place to ensure compliance is sustained.

Assure

Friends and family test – 100%

Data Quality – compliant across all domains.

Relationships with commissioners – Continue to be strong.

Barnsley Physical Health and Wellbeing Care Group

Headlines

The care group continue to perform well against most metrics. Achieving the Trust targets for supervision remain challenging despite work to share information on types of supervision and standardised documentation and continued focussed work is taking place within the care group to improve this position.
The sickness rate has improved and remains within Trust threshold following a period of high levels.

Barnsley Physical Health and Wellbeing

Metrics	Strategic Objective	CQC Domain	Threshold	Jul-26	Aug-26	Sep-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	94.0%	97.7%	99.1%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/3)	0% (0/1)	0% (0/1)	
% people dying in a place of their choosing	Person first and in the centre	Responsive	80%	90.3%	89.5%	89.3%	
% of staff receiving supervision within policy guidance - Clinical	Best Quality	Safe	80%	77.0%	77.8%	76.9%	
% of staff receiving supervision within policy guidance - Management	Best Quality	Safe	80%	52.3%	62.6%	66.8%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	88.6%	86.1%	86.9%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	96.8%	95.8%	96.3%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive	92%	97.1%	97.8%	96.7%	
Safer staffing (Overall)	Best Quality	Safe	90%	97.3%	92.0%	89.0%	
Safer staffing (Registered)	Best Quality	Safe	80%	100.0%	94.7%	96.9%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	5.5%	4.9%	4.7%	
Maximum 6 week wait for diagnostic procedures	Best Quality	Responsive	52.6%	100.0%	100.0%	95.0%	
Community services waiting list - All	Best Quality	Responsive	Trend monitor	7,008	6,942	6,962	
Total number of reported incidents	Best Quality	Safe	Trend monitor	292	271	250	

Barnsley Physical Health and Wellbeing Care Group

Alert/Action

• Virtual Ward (VW) occupancy levels for September have dipped further below the 80% occupancy target at 74.7%. Acute consultant capacity continues to impact on Frailty pathway admissions during September. Respiratory virtual has seen improvements in occupancy levels over September but still below target trajectory and continues to be the least utilised pathway and there is still further work to ensure that colleagues across the partnership maximise use of this pathway for appropriate patients.

Advise

• Staff receiving supervision – Achieving targets for supervision remains challenging in the care group but continues to be an area of focus, particularly in terms of recording. We continue to see gradual improvements and are working towards achieving compliance by the end of Quarter 3. Our Director of Services will also be triangulating sickness data with supervision levels. The issue where leaders were unable to see their team data has now been resolved and therefore, we expect to see an improvement as a result of being able to utilise the monitoring systems better. Managers and service leads are reviewing the number of supervisors to ensure sufficient resource to support the size of each service. We have identified a significant gap in District Nursing (DN) of numbers of trained supervisors to size of workforce; we are developing a plan to address this although workload capacity is being cited as a reason not to be trained. Our DNs have been operating at Operational Escalation Level (OPEL) 3 for a sustained period.
Figures for September against the target of 80% are:
Clinical supervision – 76.9%
Management supervision – 66.8%
• Medical devices – the compliance rate for September is 84%, close to the Trust-wide level of 88%. Assurance has been provided that out-of-date medical devices are not being used. Management team continue to promote Medical Equipment servicing sessions.
• In September, there was 1 instance of a pressure ulcer that developed under SWYPFT care where there was an area for improvement identified. This was in relation to the scheduling of visits following the initial visit. A debrief has been completed with staff involved.
• Friends and Family Test (FFT) – September has seen a slight reduction but falls just below compliance at 93%. The care group has seen a drop in the number of responses received during the last 2 months. In September, of the 56 comments received 2 were neither good nor poor; 2 were very poor. The care group is exploring the reason for the drop in the number of responses received and reviewing ways to increase the numbers.
• Safer staffing – please see Ward Trend narrative later in this report.

Assure

• Overall sickness rates have continued to improve to maintain compliance for the month of September at 4.7%. We are continuing to see instances of long-term sickness in some areas; these relate to serious illnesses which are unavoidable. The care group Year to Date figure has also improved again to 5.3%. People Directorate colleagues continue to support the care group in reviewing trends and triangulating with other data, whilst excluding some reasons e.g. elective surgery and diagnosis of cancer. Targeted work on short term sickness continues alongside utilisation of resources available to us in respect of staff off work sick due to stress & anxiety, whether this be home or work related. In addition, the care group is looking at future instances to ensure that recording absence includes consideration of the most appropriate reason e.g. Sickness Absence / Carer's Leave / Dependant Leave. We are also linked into the review of the Supporting Wellbeing (Sickness and Absence Procedure) via one of our General Managers.
• Appraisal reporting has now transitioned from the requirement to have an appraisal in the last 365 days to having an appraisal within the financial year with a completion date of the end of September.
The current focus is the target is for Bands 7 and below to have a completed appraisal by 30 September. As of 9 October, the care group has reached 96.7% and therefore achieved compliance. NB: this is reported as 99.1% on the IPR care group report using the previous system.
• Paediatric Audiology 6-week target for diagnostic procedures has dropped slightly to 95.1% in September. This is still well within the national trajectory of 52.56%.
The total number on the waiting list as at 11.10.26 was 80 patients, with no patients waiting over 6 weeks (regaining 100% compliancy); this shows an improvement since the end of September.
• Information Governance training has achieved 96.3% for September, maintaining compliancy with a continued focussed effort on monitoring by managers.
• Urgent Community Response Service 2-hour target has achieved 83.3% for September which continues to be above the 70% threshold.
• Musculo Skeletal Service (MSK) are seeing a continued achievement against the national target of 92% for 18-week RTT (Referral to Treatment) – 96.67% for September.
• People dying in their place of choosing remains compliant at 89.3% for September, exceeding the 80% threshold.
• CPR training maintains compliance at 86.9% for September. Training provided in Barnsley is limited for the rest of the year e.g. there are no ILS (Immediate Life Support) training sessions available locally for the rest of 2026.
• Clinically Ready for Discharge – the Care Group is fully compliant at 0%. Sustained compliance on our 2 wards is due to most admissions/discharges being planned. Anticipated discharge dates are set on admission and discussed at the weekly MDT, adjusting when clinically appropriate.
• 18-week waiters - Overall, our community services are achieving the national expectation of 78% of being seen within 18 weeks, with continuing compliance at 97.31% for September. Both adults and children's elements are now above 97%. We have seen a significant improvement for Children and Young People's services over the last 2 months.
• 52-week waiters – the care group continues to achieve compliance at 0%.

The following section of the report has been created to give assurance regarding the quality and safety of the care we provide on our inpatient wards. A number of key metrics have been identified the wards and performance against these for the past three months is stated. The wards in Cheswold Park Hospital are now incorporated into this report and the monthly data will be added over the financial year so that a three month rolling position is also shown. Figures in bold and italics are provisional and will be refreshed next month.

Ward Level Headlines - Working Age Adults, Older Peoples (WAA and OPS) and Rehab Services

Appraisal
- All 17 wards were at or above the 90% appraisal compliance threshold in September; 16 achieved 100% compliance.
- Oversight of appraisal performance is maintained by the senior leadership team at the weekly inpatient quality and performance meeting.

Sickness
- 8 wards had sickness below the 5% threshold in September – of note Ward 18 had no sickness during September.
- 1 ward—Crofton—improved from above the 5% sickness threshold in August to below threshold in September following the return of a staff member from LTS.
- Although still above threshold, sickness on Melton (6.8%), Nostell (7.2%), Poplars (12.7%), Beechdale (6.5%) and Ward 19 Male (9.0%) has reduced compared with August.
    - Poplars sickness is a mixture of both long and short-term sickness and 2 of those absences relate to injuries whilst at work.
- Sickness remained above threshold and increased on Walton (9.7%), Ashdale (17.2%), Willow (14.6%) and Ward 19 Female (8.6%) compared with August.
    - Ashdale absences relate to long-term sickness with themes of personal stress and long-term physical health conditions and also short-term absences of seasonal illness.
    - Willow absences relate to long-term sickness, although no specific themes.
    - Three short-term sicknesses on Walton relate to musculoskeletal injuries – two of which are work related.
- Ward managers are supported by People Directorate colleagues to actively manage long term sickness and timely referrals to occupational health are made.

Supervision
- 16 wards were at or above the 80% clinical supervision compliance target in September.
- 15 wards were at or above the 80% management supervision compliance target in September.
- Crofton was below compliance for both clinical (72.0%) and management (72%) supervision, although a noted improvement in performance since August. In the absence of the ward manager, oversight continues to be maintained by the ACP and Band 6s, supported by the matron. Resolution to the Ward Manager absence continues to progress through the appropriate operational process with an expected conclusion in early November.
- Walton (70.7%) were below the management supervision compliance target in September. Focused work has been undertaken and current compliance is 89.1% (as of 16.10.26).

Mandatory Training
Information Governance
- 14 wards were at or above the 95% Information Governance compliance threshold in September; 8 wards achieved 100% compliance.
- Clark (92.9%) and Ashdale (94.4%) fell just under compliance – staff outside compliance are being prioritised to complete the e-learning and both wards are above compliance as of 16.10.26.
- Enfield Down (94.0%) are below threshold with 3 staff outside compliance. Priority will be given to them completing the e-learning training.
- The senior leadership team maintain close oversight of information governance training compliance via the weekly inpatient quality and performance meeting.

CPR
- 14 wards were at or above the 80% CPR compliance threshold in September.
- Ward 18 (68.4%), Ward 19 Female (68.2%), and Lyndhurst (77.8%) are all below compliance in September. Staff out of compliance have either attending recent training sessions or are booked onto sessions throughout October. Compliance for all three wards is above threshold as of 16/10/26.
- Mitigations continue through roster planning to ensure appropriately trained staff are available on each shift.

RRPI
- 13 wards were at or above the RRP compliance threshold (80%) in September.
- Ashdale (75.0%), Enfield Down (76.9%) and Poplars (77.8%) are all at or above compliance as of 19.10.26 following staff attending recent training dates.
- Willow (75.0%) compliance is impacted by staff long term sickness and maternity leave. Staff who are able to complete training are booked onto future training dates during October and November.
- Rota planning and oversight from ward managers ensures adequate numbers of RRPI and CPR trained staff on each shift.

Fire Safety
- 14 wards were at or above the Fire Safety compliance threshold.
- Stanley (83.3%) remains just below compliance with staff booked to attend training in October. Current compliance is above threshold at 90.5% (as of 16.10.26).
- Poplars (78.1%) dropped below compliance, but staff have recently attended a training session and current compliance is 86.1% (as of 16/10/26).
- Ward 19 Female (77.3%) has dropped below compliance, partially impacted by long-term sickness and staff being unable to attend training. A locality training session is booked for November.

Ward Level Headlines - Working Age Adults, Older Peoples (WAA and OPS) and Rehab Services Continued

Bed Occupancy

• Where wards are overoccupancy, staffing levels are reviewed and where necessary increased to maintain wards safety.
• Bed occupancy exceeding target is reflective of general increased demand for admissions, particularly across working age adults.
• Where the bed occupancy exceeds target, plans are in place to mitigate any impact on quality of high occupancy such as increased staffing levels.
• Occupancy calculations at Poplars is based on 15 beds, however they operate with a maximum capacity of 12 beds, agreed with commissioners several years ago.
• Occupancy levels in rehabilitation units are affected by the fact that within the overall commissioned bed base the service model offers a flexible usage of beds and community packages of care at any one time depending on service user need. Occupancy calculations are based on the full commissioned bed base, not accounting for the agreed flexible usage.

Average Length of Stay (ALOS)

• Length of stay (LOS) is measured at the point of discharge. The discharge of service users with a significantly long length of stay in any given month will impact to increase the overall average length of stay for the ward.
• The nature and function of Rehab and Recovery Units mean service users will have longer length of stays.
• Rehab and Recovery length of stays also include any acute/PICU ward stays.

Safer Staffing

• There have been recent establishment reviews for the OPS wards – two throughout 2025 and one in April 2026 however these are pending EMT approval.
• There has been no approved review of older adult staffing establishments since 2016. Overall safer staffing rates being above 100% on OPS wards reflects wards being staffed to maintain patient safety in relation to service users: at risk of falls and with frailty; escorts to the acute trust due to complex physical health; complex dementia diagnoses and associated increased levels of violence and aggression. This is particularly pertinent for Poplars who are an isolated unit and whose service user population is people diagnosed with dementia.
• The high overall safer staffing rates in September for Poplars (191.9%) reflects staffing increases for the reasons outlined above.
• Crofton (154.8%) safer staffing reflects staffing increases to support a small number of service users with complex needs requiring enhanced observation levels for a sustained period. The service is undertaking a deep dive into temporary staffing use on Crofton to increase our understanding and plan appropriate actions.

Unfilled Shifts

• Headroom does not account for people on maternity leave. Consistently across the inpatient service we have 10 staff on maternity leave every month. To maintain safer staffing and roster requirements these shifts all require back fil.
• Ad hoc but consistent workforce gaps also arise from staff being allocated 'other leave' in line with trust policy and phased return to work recommendations.
• Following a deep dive analysis into working age adult budgets and roster alignment it has been identified that the current funding for the inpatient wards is in deficit by 10WTE's, therefore, every time a roster is produced, we need an equivalent of 10 staff to produce the rosters that the service has had agreed via previous establishment review (March 2024).
• Staff who are being supported to train as registered nurses are not available in the roster. Again, to maintain roster and safer staffing requirements back fill is required. There are currently 10 people in WAA undertaking this training.
• Ward leadership teams adhere to the Rostering, Work Time, and Attendance Policy. Where shifts remain unfilled, support will be sought from neighbouring wards and ward managers will work clinically to maintain ward safety.

Clinically Ready for Discharge (CRFD)

• CRFD rates are significantly above threshold on:
  - Clark CRFD is 25.8% and is reflective of three service users awaiting placement.
  - Ward 18 CRFD has increased to 14.5% and is reflective of 5 service users awaiting either housing or supported accommodation.
  - Nostell CRFD is 15.1% and is reflective of four service users, one of whom has recently been discharged.
  - Ward 19 Male CRFD is 17.8% and if reflective of 2 service users awaiting placement.
  - Poplars CRFD although still high at 26.2%, has reduced compared to August and is reflective of three service users awaiting placements. To note, whilst Poplars CRFD is consistently high each month, it is not the same service users that remain CRFD for protracted periods of time. Most service users, on discharge from Poplars, are transferred to other care providers, involving lengthy placement searches and local authority processes. The Poplars leadership team and matron are actively engaged with colleagues in local authority and ICB to ensure that delays are highlighted early, barriers are worked through, and challenges escalated timely.
• Nine other wards are above the threshold for CRFD with Nostell, Ashdale, and Willow at 10% or above. This is due to the number of service users with complex needs who are awaiting placement or suitable accommodation.
• Across all wards the multi-disciplinary team continue to collaborate to progress pathways as timely as possible.
• There is a weekly check and challenge meeting led by the Director of Service to ensure senior oversight and focus and timely external escalations.

Ward Level Headlines - Working Age Adults, Older Peoples (WAA and OPS) and Rehab Services Continued

FIRM Risk assessments

• To understand the breaches, the inpatient SLT have recently reviewed and mapped the process for completing a risk assessment within 24hours of admission. As a result of this QI work, we have reviewed and agreed practice standards for documenting the review of FIRM risk assessments on admission. These locally agreed standards were implemented on 22nd July and have been shared into the trust wide risk assessment quality improvement work.
• Overall compliance in September is above target (96.8%).
• There was a total of 4 breaches for 24hr target.
• During September Nostell, Ward 18, Ashdale, and Beechdale had 1 FIRM breach each.
• Compliance monitoring dashboards support oversight and a deep dive will be conducted by the inpatient matron for each breach to identify learning and inform improvement. These will be reviewed at the weekly inpatient quality and performance meeting to monitor themes.
• The inpatient team receive a handover of risk prior to admission and at the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed. A Staying Safe risk management care plan is also implemented within 24hrs of admission.

Physical violence (Patient on Patient)

• 14 incidents of patient-on-patient physical violence throughout July across multiple wards.
• Service users are supported on an individual basis by staff teams and risks are managed through individual care planning. Appropriate safeguarding actions taken by ward teams, including liaison with trust safeguarding specialist advisors and reporting to the police.

Physical violence (Patient on Staff)

• Six incidents on Ward 19 Female. These relate to a service user who has a diagnosis of dementia and a risk profile of violence and aggression, particularly on intervention (e.g. during self-cares).
• Seven incidents on Poplars relate to a small number of service users with behavioural and psychological symptoms of dementia and a risk profile of violence and aggression.
• Where service users are a known risk of violence and aggression, risk specific care plans are in place with input from trust RRP specialist advisors as needed.
• Staff involved in incidents are supported by ward leadership teams including both managerial and clinical supervision.

Restraint incidents

• High incidence on Walton (10) is reflective of patient population with a risk profile of violence and aggression.
• High incidence on Elmdale (12) is reflective of current patient population and the presentation and risk profile of service users, including restraint to prevent self-harm.
• Ward teams seek advice and support from RRPI specialist advisors as needed to inform individualised and person-centred care planning for those service users with a known risk of violence and aggression.

Prone restraint incidents

• Zero prone restraint incidents in September.

Cancelled Agreed S17 Leave

• Ward 18 (3) – no reasons recorded.

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Beamshaw Suite Jul-26	Beamshaw Suite Aug-26	Beamshaw Suite Sep-26	Clark Suite Jul-26	Clark Suite Aug-26	Clark Suite Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	89.5%	100.0%	95.2%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	2.4%	3.9%	3.9%	6.8%	1.0%	1.5%
Supervision - Clinical	Best place to work and learn	Well led	80%	92.9%	70.4%	92.9%	66.7%	67.9%	93.1%
Supervision - Management	Best place to work and learn	Well led	80%	92.9%	70.4%	92.9%	74.1%	92.9%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.4%	100.0%	100.0%	100.0%	96.6%	96.7%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.3%	86.2%	100.0%	96.3%	96.6%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	85.7%	93.1%	92.3%	96.3%	96.4%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.9%	93.1%	88.5%	96.3%	100.0%	92.9%
Bed occupancy (excluding leave)**	Best Quality	Safe	85%	98.8%	103.5%	101.2%	98.8%	103.5%	101.2%
Bed occupancy (including leave)**	Best Quality	Safe	Trend Monitor	105.0%	108.4%	108.6%	105.0%	108.4%	108.6%
Average Length of Stay	Best Quality	Safe	Trend Monitor	59	39	47	28	43	42
Safer staffing (Overall)	Best Quality	Safe	90%	115.6%	123.7%	131.3%	102.3%	106.5%	110.7%
Safer staffing (Registered)	Best Quality	Safe	80%	93.5%	92.0%	99.0%	93.7%	97.8%	98.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	5.8%	9.2%	5.9%	22.6%	28.6%	25.8%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	85.7%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	1	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	4	0	1	6	4
Restraint incidents	Best Quality	Safe	Trend Monitor	2	5	*0*	4	15	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/17)	0% (0/13)	0% (0/13)	12.5% (5/40)	0% (0/33)	0% (0/34)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	5	18	10	9	5	4

*** Bed occupancy is combined with Clark Suite due to use of swing beds*

*** Bed occupancy is combined with Beamshaw Suite due to use of swing beds*

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Melton Suite Jul-26	Melton Suite Aug-26	Melton Suite Sep-26	Nostell Jul-26	Nostell Aug-26	Nostell Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	93.3%	96.4%	100.0%	100.0%	94.1%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	4.8%	12.3%	6.8%	7.2%	8.2%	7.2%
Supervision - Clinical	Best place to work and learn	Well led	80%	79.4%	75.0%	81.3%	87.1%	93.8%	93.9%
Supervision - Management	Best place to work and learn	Well led	80%	79.4%	75.0%	81.3%	83.9%	90.6%	93.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	94.1%	93.5%	97.1%	96.6%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	97.1%	100.0%	100.0%	100.0%	93.3%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	73.5%	87.1%	85.3%	100.0%	93.3%	96.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	94.1%	100.0%	94.1%	82.8%	86.7%	85.7%
Bed occupancy (excluding leave)**	Best Quality	Safe	85%	84.9%	105.4%	104.4%	93.8%	98.2%	98.3%
Bed occupancy (including leave)**	Best Quality	Safe	Trend Monitor	93.0%	110.2%	104.4%	103.9%	104.6%	103.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	46	77	77	25	63	28
Safer staffing (Overall)	Best Quality	Safe	90%	125.6%	122.4%	123.9%	106.7%	101.9%	103.8%
Safer staffing (Registered)	Best Quality	Safe	80%	93.0%	90.5%	94.5%	124.4%	115.4%	113.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	15.1%	7.7%	11.3%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	90.0%	76.5%	90.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	2	0	1	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	4	0	1	2	8	0
Restraint incidents	Best Quality	Safe	Trend Monitor	2	2	*0*	4	14	*3*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	32.5% (13/40)	0% (0/6)	0% (0/6)	1.4% (1/74)	0% (0/58)	0% (0/107)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	15	14	17	8	10	7

*** Bed occupancy is combined with Stanley due to use of swing beds*

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Stanley Jul-26	Stanley Aug-26	Stanley Sep-26	Walton Jul-26	Walton Aug-26	Walton Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	100.0%	93.3%	93.5%	94.6%
Sickness	Best place to work and learn	Well led	5.0%	8.0%	4.0%	3.5%	6.2%	8.0%	9.7%
Supervision - Clinical	Best place to work and learn	Well led	80%	94.9%	97.4%	92.5%	89.7%	75.6%	80.5%
Supervision - Management	Best place to work and learn	Well led	80%	92.3%	94.9%	85.0%	89.7%	73.3%	70.7%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	97.2%	97.4%	97.6%	97.4%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	97.4%	100.0%	87.5%	87.2%	87.8%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	92.1%	86.8%	86.1%	94.9%	97.6%	87.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	81.6%	84.2%	92.7%	92.3%	95.1%	92.3%
Bed occupancy (excluding leave)**	Best Quality	Safe	85%	97.7%	98.2%	98.3%	92.9%	91.0%	95.0%
Bed occupancy (including leave)**	Best Quality	Safe	Trend Monitor	103.9%	104.6%	103.0%	100.0%	103.2%	109.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	31	71	42	57	34	68
Safer staffing (Overall)	Best Quality	Safe	90%	105.1%	115.7%	114.4%	114.4%	114.5%	112.6%
Safer staffing (Registered)	Best Quality	Safe	80%	96.4%	96.5%	102.5%	88.4%	91.6%	93.5%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	10.0%	6.7%	4.0%	10.1%	6.9%	6.5%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	0	3	0	0	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	2	4	4	1	2
Restraint incidents	Best Quality	Safe	Trend Monitor	11	0	*5*	7	24	*10*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	2	0	0	1	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	2	0	0	1	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/220)	0% (0/180)	0% (0/130)	0% (0/122)	0% (0/140)	0% (0/107)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	11	10	11	5	9	6

*** Bed occupancy is combined with Nostell due to use of swing beds*

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Ashdale Jul-26	Ashdale Aug-26	Ashdale Sep-26	Ward 18 Jul-26	Ward 18 Aug-26	Ward 18 Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	100.0%	82.6%	69.2%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	7.2%	13.1%	17.2%	1.5%	2.1%	0.0%
Supervision - Clinical	Best place to work and learn	Well led	80%	65.6%	82.4%	94.3%	87.8%	37.1%	97.0%
Supervision - Management	Best place to work and learn	Well led	80%	65.6%	82.4%	94.3%	87.8%	40.0%	97.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.3%	100.0%	100.0%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.2%	88.9%	80.0%	95.0%	94.7%	90.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	83.3%	85.7%	82.9%	57.5%	71.1%	91.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	94.6%	94.4%	94.4%	95.0%	94.7%	92.1%
Bed occupancy (excluding leave)	Best Quality	Safe	85%	98.7%	98.3%	99.4%	98.5%	97.8%	98.4%
Bed occupancy (including leave)	Best Quality	Safe	Trend Monitor	103.4%	102.2%	102.6%	96.2%	103.6%	100.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	189	84	45	37	25	33
Safer staffing (Overall)	Best Quality	Safe	90%	102.3%	101.6%	97.4%	100.5%	103.8%	103.1%
Safer staffing (Registered)	Best Quality	Safe	80%	106.1%	102.1%	94.4%	110.1%	111.8%	108.3%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	8.5%	9.8%	10.1%	0.6%	5.5%	14.5%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	90.9%	62.5%	88.9%	94.7%	96.0%	95.2%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	2	0	1	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	1	1	2	2	1
Restraint incidents	Best Quality	Safe	Trend Monitor	5	6	*3*	1	6	*2*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/653)	0% (0/636)	0% (0/625)	0% (0/337)	0% (0/477)	0.4% (3/852)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	2	3	0	4	3	5

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Elmdale Jul-26	Elmdale Aug-26	Elmdale Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	86.4%	96.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	3.7%	1.6%	1.9%
Supervision - Clinical	Best place to work and learn	Well led	80%	90.9%	85.3%	87.9%
Supervision - Management	Best place to work and learn	Well led	80%	90.9%	85.3%	87.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.1%	94.1%	97.2%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.2%	88.2%	87.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.9%	84.8%	82.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	97.1%	97.1%	97.2%
Bed occupancy (excluding leave)	Best Quality	Safe	85%	95.3%	98.0%	96.0%
Bed occupancy (including leave)	Best Quality	Safe	Trend Monitor	97.6%	103.1%	101.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	20	28	40
Safer staffing (Overall)	Best Quality	Safe	90%	108.9%	111.5%	107.3%
Safer staffing (Registered)	Best Quality	Safe	80%	99.7%	96.4%	95.6%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	1.2%	4.1%	6.9%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	95.7%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	3	3
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	5	1	1
Restraint incidents	Best Quality	Safe	Trend Monitor	13	15	*12*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/290)	0% (0/276)	0% (0/397)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	9	12	7

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Crofton Jul-26	Crofton Aug-26	Crofton Sep-26	Poplars CUE Jul-26	Poplars CUE Aug-26	Poplars CUE Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	83.3%	83.3%	100.0%	92.9%	96.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	8.8%	9.0%	4.7%	12.9%	19.1%	12.7%
Supervision - Clinical	Best place to work and learn	Well led	80%	84.0%	52.0%	72.0%	100.0%	86.7%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%	72.0%	44.0%	72.0%	100.0%	86.7%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.6%	92.6%	92.3%	86.1%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	80.0%	80.0%	80.0%	82.9%	90.3%	96.8%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	85.2%	92.6%	88.9%	80.6%	100.0%	93.9%
Bed occupancy (excluding leave)	Best Quality	Safe	85%	97.4%	100.4%	90.4%	74.6%	76.1%	67.3%
Bed occupancy (including leave)	Best Quality	Safe	Trend Monitor	111.5%	114.5%	96.3%	74.6%	80.0%	68.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	49	59	60	119	105	96
Safer staffing (Overall)	Best Quality	Safe	90%	169.9%	165.9%	154.8%	186.1%	179.1%	191.9%
Safer staffing (Registered)	Best Quality	Safe	80%	115.1%	113.2%	112.4%	105.1%	87.2%	93.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	3.4%	1.1%	6.5%	16.7%	47.3%	26.2%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	62.5%	100.0%	100.0%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	6	7	0	3	3	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	0	1	8	11	7
Restraint incidents	Best Quality	Safe	Trend Monitor	7	11	*1*	3	10	*3*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/8)	0% (0/9)	0% (0/19)	20% (1/5)	0% (0/4)	0% (0/4)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	11	11	16	15	19	19

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Willow Jul-26	Willow Aug-26	Willow Sep-26	Beechdale Jul-26	Beechdale Aug-26	Beechdale Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	8.5%	12.2%	14.6%	8.6%	11.5%	6.5%
Supervision - Clinical	Best place to work and learn	Well led	80%	82.4%	66.7%	100.0%	100.0%	95.8%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%	82.4%	66.7%	100.0%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	84.2%	75.0%	100.0%	100.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.5%	90.0%	82.4%	100.0%	100.0%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	94.7%	90.0%	100.0%	100.0%	100.0%	95.7%
Bed occupancy (excluding leave)	Best Quality	Safe	85%	94.2%	90.6%	82.3%	99.2%	97.4%	95.2%
Bed occupancy (including leave)	Best Quality	Safe	Trend Monitor	101.9%	107.1%	85.3%	101.0%	108.9%	106.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	75	54	60	50	159	119
Safer staffing (Overall)	Best Quality	Safe	90%	122.1%	135.4%	124.2%	164.9%	142.4%	145.8%
Safer staffing (Registered)	Best Quality	Safe	80%	84.3%	82.8%	86.5%	96.4%	95.9%	93.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	3.8%	6.4%	10.2%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	1	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	2	0	*1*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	2.9% (2/68)	0% (0/7)	0% (0/5)	0% (0/33)	0% (0/48)	0% (0/49)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	27	10	6	13	8	5

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Ward 19 - Male			Ward 19 - Female		
				Jul-26	Aug-26	Sep-26	Jul-26	Aug-26	Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	7.6%	11.2%	9.0%	9.4%	7.8%	8.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	96.2%	95.8%	95.8%	95.2%	94.7%	90.0%
Supervision - Management	Best place to work and learn	Well led	80%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	95.8%	100.0%	95.8%	100.0%	95.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	85.2%	87.5%	77.8%	87.5%	90.5%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	92.6%	95.8%	96.0%	79.2%	90.5%	91.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.6%	95.8%	95.8%	79.2%	85.7%	78.3%
Bed occupancy (excluding leave)	Best Quality	Safe	85%	96.3%	98.5%	94.9%	93.8%	94.2%	93.3%
Bed occupancy (including leave)	Best Quality	Safe	Trend Monitor	103.4%	106.0%	106.2%	98.7%	98.3%	98.4%
Average Length of Stay	Best Quality	Safe	Trend Monitor	60	73	113	80	65	51
Safer staffing (Overall)	Best Quality	Safe	90%	129.5%	116.2%	117.6%	126.9%	131.5%	158.2%
Safer staffing (Registered)	Best Quality	Safe	80%	94.6%	80.8%	83.2%	104.3%	98.3%	106.5%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	5.3%	17.8%	2.2%	16.6%	9.3%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	4	0	2	3	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	7	3	3	3	4	6
Restraint incidents	Best Quality	Safe	Trend Monitor	6	2	*5*	9	5	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/90)	0% (0/30)	0% (0/13)	0% (0/11)	5.9% (1/17)	0% (0/9)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	1	3	1	16	13	13

Inpatients - Mental Health - Rehab

Metrics	Strategic Objective	CQC Domain	Threshold	Enfield Down Jul-26	Enfield Down Aug-26	Enfield Down Sep-26	Lyndhurst Jul-26	Lyndhurst Aug-26	Lyndhurst Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	95.8%	97.9%	100.0%	95.8%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	3.7%	3.7%	4.8%	5.6%	2.8%	4.1%
Supervision - Clinical	Best place to work and learn	Well led	80%	91.1%	95.6%	97.6%	96.4%	100.0%	96.2%
Supervision - Management	Best place to work and learn	Well led	80%	88.9%	95.6%	97.6%	100.0%	100.0%	84.6%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	100.0%	100.0%	96.3%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	83.1%	80.8%	84.1%	81.5%	80.8%	81.8%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	88.9%	93.3%	89.1%	77.8%	92.3%	96.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	96.1%	98.1%	92.2%	92.6%	100.0%	92.6%
Bed occupancy (excluding leave)	Best Quality	Safe	Trend Monitor	62.5%	61.4%	63.5%	59.4%	63.8%	71.4%
Bed occupancy (including leave)	Best Quality	Safe	Trend Monitor	64.5%	64.8%	66.1%	64.3%	67.3%	71.4%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	94	N/A	N/A	860	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	101.0%	99.7%	97.4%	98.1%	98.1%	99.1%
Safer staffing (Registered)	Best Quality	Safe	80%	98.3%	97.6%	97.6%	98.4%	98.2%	98.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	100.0%	N/A	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	0	1	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	5.1% (5/98)	1.2% (1/82)	0% (0/120)	0% (0/44)	0% (0/13)	0% (0/140)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	4	1	0	0	0	0

Inpatients - Forensic West Yorkshire

Medium Secure

• Appraisal compliance has now reached 100% across all wards, reflecting the sustained commitment and focused efforts of Ward Managers.
• No prone restraint incidents were recorded across any medium secure ward during September 2026.
• Inpatient risk assessments at 100%.
• Workforce pressures remain the principal risk, particularly sickness and supervision compliance. No apparent correlation between Incidents and sickness absence.
• Three wards were above the compliance threshold for sickness absence: Chippendale (13.4%), Priestley (14%) and Waterton (14%). Current challenges within the service primarily relate to long-term sickness absence. The service is working closely with the People Directorate to support attendance management, with identified hotspot areas forming a key focus of the Trust-wide sickness reduction plan.
• There is a continued improving trajectory for both clinical and management supervision compliance, with clinical supervision now compliant in all areas and management supervision now achieving compliance in all but two areas (Chippendale: 58.8% and Appleton: 70.6%).
• To improve supervision compliance and ensure all staff receive effective clinical and management supervision, the service is reviewing systems and structures, sharing good practice, updating guidance, and implementing a supervision recovery plan. We have noted our predicted improvement in October, with work continuing to embed new processes continuing.
• Mandatory training compliance remains strong across the service. Only one hotspot has been identified within Information Governance training across Appleton (88.9%), Chippendale (94.7%) and Waterton (94.4%). This is understood to reflect the number of staff requiring training updates during this period. Targeted intervention and oversight from Ward Managers are in place to support timely completion and a return to full compliance.
• Safer staffing indicators remain compliant across services. Overall fill rates range between 93.5% and 170.6%, with registered staff fill rates between 89.7% and 135.6%. Higher fill rates reflect targeted staffing responses to periods of increased patient acuity and enhanced clinical need, ensuring safe and effective care is maintained.
• Section 17 leave continues to be closely monitored through morning huddles and service performance reviews.
• Bed Occupancy remains positive across the service, with Appleton (50%) well understood and plans in place to increase admissions following requests to consider out of area service users for placement. Processes in place to admit to Hepworth capacity.
• Bronte and Johnson demonstrated the strongest overall performance profiles.

Leadership Actions

• Ward managers to develop and implement recovery plans where sickness absence remains high, with particular focus on Chippendale, Waterton and Priestley.
• Ward, Service and General Managers will implement and embed the actions identified within the Supervision Recovery Plan, strengthening supervision systems, guidance and oversight arrangements to support the delivery of high-quality supervision and achieve sustained compliance.
• Targeted focus on Appleton, Chippendale and Waterton to complete outstanding Information Governance training and provide assurance that compliance is improving.
• Learning from Bronte and Johnson's performance to be shared across the service to support improvement in other ward areas.
• Progress against all actions to be monitored through monthly performance and quality meetings.

Low Secure Service

•Appraisal compliance has now reached 100% across all wards, reflecting the sustained commitment and focused efforts of Ward Managers.
•No prone restraint incidents were recorded across Low Secure services during September 2026.
•Inpatient risk assessments at 100%.
•Workforce pressures remain the key area of concern, particularly supervision compliance and sickness absence
•Supervision compliance continues to improve gradually with Newhaven within compliance for both Management and Clinical supervision; however, performance remains below the expected trajectory. Clinical supervision is below compliance for Thornhill (53.65), Sandal (68.8%), and Ryburn (50%). Management Supervision is below compliance for Sandal (65.5%) and Ryburn (70%). Delivery of the supervision recovery plan will continue, with targeted actions to further improve compliance and support the consistent embedding of effective supervision practices.
• Three wards were above compliance for sickness absence, Ryburn (5.5%), Sandal (7.1%) and Newhaven (8.7%). The service is working closely with the People Directorate to support attendance management, with identified hotspot areas forming a key focus of the Trust-wide sickness reduction plan.
•Mandatory training compliance continues to perform well overall. Targeted intervention is currently focused on Information Governance compliance in Newhaven (93.3%) and Thornhill (94.1%), and CPR compliance on Thornhill (79.4%) and Sandal (65.5%). The current position is largely attributable to a high volume of staff requiring updates within the same reporting period. Additional assurance is in place for CPR training, with staff scheduled to attend training throughout October and November. Ward Managers and Service Managers are providing enhanced oversight, and improvement plans are in place to support recovery to full compliance
•Section 17 leave continues to be closely monitored through morning huddles and service performance reviews.
•Safety incidents remain low, with one incident of patient-on-staff violence reported in Sandal. Reductions in safety incidents within Newhaven are encouraging and reflect greater stability within the service user group.
•Safer staffing performance remains positive, with fill rates ranging from 98.4% to 132% overall and 94.1% to 109.4% for registered staff. Workforce levels have been increased in response to patient acuity and clinical need, ensuring appropriate staffing is maintained to support safe service delivery.

Leadership Actions

• Implement plans on Ryburn, Sanal and Newhaven with support from People Directorate to reduce sickness absence and improve workforce resilience.
• Managers will review and strengthen supervision systems in line with recovery plan, guidance and oversight arrangements to improve compliance, share good practice, and deliver the supervision recovery plan towards full compliance by December.
• Restore mandatory training compliance through completion of outstanding Information Governance training on Thornhill and Newhaven, and CPR training in Sandal and Thornhill.

Inpatients - Forensic West Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Appleton Jul-26	Appleton Aug-26	Appleton Sep-26	Bronte Jul-26	Bronte Aug-26	Bronte Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	93.3%	93.3%	100.0%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	4.0%	6.2%	3.4%	0.7%	3.3%	3.3%
Supervision - Clinical	Best place to work and learn	Well led	80%	88.9%	94.1%	88.2%	86.4%	86.4%	91.3%
Supervision - Management	Best place to work and learn	Well led	80%	88.9%	64.7%	70.6%	90.9%	90.9%	91.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	94.4%	100.0%	100.0%	100.0%	95.5%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	94.4%	100.0%	100.0%	100.0%	95.5%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	83.3%	100.0%	83.3%	90.5%	95.5%	81.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	88.9%	94.1%	88.9%	85.7%	86.4%	85.7%
Bed occupancy (including leave)	Best Quality	Safe	90%	50.0%	50.0%	50.0%	100.0%	100.0%	100.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	93.5%	101.4%	93.5%	196.0%	174.5%	170.6%
Safer staffing (Registered)	Best Quality	Safe	80%	86.1%	89.8%	90.5%	137.7%	127.3%	135.6%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	2	2	2	0
Restraint incidents	Best Quality	Safe	Trend Monitor	2	7	3	2	2	2
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	N/A	66.7% (4/6)	0% (0/4)	0% (0/7)	0% (0/2)	0% (0/6)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	1	0	0	9	11	2

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Chippendale			Hepworth		
				Jul-26	Aug-26	Sep-26	Jul-26	Aug-26	Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	17.0%	11.1%	13.4%	10.7%	8.4%	4.8%
Supervision - Clinical	Best place to work and learn	Well led	80%	88.2%	94.1%	88.2%	66.7%	89.5%	85.7%
Supervision - Management	Best place to work and learn	Well led	80%	82.4%	100.0%	58.8%	61.1%	94.7%	81.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	94.4%	93.8%	100.0%	94.7%	100.0%	95.2%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	94.4%	93.8%	100.0%	100.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	83.3%	87.5%	84.2%	78.9%	89.5%	81.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	88.9%	93.8%	94.7%	94.7%	94.7%	95.2%
Bed occupancy (including leave)	Best Quality	Safe	90%	91.7%	91.7%	95.0%	83.0%	84.9%	88.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	96.7%	97.3%	103.8%	96.3%	94.4%	95.3%
Safer staffing (Registered)	Best Quality	Safe	80%	106.1%	102.5%	104.2%	89.5%	87.0%	89.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	0	0	0	1	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	1
Restraint incidents	Best Quality	Safe	Trend Monitor	2	0	*0*	0	1	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/23)	4.8% (1/21)	14.3% (3/21)	0% (0/4)	50% (2/4)	20% (1/5)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	3	1	8	2	0	1

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Johnson			Priestley		
				Jul-26	Aug-26	Sep-26	Jul-26	Aug-26	Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	100.0%	93.8%	93.8%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	2.0%	0.6%	4.1%	7.3%	10.5%	14.0%
Supervision - Clinical	Best place to work and learn	Well led	80%	77.4%	100.0%	100.0%	61.1%	58.8%	84.2%
Supervision - Management	Best place to work and learn	Well led	80%	87.1%	96.8%	100.0%	55.6%	82.4%	94.7%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.9%	96.9%	96.9%	95.0%	94.7%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.9%	84.4%	96.0%	94.7%	94.4%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.8%	78.1%	84.4%	84.2%	83.3%	83.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.9%	90.6%	93.8%	85.0%	73.7%	89.5%
Bed occupancy (including leave)	Best Quality	Safe	90%	100.0%	100.0%	100.0%	94.1%	99.6%	100.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	99.9%	100.0%	99.8%	94.2%	98.7%	97.5%
Safer staffing (Registered)	Best Quality	Safe	80%	96.4%	103.4%	104.1%	84.9%	90.6%	96.5%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	0	0	2	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	5.4% (2/37)	6.3% (2/32)	13.2% (5/38)	9.1% (1/11)	9.1% (1/11)	7.1% (1/14)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	1	0	0	0	0	1

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Waterton Jul-26	Waterton Aug-26	Waterton Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	16.3%	15.0%	14.0%
Supervision - Clinical	Best place to work and learn	Well led	80%	75.0%	38.1%	80.0%
Supervision - Management	Best place to work and learn	Well led	80%	54.2%	81.0%	85.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.5%	95.2%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.5%	85.7%	88.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	89.5%	90.5%	88.9%
Bed occupancy (including leave)	Best Quality	Safe	90%	92.7%	93.8%	97.1%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	96.9%	95.5%	98.1%
Safer staffing (Registered)	Best Quality	Safe	80%	95.3%	88.4%	97.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/71)	0% (0/69)	2.7% (2/73)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	1	0	0

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Thornhill			Sandal		
				Jul-26	Aug-26	Sep-26	Jul-26	Aug-26	Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	100.0%	92.0%	96.2%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	1.5%	1.4%	2.6%	6.7%	3.2%	7.1%
Supervision - Clinical	Best place to work and learn	Well led	80%	45.5%	42.9%	53.6%	72.7%	65.6%	68.8%
Supervision - Management	Best place to work and learn	Well led	80%	33.3%	50.0%	89.3%	24.2%	56.3%	65.6%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.9%	90.3%	96.8%	93.1%	100.0%	96.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	93.5%	100.0%	93.1%	90.0%	94.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.8%	87.1%	87.1%	69.0%	63.3%	68.8%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	97.0%	93.5%	97.1%	96.6%	96.7%	93.1%
Bed occupancy (including leave)	Best Quality	Safe	85%	96.6%	99.1%	100.0%	90.5%	83.3%	89.6%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	98.3%	103.0%	113.7%	133.0%	146.0%	132.7%
Safer staffing (Registered)	Best Quality	Safe	80%	98.3%	100.6%	95.4%	97.1%	99.3%	109.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	N/A	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	1
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	10.8% (16/148)	6.0% (8/134)	15.4% (16/104)	13.3% (4/30)	22.2% (2/9)	5.9% (3/51)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	3	1	3	7	8	31

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Ryburn Jul-26	Ryburn Aug-26	Ryburn Sep-26	Newhaven Jul-26	Newhaven Aug-26	Newhaven Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	90.9%	100.0%	100.0%	80.8%	88.5%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	16.8%	10.0%	5.5%	11.6%	9.7%	8.7%
Supervision - Clinical	Best place to work and learn	Well led	80%	50.0%	50.0%	50.0%	92.3%	87.5%	92.0%
Supervision - Management	Best place to work and learn	Well led	80%	30.0%	50.0%	70.0%	80.8%	75.0%	96.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	95.8%	92.6%	96.2%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	100.0%	95.8%	88.9%	88.9%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	100.0%	88.9%	100.0%	91.3%	95.7%	92.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	100.0%	100.0%	92.6%	96.7%
Bed occupancy (including leave)	Best Quality	Safe	85%	95.4%	100.0%	100.0%	81.3%	81.3%	79.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	1,278	N/A	N/A	N/A	N/A	1,591
Safer staffing (Overall)	Best Quality	Safe	90%	99.1%	99.1%	98.4%	108.7%	107.8%	108.6%
Safer staffing (Registered)	Best Quality	Safe	80%	98.3%	98.3%	100.1%	102.3%	97.8%	94.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	2	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	6	1	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	3	2	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/1)	0% 90/2)	0% (0/2)	3.6% (1/28)	4.5% (1/22)	4.2% (1/24)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	1	0	2	2	2

Inpatients - Non-Mental Health

• Appraisal rate (90%):
Both units have seen an increase since last month and have achieved compliance.

• Supervision (80%):
Staff receiving supervision – figures for September against the target of 80% are now compliant across all elements. Work continues to improve clinical and managerial supervision; both uptake and recording. As a result of plans put in place during July to improve the trajectory by undertaking clinical and managerial supervision during handovers and recording this daily, we are continuing to see more consistent figures in both teams.

• Sickness (5%):
NRU – sickness for September increased and remains outside compliance at 10.3%.The current position continues to include some instances of long term sickness.
SRU – Sickness for September has improved slightly and is now 6.2%. The current position includes several instances of long term sickness.
Sickness on both units is being monitored and managed via Supporting Wellbeing (Sickness and Attendance Procedure). As noted last month, some staff continue to be off work on a long-term basis and therefore continue to impact this month's figures.

• Information Governance (95%):
NRU continues to achieve compliance at 100% for September.
SRU continues to achieve compliance 97.1% for September.

• CPR (80%):
NRU continues to achieve compliance during September at 91.4%.
SRU continues to achieve compliance during September at 81.8%.
Learning and Development colleagues are exploring the use of local venues to enable Barnsley staff to attend this training more easily and reduce the amount of travel time. See also narrative in the care group section for wider Care Group; this also applies to our wards.

• Fire Safety Training (85%):
NRU – has seen a further improvement above compliancy during September at 94.6%.
SRU – continues to maintain compliance during September at 91.2%.

• Safer Staffing - overall (90%):
NRU – within compliance – at 116%
SRU – below compliance – 72.1%. Due to unusually low bed occupancy during September (57.2%), safe staffing levels were allowed to remain below recommended levels.
Safer staffing (registered 80%) is within compliance for both units.
To note: the establishment figures for both wards were reviewed in November 2025 and work continues to realign this on e-roster following further meetings in the first half of 2026. The recommendations to correct the roster fill rate for SRU will take effect from 28.9.26. Until this date, there may be ongoing instances where the figures do not show as compliant.

Metrics	Strategic Objective	CQC Domain	Threshold	Neuro Rehabilitation Unit (NRU)			Stroke Rehabilitation Unit (SRU)		
				Jul-26	Aug-26	Sep-26	Jul-26	Aug-26	Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	97.0%	100.0%	100.0%	97.1%	98.5%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	9.4%	7.1%	10.3%	4.9%	6.9%	6.2%
Supervision - Clinical	Best place to work and learn	Well led	80%	75.0%	100.0%	94.4%	68.7%	88.1%	89.2%
Supervision - Management	Best place to work and learn	Well led	80%	44.4%	91.4%	91.7%	37.3%	74.6%	80.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	97.3%	100.0%	95.8%	95.7%	97.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	80.0%	85.7%	91.4%	82.4%	83.3%	81.8%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	86.5%	89.2%	94.6%	93.1%	91.3%	91.2%
Bed occupancy (Barnsley Commissioned beds only)	Best Quality	Safe	80%	90.1%	93.5%	79.7%	88.7%	93.0%	57.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	71	58	94	37	39	30
Safer staffing (Overall)	Best Quality	Safe	90%	118.0%	112.0%	116.0%	82.7%	77.8%	72.1%
Safer staffing (Registered)	Best Quality	Safe	80%	106.9%	98.7%	112.7%	94.3%	91.3%	84.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	1
Unfilled Shifts	Best Quality	Safe	Trend Monitor	4	3	5	11	30	9

Inpatients - Mental Health - Learning Disability

Headlines

• Strong overall quality and governance position with appraisals (97.1%), clinical supervision (100%) and management supervision (100%) and all mandatory training standards achieved.
• Patient-on-staff assaults remain low, with three incidents reported during the period. The nature and frequency of incidents are understood to be consistent with the needs, risks and presentation of the current service user group
• No prone restraints and strong risk assessment compliance (100%) provides assurance regarding safety processes.
• Sickness absence has reduced to 3.6%, bringing performance in line with the organisational target. This represents a positive improvement from the previous reporting period and demonstrates the effectiveness of ongoing management oversight, attendance support and workforce wellbeing initiatives.
Safer staffing fill rates remain high, at 144% overall and 161.7% for registered staff. The increased staffing level is understood to be proportionate to the complexity, acuity and clinical needs of the current service user cohort, ensuring appropriate support, risk management and safe service delivery.
• The proportion of patients clinically ready for discharge has improved (51%), reflecting positive progress in patient flow. However, the position continues to highlight ongoing system-wide challenges in securing timely onward placements, with escalation and partnership arrangements remaining in place to support discharge planning and flow.

Metrics	Strategic Objective	CQC Domain	Threshold	Horizon Jul-26	Horizon Aug-26	Horizon Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	93.9%	94.1%	97.1%
Sickness	Best place to work and learn	Well led	5.0%	7.9%	7.6%	3.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	86.1%	88.9%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%	83.3%	88.9%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.4%	97.4%	97.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.1%	92.3%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	72.2%	73.0%	84.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	97.4%	92.3%	90.0%
Bed occupancy (excluding leave)	Best Quality	Safe	N/A	44.0%	40.7%	60.4%
Bed occupancy (including leave)	Best Quality	Safe	Trend Monitor	44.0%	40.7%	60.4%
Average Length of Stay	Best Quality	Safe	Trend Monitor	20	10	322
Safer staffing (Overall)	Best Quality	Safe	90%	115.7%	108.8%	144.1%
Safer staffing (Registered)	Best Quality	Safe	80%	151.5%	125.6%	161.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	85.3%	92.1%	51.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	0	3
Restraint incidents	Best Quality	Safe	Trend Monitor	3	1	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/138)	0% (0/145)	0% (0/127)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	36	10	10

Inpatients - Forensic South Yorkshire

Relationships with the South Yorkshire Provider Collaborative are much improved with joint working regarding future bed modelling continuing to be a priority. SWYPFT policy integration continues.

Low Secure Services

• Bed Occupancy: Hamilton, Don and Calder are operating at full occupancy (100%) Planned admissions to Aire have taken place and occupancy has increased from78.3% to 90.8% with further admissions awaiting warrants/court processes. Internal moves planned to Esk however water quality has closed 1 bedroom there which will impact on flow. One bedroom on Aire remains out of use due to water quality issue.
• Supervision: All wards are within threshold for both clinical and management supervision as a result of focussed work around recording by leadership team. Ongoing work to embed and sustain this compliance.
• Appraisals: All wards above threshold for appraisal completion.
• Mandatory Training: Compliance is strong across all wards. Don is below threshold for reducing restrictive practice training however staff are booked on the training, and compliance improvement should be reflected in next months report.
• Staffing: Focussed work on roster completion has supported the accuracy of data reflected against safer staffing.
• Restrictive Practice: No prone restraint incidents were reported across any ward.

Medium Secure Services (Foss and Skipton)

• Staffing: Focussed work on roster completion has supported the accuracy of data reflected against safer staffing. Skipton remains very slightly below threshold – impacted by the extra package of care and high staffing level associated with this.
• Patient Flow and Workforce: Foss continues to experience high sickness (10%) but these issues have been addressed through conclusion of the relevant sickness absence processes and this should be reflected with improvements in future months.
• Supervision: Foss and Skipton both exceed target for clinical and management supervision.
• Bed Occupancy: Both wards exceed occupancy target.
• Appraisals: Both wards have consistently exceeded target.
• Mandatory Training: Compliance is strong across both wards. All areas above target.
• Restrictive Practice: No prone restraint incidents were reported.

				Medium Secure Services Foss			Skipton		
Metrics	Strategic Objective	CQC Domain	Threshold	Jul-26	Aug-26	Sep-26	Jul-26	Aug-26	Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	96.0%	100.0%	95.8%	96.2%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	7.2%	7.1%	10.0%	3.8%	2.0%	4.3%
Supervision - Clinical	Best place to work and learn	Well led	80%	92.6%	100.0%	100.0%	79.3%	90.3%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%	85.2%	100.0%	100.0%	82.8%	90.3%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.3%	96.2%	96.0%	100.0%	96.6%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.9%	92.3%	88.0%	83.9%	89.7%	84.8%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	96.3%	96.2%	84.0%	92.9%	89.3%	82.8%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	96.3%	96.2%	96.0%	96.8%	96.6%	97.0%
Bed occupancy (including leave)	Best Quality	Safe	90%	92.6%	97.9%	100.0%	91.7%	91.7%	91.7%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	107.8%	101.5%	100.3%	100.8%	92.9%	99.2%
Safer staffing (Registered)	Best Quality	Safe	80%	101.1%	99.5%	100.5%	69.4%	69.1%	79.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	1	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	1	0	1
Restraint incidents	Best Quality	Safe	Trend Monitor	4	2	*2*	4	5	*4*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	27% (10/37)	5.1% (2/39)	12.9% (4/31)	5.1% (2/39)	8.0% (2/25)	7.4% (2/27)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	17	18	4	19	18	9

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Esk			Hamilton/Wentbridge		
				Jul-26	Aug-26	Sep-26	Jul-26	Aug-26	Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	95.2%	95.5%	100.0%	83.9%	90.6%	96.9%
Sickness	Best place to work and learn	Well led	5.0%	0.8%	1.0%	0.6%	4.6%	3.3%	3.0%
Supervision - Clinical	Best place to work and learn	Well led	80%	68.2%	43.5%	82.6%	76.5%	70.6%	97.0%
Supervision - Management	Best place to work and learn	Well led	80%	50.0%	52.2%	82.6%	58.8%	50.0%	97.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	87.5%	100.0%	100.0%	100.0%	97.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	81.8%	75.0%	81.8%	97.0%	97.0%	97.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	95.2%	95.7%	95.2%	84.8%	87.9%	97.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Bed occupancy (including leave)	Best Quality	Safe	90%	87.3%	81.5%	81.7%	96.5%	100.0%	100.0%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	5,508	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	96.4%	109.4%	104.8%	132.9%	132.6%	131.0%
Safer staffing (Registered)	Best Quality	Safe	80%	85.6%	89.6%	100.4%	92.0%	89.4%	98.3%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	0	1	6	10	2
Restraint incidents	Best Quality	Safe	Trend Monitor	1	1	*2*	5	5	*2*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	37.9% (11/29)	13.0% (3/23)	28% (7/25)	5.9% (1/17)	13.3% (2/15)	0% (0/25)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	5	9	5	55	33	25

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Aire Jul-26	Aire Aug-26	Aire Sep-26	Don Jul-26	Don Aug-26	Don Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	61.5%	73.9%	95.5%	79.2%	79.2%	90.9%
Sickness	Best place to work and learn	Well led	5.0%	10.3%	9.2%	9.8%	2.0%	3.0%	0.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	69.5%	76.2%	86.4%	24.0%	64.0%	83.3%
Supervision - Management	Best place to work and learn	Well led	80%	69.5%	76.2%	86.4%	24.0%	68.0%	83.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	92.6%	95.7%	100.0%	91.7%	91.3%	95.8%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.9%	91.3%	88.9%	79.2%	78.3%	79.2%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	88.9%	78.3%	92.6%	91.7%	95.7%	83.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Bed occupancy (including leave)	Best Quality	Safe	90%	76.9%	83.3%	90.8%	93.8%	100.0%	100.0%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	464	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	89.9%	86.5%	93.2%	107.4%	105.3%	110.0%
Safer staffing (Registered)	Best Quality	Safe	80%	94.1%	91.4%	90.6%	90.2%	83.9%	94.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	1	0	*0*	1	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	14.8% (4/27)	21.4% (6/28)	10% (2/20)	17.3% (9/52)	12.5% (6/48)	9.6% (5/52)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	8	20	12	13	20	14

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Calder Jul-26	Aug-26	Sep-26
Appraisal rate	Best place to work and learn	Well led	90%	90.5%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	4.9%	13.3%	9.7%
Supervision - Clinical	Best place to work and learn	Well led	80%	100.0%	94.4%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%	100.0%	94.4%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	95.2%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	95.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	100.0%
Bed occupancy (including leave)	Best Quality	Safe	90%	93.8%	99.0%	100.0%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	94.8%	96.6%	99.0%
Safer staffing (Registered)	Best Quality	Safe	80%	90.4%	92.1%	95.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	1	1
Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	7.1% (4/56)	7.5% (4/53)	7.3% (4/55)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	3	10	6

Overall Financial Performance 2026/27

Executive Summary / Key Performance Indicators

	Performance Indicator	Strategic Objective	CQC Domain	Year to Date	2026/27 Forecast	Narrative
	NHS Oversight Framework - finance metric	Best Value	Well Led	1	1	From July 2026 the NHS Oversight Framework (NOF) finance rating has been incorporated into the monthly provider finance return (PFR). This includes the main finance rating and temporary staffing metrics. At September 2026, as the Trust remains ahead of plan, this rating is 1.
1	Surplus / (Deficit)	Best Value	Well Led	(£1.8m)	£0m	The financial performance in September 2026 is a surplus of £384k which is £32k worse than plan in month. The year to date position remains just ahead of plan (£3k). This movement, from deficit to surplus, was planned with the receipt, in month, of £644k income relating to national low value activity calculations. To deliver the financial target of breakeven will require a positive / surplus run rate for the remainder of the year.
2	Agency Spend	Best Value	Well Led	£0.9m	£1.8m	Agency spend, which continues to be limited to a small number of medical posts, has an average run rate of £144k per month. There are slightly variations each month. Recruitment plans continue to be implemented. As monitored within the NHS Oversight Framework this is 0.6% of the Trust year to date total pay bill.
3	Bank Spend	Best Value	Well Led	£11.4m	£20.9m	Bank spend has continued to fluctuate and, following two months of reductions, has increased to £2,023k in September (increase of £229k). This is across medical, unregistered and unregistered nursing categories and mainly for staffing required to support adult inpatient wards. The year to date £11.4m represents 7.3% of the total Trust pay bill. Although actions continue the forecast, reflected in the amber rating, is that the bank expenditure target will be exceeded.
4	Financial sustainability and efficiencies	Best Value	Well Led	£7.1m	£17.7m	The Trust value for money programme continues to report as ahead of the plan for the year to date due to reduction in corporate costs and maintained run rate reductions in temporary staffing and out of area placements. The forecast remains that the target will be delivered in full. To achieve this schemes planned for the second half of the year need to have a positive impact on the Trust run rate.
5	Cash	Best Value	Well Led	£55.3m	£57.1m	The current cash position continues to be positive but, in line with national focus in this area, best practice continues to be reviewed to ensure that we have effective management of the Trust working capital position.
6	Capital Spend	Best Value	Well Led	£4m	£14.9m	The Trust continues to progress with it's capital programme. Pricing, and profiles, are expected to be agreed shortly for the main schemes. Mitigations to manage within the in year allocation are being developed to ensure that this can be fully and appropriately utilised.
7	Better Payment Practice Code	Best Value	Well Led	98%		This performance is based upon a combined NHS / Non NHS value. The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.

Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

South West Yorkshire Partnership Teaching
NHS Foundation Trust

Finance Report

Month 6 (2026 / 27)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0 Executive Summary / Key Performance Indicators

Key Performance Indicator		Year to Date	Forecast 2026 / 27	Narrative
NOF 1	NHS Oversight Framework	1	1	From July 2026 the NHS Oversight Framework (NOF) finance rating has been incorporated into the monthly provider finance return (PFR). This includes the main finance rating and temporary staffing metrics. At September 2026, as the Trust remains ahead of plan, this rating is 1.
1	Surplus / (Deficit)	(£1.8m)	£0m	The financial performance in September 2026 is a surplus of £384k which is £32k worse than plan in month. The year to date position remains just ahead of plan (£3k). This movement, from deficit to surplus, was planned with the receipt, in month, of £644k income relating to national low value activity calculations. To deliver the financial target of breakeven will require a positive / surplus run rate for the remainder of the year.
2	Agency Spend	£0.9m	£1.8m	Agency spend, which continues to be limited to a small number of medical posts, has an average run rate of £144k per month. There are slightly variations each month. Recruitment plans continue to be implemented. As monitored within the NOF this is 0.6% of the Trust year to date total pay bill.
3	Bank Spend	£11.4m	£20.9m	Bank spend has continued fluctuate and, following two months of reductions, has increased to £2,023k in September (increase of £229k). This is across medical, unregistered and unregistered nursing categories and mainly for staffing required to support adult inpatient wards. The year to date £11.4m represents 7.3% of the total Trust pay bill. Although actions continue the forecast, reflected in the amber rating, is that the bank expenditure target will be exceeded.
4	Financial sustainability and efficiencies	£7.1m	£17.7m	The Trust value for money programme continues to report as ahead of the plan for the year to date due to reduction in corporate costs and maintained run rate reductions in temporary staffing and out of area placements. The forecast remains that the target will be delivered in full. To acheive this schemes planned for the second half of the year need to have a positive impact on the Trust run rate.
5	Cash	£55.3m	£57.1m	The current cash position continues to be positive but, in line with national focus in this area, best practice continues to be reviewed to ensure that we have effective management of the Trust working capital position.
6	Capital	£4m	£14.9m	The Trust continues to progress with it's capital programme. Pricing, and profiles, are expected to be agreed shortly for the main schemes. Mitigations to manage within the in year allocation are being developed to ensure that this can be fully and appropriately utilised.
7	Better Payment Practice Code	98%		This performance is based upon a combined NHS / Non NHS value. The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.

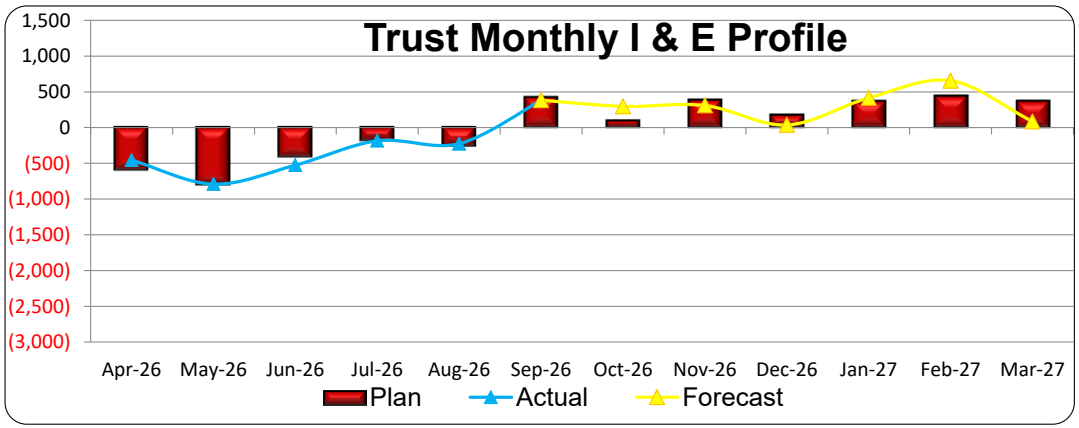
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

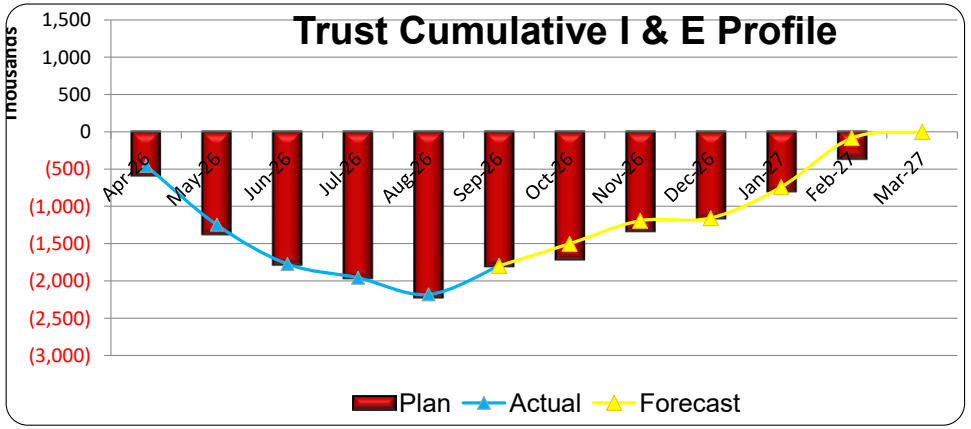
2.0 Income & Expenditure Position 2026 / 27

The table below presents the total consolidated financial position for South West Yorkshire Partnership Teaching NHS Foundation Trust. This incorporates it's role as co-ordinating provider for a number of Mental Health Provider Collaboratives but excludes it's linked charities which are consolidated into the Trust's group annual accounts. The impact of the Provider Collaboratives, and budgets held centrally, are highlighted separately within this report.

Total Financial Position

Description	Budget Staff	Actual Worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Healthcare contracts					35,616	35,343	(272)	210,413	210,289	(124)	419,784	418,044	(1,740)
Other Operating Revenue					1,386	2,125	740	7,905	8,975	1,071	15,875	17,062	1,187
Total Revenue					**37,001**	**37,469**	**467**	**218,318**	**219,265**	**947**	**435,659**	**435,106**	**(554)**
Employee expenses	5,396	5,416	20	0.4%	(25,796)	(26,502)	(707)	(154,813)	(156,758)	(1,946)	(307,780)	(313,568)	(5,788)
Operating expenses exc. Employee expenses					(10,518)	(10,451)	66	(63,739)	(63,557)	183	(124,647)	(120,012)	4,635
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,396**	**5,416**	**20**	**0.4%**	**(36,313)**	**(36,954)**	**(640)**	**(218,552)**	**(220,315)**	**(1,763)**	**(432,426)**	**(433,579)**	**(1,153)**
Operating Surplus / (Deficit)	**5,396**	**5,416**	**20**	**0.4%**	**688**	**515**	**(173)**	**(234)**	**(1,050)**	**(816)**	**3,233**	**1,527**	**(1,706)**
Finance expense					(56)	(57)	(1)	(336)	(354)	(17)	(673)	(676)	(3)
PDC Paid					(362)	(307)	55	(2,172)	(1,842)	330	(4,343)	(3,684)	659
Finance income					135	225	90	872	1,399	527	1,645	2,749	1,104
Surplus / (Deficit) - Total	**5,396**	**5,416**	**20**	**0.4%**	**405**	**376**	**(29)**	**(1,870)**	**(1,847)**	**23**	**(138)**	**(84)**	**54**
Adjusted Financial Performance													
Depn Peppercorn Leases (IFRS16)					11	8	(3)	69	49	(20)	138	84	(54)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - ICB performance measure	**5,396**	**5,416**	**20**	**0.4%**	**416**	**384**	**(32)**	**(1,801)**	**(1,798)**	**3**	**0**	**(0)**	**(0)**





Income & Expenditure Position 2026 / 27

The consolidated Trust surplus in September 2026 is £384k.
This is £32k worse than plan.

In line with national guidance the Trust submitted a risk assessed breakeven financial plan for 2026 / 27. Within this position there were identified risks and opportunities and these will be continually assessed as the year progresses. These are discussed monthly at the Trust Finance, Investment and Performance Committee.

NHS England - monthly submission

The actual financial performance reported here is consistent with the monthly return made to NHS England. The corresponding declaration is made within the return itself.

The submission is for the total consolidated financial position which operates as a single segment for the purpose of providing healthcare services. Within this report the financial information is split into core Trust, Provider Collaboratives and budgets held centrally. Financial performance is summarised in the table below.

	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
Description	**WTE**	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Trust (core)	5,372	5,394	22	0.4%	64	(183)	(247)	(3,254)	(2,127)	1,127	(4,446)	(8,158)	(3,712)
Provider Collaboratives	23	22	(2)	7.1%	42	532	490	(40)	(330)	(290)	18	(1,209)	(1,227)
Budgets held centrally	0	0	0	0.0%	310	34	(276)	1,493	659	(834)	4,428	9,367	4,939
Total - Consolidated position (ICB performance measure)	**5,396**	**5,416**	**20**	**0.4%**	**416**	**384**	**(32)**	**(1,801)**	**(1,798)**	**3**	**0**	**(0)**	**(0)**

The core Trust plan has moved from a monthly deficit to a monthly surplus. In September 2026 this is primarily due to the inclusion of low value activity income. However, despite receipt of this income as planned, the position is a deficit in month due to an overall deteriatoration of the run rate. These movements are explained in detail within the remainder of the report.

The focus remains on actions required in order to improve, and sustain, an improved run rate. Based on the current modelling this improvement is approximately £0.8m per month for the remainder of the year although the Trust forecast scenario modelling continues to assess all options and mitigations available to us.

The provider collaboratives position remains challenging with continued operational and financial pressures in both South Yorkshire and West Yorkshire. The run rate has maintained in South Yorkshire, whilst spend has reduced in West Yorkshire in month. The collaborative position is also supported by additional non-recurrent income.

Budgets held centrally remains for items that are not able to be coded through care groups. Actual expenditure remains limited; £22k of non recurrent benefits have been realised in month (revised £813k for the year to date). The budget requires additional value for money schemes to be allocated against it and improvements in the run rate of all areas to acheive the breakeven target.

2.0 Income & Expenditure Position 2026 / 27

This section focusses on the financial performance of South West Yorkshire Partnership Teaching NHS Foundation Trust. This excludes the financial impact of Provider Collaboratives and budgets held centrally which are presented separately. The movement between the total consolidated financial position and the table below is reconciled on the previous page for ease.

To confirm that the individual analysis within this report highlights the Trust only values unless explicitly stated otherwise.

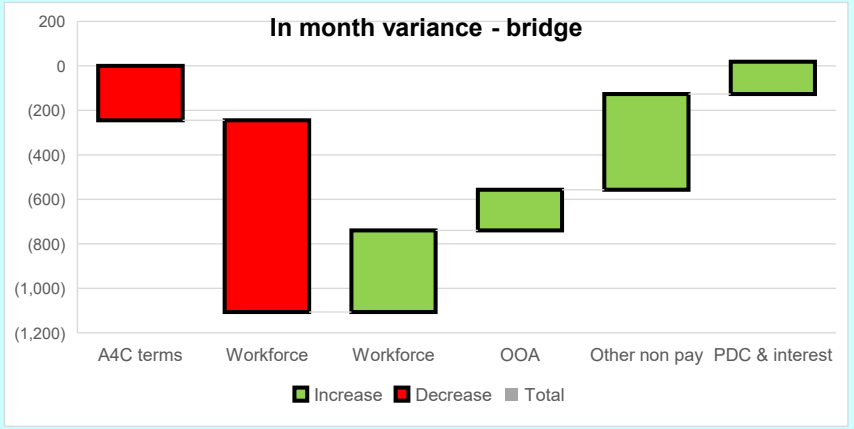
Total Financial Position - Core Trust only

	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
Description / Heading	**WTE**	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Healthcare contracts					25,862	25,544	(318)	151,890	151,434	(456)	302,738	300,350	(2,388)
Other Operating Revenue					1,275	1,331	56	7,556	7,786	230	14,920	15,482	563
Total Revenue					**27,137**	**26,875**	**(262)**	**159,445**	**159,220**	**(226)**	**317,658**	**315,833**	**(1,825)**
Employee expenses	5,372	5,394	22	0.4%	(25,651)	(26,390)	(740)	(153,747)	(156,121)	(2,374)	(305,649)	(312,148)	(6,499)
Operating expenses exc. Employee expenses					(1,150)	(536)	614	(7,386)	(4,478)	2,908	(13,221)	(10,316)	2,905
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,372**	**5,394**	**22**	**0.4%**	**(26,801)**	**(26,926)**	**(126)**	**(161,133)**	**(160,599)**	**534**	**(318,871)**	**(322,464)**	**(3,594)**
Operating Surplus / (Deficit)	**5,372**	**5,394**	**22**	**0.4%**	**336**	**(51)**	**(387)**	**(1,688)**	**(1,379)**	**308**	**(1,213)**	**(6,632)**	**(5,419)**
Finance expense					(56)	(57)	(1)	(336)	(354)	(17)	(673)	(676)	(3)
PDC Paid					(362)	(307)	55	(2,172)	(1,842)	330	(4,343)	(3,684)	659
Finance income					135	225	90	872	1,399	527	1,645	2,749	1,104
Surplus / (Deficit) - Total	**5,372**	**5,394**	**22**	**0.4%**	**53**	**(191)**	**(243)**	**(3,323)**	**(2,176)**	**1,147**	**(4,584)**	**(8,242)**	**(3,659)**
Depn Peppercorn Leases (IFRS16)					11	8	(3)	69	49	(20)	138	84	(54)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - ICB	**5,372**	**5,394**	**22**	**0.4%**	**64**	**(183)**	**(247)**	**(3,254)**	**(2,127)**	**1,127**	**(4,446)**	**(8,158)**	**(3,712)**

The Trust plan for 2026 / 27 is profiled with a deficit in the early part of the year and reducing as value for money schemes have an impact. The budget requirement for these schemes are held centrally until schemes are identified. At this stage the Trust (core) remains in a deficit position.

The key headlines, against these budget assumptions, are included below and illustrated within the bridge:

	£k
Workforce - Terms and conditions review following implementation of national Agenda for Change	(244)
Workforce - continued inpatient pressures (adult, older people, Forensics). Continued utilisation of more WTE than originally planned.	(863)
Workforce - continuation of utilisation of less staffing than plan. Support care group, Barnsley Physical Health & Wellbeing and Specialist	367
Non pay - Out of area placements have continued, despite significant operational pressures, to be maintained less than planned.	183
Non pay - underspend in month across a number of catagories including establishment and training	431
PDC (Public dividend capital) and interest - updated calculation for the year to date based on current capital profile and cash position	145

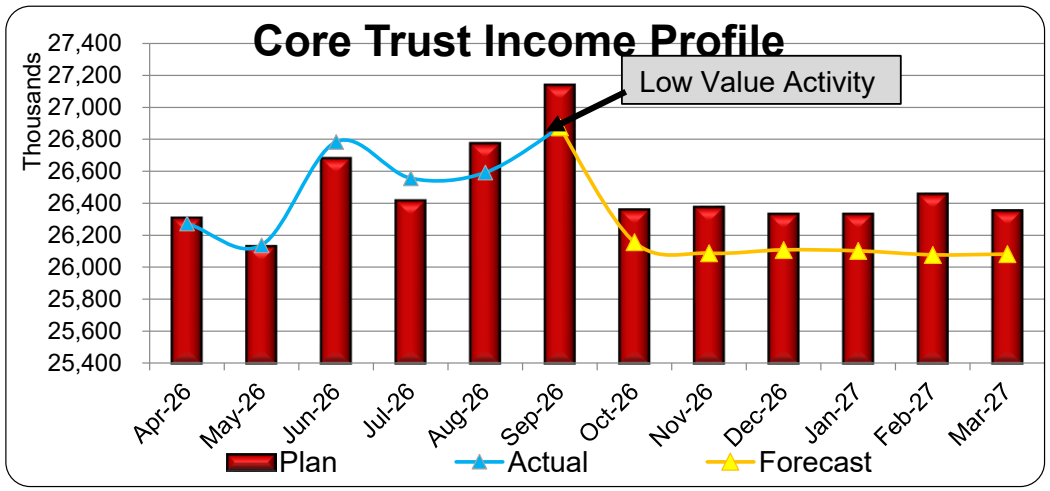


2.1 Income Information

The Trust receives income from it's commissioners in order to deliver healthcare services to meet the defined needs of the local population. The majority of this funding is in the form of an Aligned Incentive Contract (AIC) with a set value agreed (fixed / block contract value). As such this provides income stability, and financial certainty, to enable the Trust to plan effectively. This is amended to take account of any tariff changes (set nationally) and for agreed changes in service provision (investment and / or disinvestment).

The table below categorises total income received by commissioner type.

	This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
Description	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Trust (core)									
NHS Commissioners	24,293	24,359	66	142,664	142,656	(8)	284,460	284,242	(218)
Specialised Commissioning (NHS E)	670	393	(277)	3,892	3,681	(211)	7,148	6,015	(1,133)
Local Authorities	454	415	(39)	2,639	2,662	23	5,253	5,227	(26)
Partnerships	260	856	596	1,509	2,152	643	3,533	3,615	82
Other Healthcare income	112	157	44	754	559	(195)	1,478	1,100	(379)
Other non clinical income	1,347	695	(652)	7,988	7,510	(477)	15,784	15,633	(151)
Total - Trust core income	**27,137**	**26,875**	**(262)**	**159,445**	**159,220**	**(226)**	**317,658**	**315,833**	**(1,825)**
Provider Collaboratives	9,754	10,529	775	58,523	59,585	1,061	117,046	118,423	1,376
Budgets held centrally	111	65	(46)	349	460	111	955	850	(105)
Total - Consolidated income	**37,001**	**37,469**	**467**	**218,318**	**219,265**	**947**	**435,659**	**435,106**	**(554)**



Risks and opportunities

Although the majority of income is fixed in nature, and aligned with contracts and budgets, there are a limited number of variances.

Income has increased in month, as planned, relating to the receipt of low value activity income. These values are calculated nationally.

These forecast variances are often offset by corresponding reductions in pay and non pay.

* Additional roles reimbursement £320k

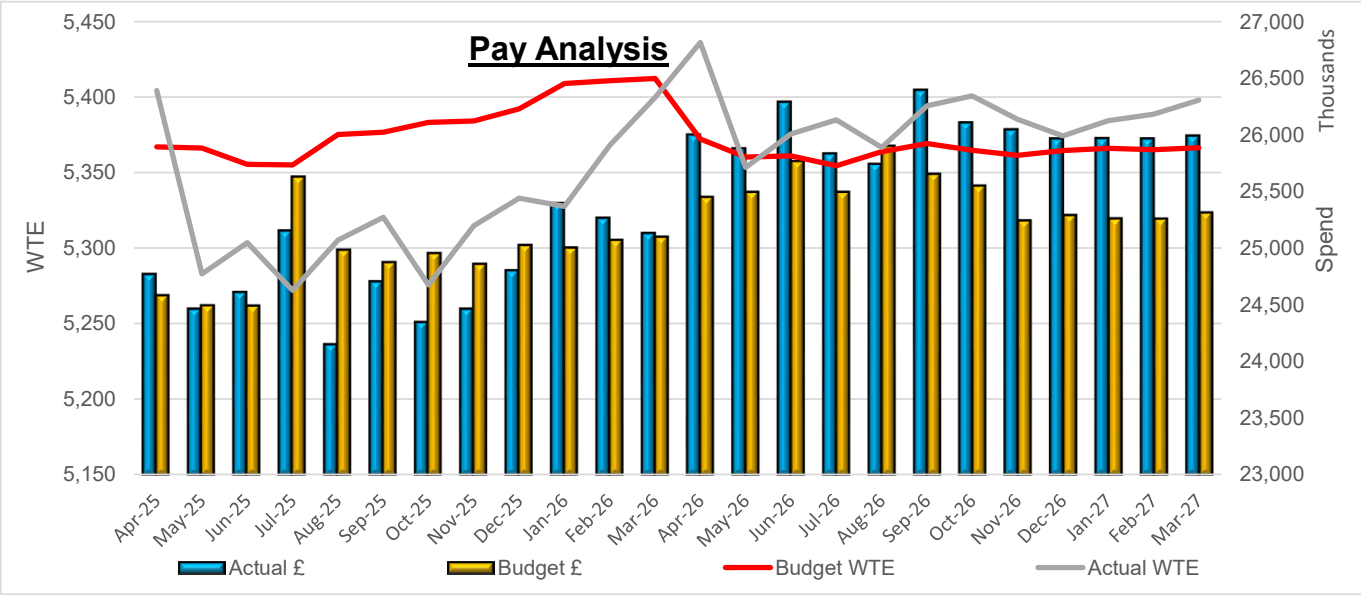
The other main variance relates to income relating to activity within provider collaboratives and Cheswold Park Hospital.

2.2 Pay Information

Our workforce is our greatest asset; ensuring that we have the right staff, with the right skills available at the right place and time in order to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Provider Collaboratives). Trust priorities include a focus on the health and wellbeing of this workforce.

Current expenditure patterns highlight the usage of temporary staff (through either internal sources such as Trust bank or through external agencies). Actions are focussed on providing the most cost effective workforce solution to meet the service needs.

	In month		Year to Date	Forecast		Movement since last month	
Description	**Worked WTE**	**£k**	**£k**	**Worked WTE**	**£k**	**Worked WTE**	**£k**
Substantive	4,933	24,201	143,810	5,038	289,439	(3)	388
Bank & locum	452	2,024	11,444	354	20,864	29	229
Agency	9	165	867	6	1,846	2	33
Total	**5,394**	**26,390**	**156,121**	**5,398**	**312,148**	**28**	**650**
Budget	**5,372**	**25,651**	**153,747**	**5,367**	**305,649**	**5**	**(249)**
Over / (Under)	**22**	**740**	**2,374**	**31**	**6,499**	**22**	**899**



The table to the left, and graph below, show the breakdown of Trust pay expenditure.

As shown by the grey line, worked WTE has continued to fluctate month on month. There has been an increase in September which is primarily bank and locum WTE.

There has been a small increase in agency staff as well which continues to be medical staff.

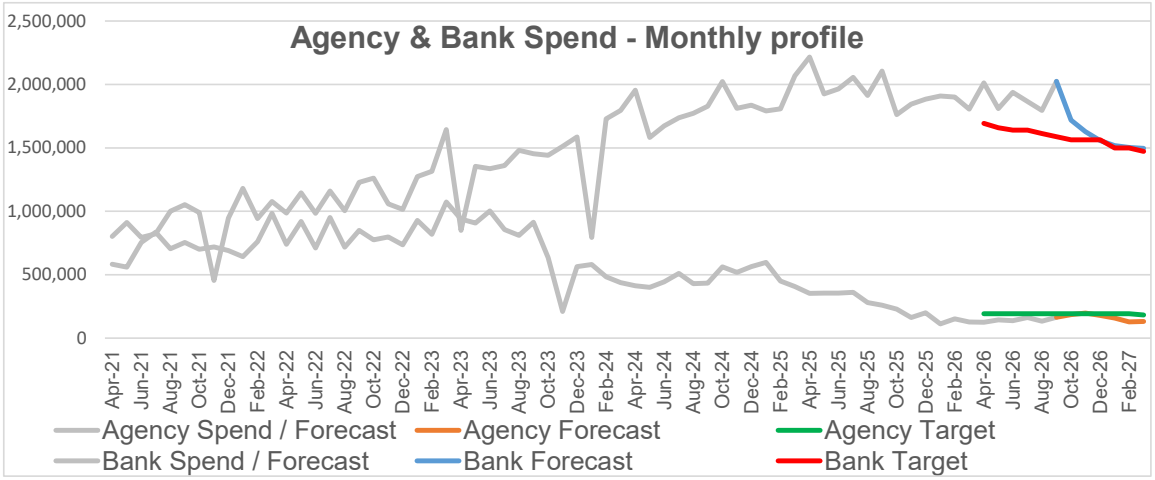
The forecast continues to be validated each month. Overall there is a net forecast increase of 4 WTE by March 2027 which is less than previous months. However there remains a stepped change from bank to substantive within this position which continues to be reviewed.

2.2 Temporary Staffing Focus

Trust spend in September 2026:
Agency £165k
Bank £2,024k

We continue to acknowledge that temporary staffing solutions continue to play an important role in the overall workforce strategy of the Trust. However this must fit within the overall context of ensuring the best possible use of resources and value for money whilst ensuring that operational pressures are effectively managed.

The focus has expanded from solely agency staff to total temporary staffing costs especially those which are paid a premium rate when compared to those paid under normal terms and conditions. This includes agency staff, Trust bank staff and also enhanced payments made to substantive Trust staff for additional hours.



Temporary Staff costs to date - by category			
Category	**Agency**	**Bank**	**Total**
	£k	**£k**	**£k**
Consultant	527	177	**704**
Other Medical	340	344	**684**
Reg Nursing	(0)	3,490	**3,490**
UnReg Nursing	0	6,846	**6,846**
Other Clinical	0	284	**284**
A & C	0	303	**303**
Other	0	0	**0**
Total	**867**	**11,444**	**12,311**
Lead Provider Collaborative		3	**3**
Budgets held centrally	(3)	0	**(3)**
Total	**864**	**11,446**	**12,310**

In line with national guidance the Trust financial plan for 2026 / 27 included spend reduction targets; c. 30% reduction in agency and 15% reduction in bank. Further reductions are required for future financial years. The target levels of expenditure per month are shown in the graph above. Delivery against these targets is monitored as part of the NHS Oversight Framework (NOF) alongside existing NHS England oversight.

Performance measurement of these targets is based upon total consolidated agency and bank expenditure and are reported as part of the Trust value for money programme and as overall key financial performance indicators (KPI). These are considered as absolute values and not in the context of other pay expenditure movements.

As shown above agency spend has been maintained at a low level. The average run rate is £144k per month. This continues to be solely on medical staffing. The current forecast remains that the target can be achieved.

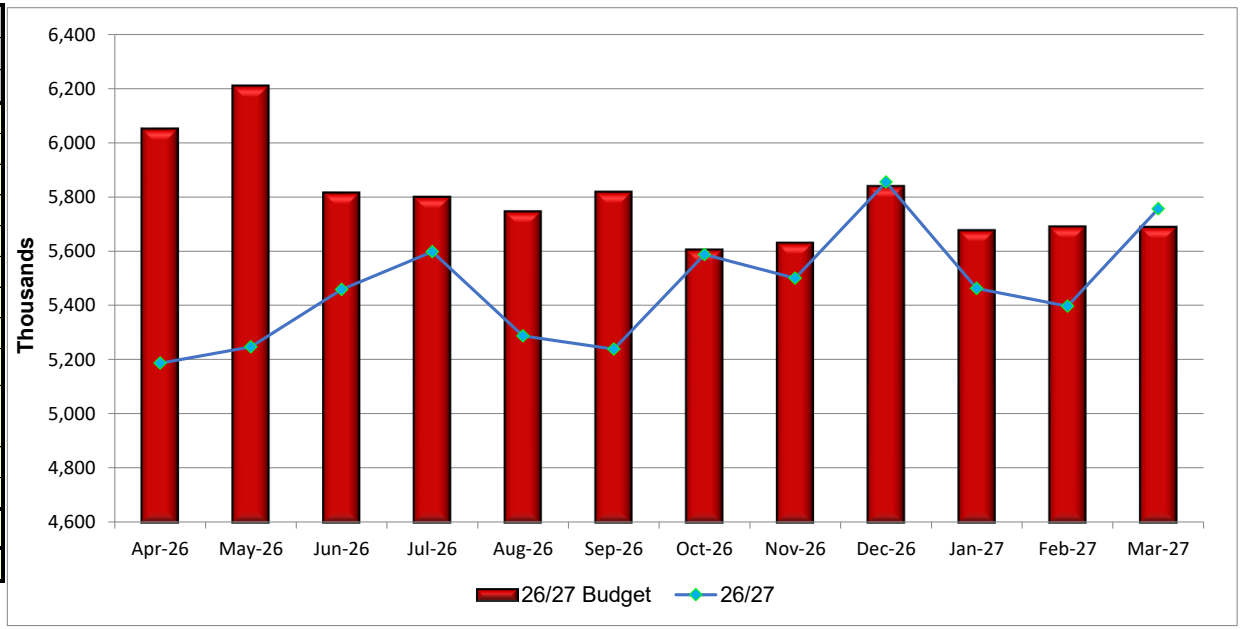
Bank spend has continued to fluctuate. Following two months of reductions this has increased by £229k in September. The average monthly run rate is £1,907k and, based on that, we will exceed the expenditure target for 2026 / 27. The increase in month is within medical staffing, registered and unregistered nurses and is mainly within adult inpatients. Utilisation continues to be monitored through the Trust temporary staffing group and is currently undergoing a series of ward specific deep dives.

2.3 Non Pay Expenditure

Whilst pay expenditure is the majority of Trust costs, non pay expenditure also presents a number of key financial challenges. This analysis focuses on non pay expenditure within the care groups and corporate services, To re-confirm that this presentation excludes non pay expenditure relating to the provider collaboratives and budgets held centrally.

Non pay spend	Apr-26 £k	May-26 £k	Jun-26 £k	Jul-26 £k	Aug-26 £k	Sep-26 £k	Oct-26 £k	Nov-26 £k	Dec-26 £k	Jan-27 £k	Feb-27 £k	Mar-27 £k	Total £k
2026 / 27	5,186	5,246	5,458	5,598	5,287	5,238	5,588	5,500	5,855	5,462	5,397	5,756	**65,571**
2025 / 26	4,754	4,656	4,507	4,812	4,475	4,802	5,002	4,795	4,511	4,633	5,023	5,833	**57,805**

Non Pay Category (per accounts)	Budget Year to date £k	Actual Year to date £k	Variance £k
Drugs	2,367	2,262	(105)
Establishment	5,405	4,644	(761)
Lease & Property Rental	4,389	4,399	10
Premises (inc. rates)	2,931	2,931	0
Utilities	1,442	1,254	(188)
Purchase of Healthcare	3,917	2,884	(1,033)
Travel & vehicles	3,056	2,924	(131)
Supplies & Services	4,498	4,436	(62)
Training & Education	718	460	(258)
Clinical Negligence & Insurance	725	715	(10)
Capital Charges Depn, PDC,	5,193	4,375	(818)
Other non pay	804	729	(74)
Total	**35,444**	**32,013**	**(3,431)**
Total Excl OOA and Drugs	**29,160**	**26,867**	**(2,293)**



Key Messages

Non pay expenditure, being less than plan, continues to support the overall Trust financial position and, as shown by the graph above, continues to fluctuate by month. There has been a reduction from August to September 2026.

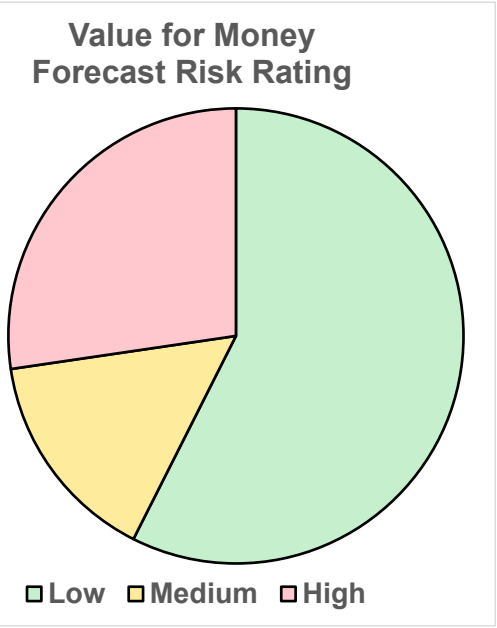
The largest reduction is on the purchase of healthcare and the next can be catagorised as Estates related (leases, utilities etc).

3.0 Value for Money & Financial sustainability

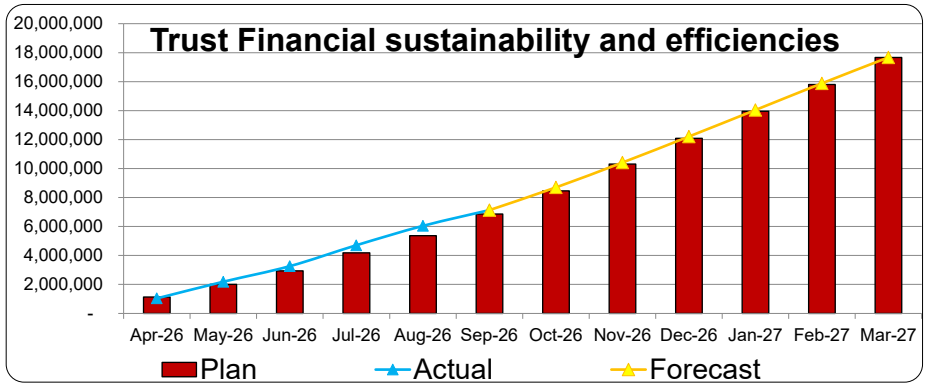
The Trust financial plan includes a requirement to demonstrate financial sustainability and efficiency in order to achieve the financial target. This is both the current financial year and as part of the longer term financial plan where continual savings are required to safeguard long term financial sustainability. For 2025 / 26 the value included in the plan was £17.7m. Additional mitigations will be required if the Trust run rate varies from plan.

This links closely with the Trust priority to improve the use of resources with a continual strive to ensure that services provide value for money and the best possible use of resources.

		Year to Date				Forecast				
Group	Key lines of enquiry	Target £k	Achieved Recurrent £k	Achieved Non Recurrent £k	Variance £k	Revised Target £k	Low £k	Medium £k	High £k	Variance £k
Pay	Workforce	480	657	171	349	3,689	829	971	4,830	2,941
	Temporary Staffing	2,771	1,821	0	(949)	4,412	1,821	1,605		(986)
	Corporate Pay	996	193	1,833	1,030	1,991	3,592			1,601
	Productivity	240	0	0	(240)	1,400				(1,400)
	Difficult Decisions	450	67	0	(383)	2,138	155			(1,983)
Non Pay	Non Pay	48	50	5	7	248	100			(148)
	Drugs optimisation	108	0	0	(108)	220	0	0		(220)
	Digitial optimisation	18	150	5	137	35	310			275
	Out of Area placements	180	871	0	691	357	871	0		514
	Difficult Decisions	0	58	0	58	0	139			139
	Non pay - establishment	102	18	12	(72)	265	35	25		(205)
Other	Provider Collaboratives	1,080	1,080	0	0	2,160	2,160			0
	Bed Sales	0	0	0	0	0				0
	Income	384	57	83	(244)	760	140	91		(528)
	Misc income - overage	0	0	0	0	0				0
Total		**6,857**	**5,022**	**2,110**	**275**	**17,675**	**10,153**	**2,693**	**4,830**	**(0)**
Recurrent		6,479	5,022		(1,457)	16,925	6,440	2,693	0	(7,792)
Non Recurrent		378		2,110	1,732	750	3,713	0	4,830	7,792



LOW	On track for delivery: The scheme is on track, savings are being realised according to the plan, and there are no significant risks to the budget.
MEDIUM	There are risks or minor delays in achieving savings. The scheme requires management attention but is generally considered resolvable. Cost overruns or timing of delivery risks.
HIGH	The scheme is failing to meet its financial targets. It is likely to be significantly over budget or fail to deliver the required savings within the timescale agreed. Or the scheme is not yet scoped.



The phasing of the Trust Value for Money schemes is set c. £1m per month for the first half of the financial year, and £1.8m in the second half as schemes progress. At the end of September 2026 / month 6 £7,132k has been reported. This is £275k ahead of plan.

The two largest drivers of this positive position continues to relate to corporate pay savings and reduced out of area placements. These are forecast to be maintained.

Development of schemes profiled later in the year continue. At this stage the largest risk relates to productivity and difficult decision schemes and a mitigation will be required for these should they fail to deliver in line with target. This is currently highlighted as red against workforce schemes.

4.0 Statement of Financial Position (SOFP) 2026 / 27

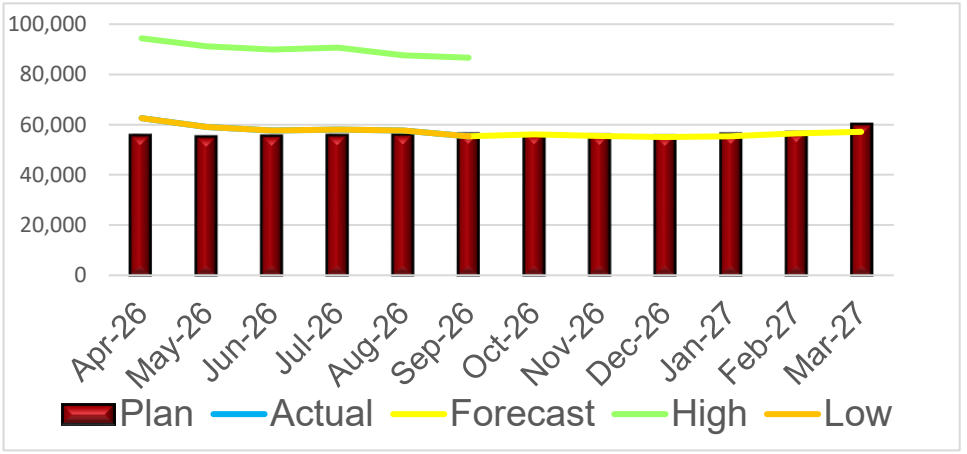
Whilst the focus is traditionally on the Trust income and expenditure position, the Statement of Financial Position (SOFP - balance sheet) presents a key snapshot of the Trusts overall financial health, stability and can provide important early warning flags of potential financial issues.

The balance sheet shows that the Trust owns (assets) and what it owes (liaiblities).

Balance Sheet / Statement of Financial Position (SOFP)	Current £k	Note
Assets		
Non-Current (Fixed) Assets	188,539	Pg 13
Inventories & Work in Progress	209	
Trade receivables (Debtors)	2,085	
Accrued Income	5,786	Pg 14
Prepayments	5,166	
Cash and Cash Equivalents	55,324	
Total Assets	**257,110**	
Liabilities		
Payables (Creditors)	(13,665)	
Accruals	(19,699)	
Deferred Income	(2,177)	Pg 14
Provisions	(3,271)	
IFRS 16 / leases liabilities	(43,708)	
Total Liabilities	**(82,521)**	
Total Net Assets/(Liabilities)	**174,589**	
Taxpayers' Equity		
Public Dividend Capital	(79,119)	
Revaluation Reserve	(12,067)	
Other Reserves	(5,220)	
Income & Expenditure Reserve	(78,182)	
Total Taxpayers' Equity	**(174,589)**	

Non Current (Fixed assets): The value of Trust assets is impacted by additional capital purchases and disposals (page 13), reduced by the impact of depreciation and amortisation and annual revaluation exercises.

Cash: The Trust cash position is shown below. The graph shows the position at the end of each month and also the highest / lowest cash point during that month. This is monitored to highlight any risk or opportunity. Actual cash is £55.3m which, for the first month, is less than plan linked to the accrued income position.

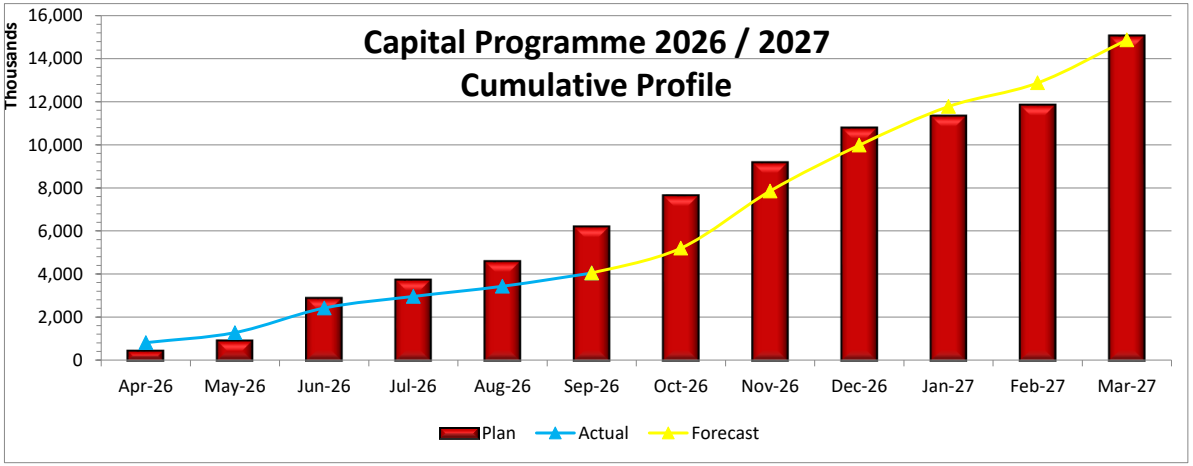


Overall the Trust balance sheet remains strong with assets greater than liabilities.

The taxpayers equity section, similar to shareholders equity, illustrates that Trust funding is entirely from public taxation.

4.1 Capital Programme 2026 / 27

Capital schemes	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Annual Budget £k	2026 / 27 Outturn £k	Variance £k
Major Capital Schemes						
Older People Transformation	2,610	438	(2,172)	5,428	4,018	(1,410)
IM & T - Digital Infrastructure	500	398	(102)	1,650	1,275	(375)
IM & T - Cyber Security	150	0	(150)	250	250	0
IM & T - Digital Care Records	96	0	(96)	200	200	0
IM & T - Digital Information Sharing	50	0	(50)	100	100	0
IM & T - Digital Insights	0	0	0	200	200	0
IM & T - Digitally Empowered Workforce	50	0	(50)	100	100	0
Net Zero Carbon	0	1,774	1,774	0	1,916	1,916
Critical risk	0	15	15	0	126	126
Equipment Replacement	0	0	0	0	10	10
Other	0	(553)	(553)	0	(277)	(277)
Leases (IFRS 16)	1,552	1,861	309	3,011	2,830	(181)
TOTALS	**5,008**	**3,933**	**(1,075)**	**10,939**	**10,748**	**(191)**
Additional allocations						
Cheswold	1,210	109	(1,101)	3,000	3,000	0
Community hub	0	0	0	750	750	0
Additional IM & T	0	0	0	375	375	0
Additional revenue incentive						
TOTALS	**6,218**	**4,042**	**(2,176)**	**15,064**	**14,873**	**(191)**
Expenditure outside allocations						
Intra NHS Leases (IFRS 16)	1,442	1,251	(191)	1,442	1,251	(191)
TOTALS - AFTER EXCLUSION	**4,776**	**2,791**	**(1,985)**	**13,622**	**13,622**	**(0)**



Capital Expenditure 2026 / 27

The table, left, summarises the Trust capital programme for 2026 / 27. This is split between the Trust core capital allocation and additional allocations which have been secured. There has been no additional funding since last month.

The main scheme relates to the development of inpatient older people services. We continue to work with partners to finalise a value and profile. This is currently expected October 2026 and will be subject to Trust Board approval.

This is later than planned and is currently £1.7m behind plan. The forecast will continue to be revisited and mitigation plans are being prepared to ensure that capital allocations are appropriately utilised across a number of financial years.

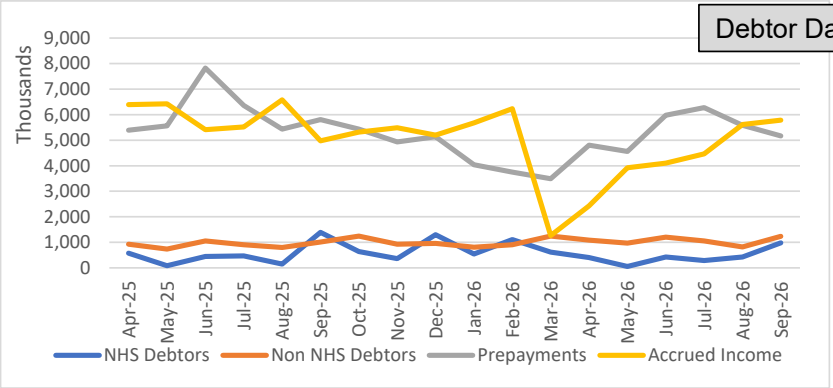
The net zero carbon / solar panel scheme, for which funding was received in 2025 / 26, is forecast to complete in October 2026.

The other category includes VAT reclaims for previous capital schemes.

4.2 Balance sheet analysis

The presentation of this data, and supporting narrative, has been revised in order to enhance the awareness of potential future risk areas and the actions being taken to manage them.

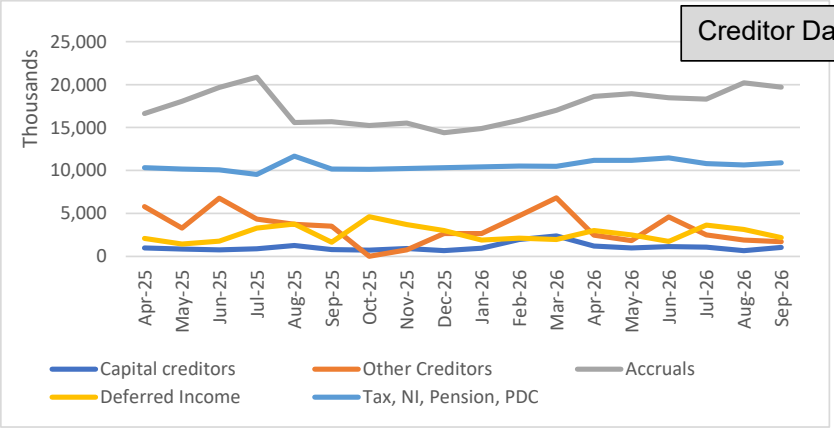
Debtors: A debtor is an individual or company who owes money to the Trust for services provided. This directly impacts on cashflow. The action is to minimise these balances as far as possible and ensure that debts are recovered in a timely manner. Both the value and age is shown below.



Debtors	Not Due £k	1 - 30 days £k	31 - 60 days £k	61 + days £k	Total £k
NHS	692	124	147	14	977
Non NHS	631	48	(5)	294	968
Total	**1,324**	**172**	**142**	**308**	**1,945**

Accrued income have continued to rise. Each line has been individually reviewed to ensure that appropriate actions are being taken. This includes raising quarterly invoices and discussions with commissioners to ensure that cash is flowing for agreed funding.

Creditors: The risk flag is when creditors are increasing, both value and timing, meaning that we are not paying Trust suppliers in a timely manner. This will temporarily increase the cash position. This can be triangulated with Better Payment Practice Code (BPPC) performance which shows the percentage of suppliers paid within 30 days.



Creditors	Not Due £k	1 - 30 days £k	31 - 60 days £k	61 + days £k	Total £k
NHS	444	36	92	192	764
Non NHS	1,086	420	233	283	2,021
Total	**1,530**	**456**	**325**	**475**	**2,785**

Overall levels have been maintained.

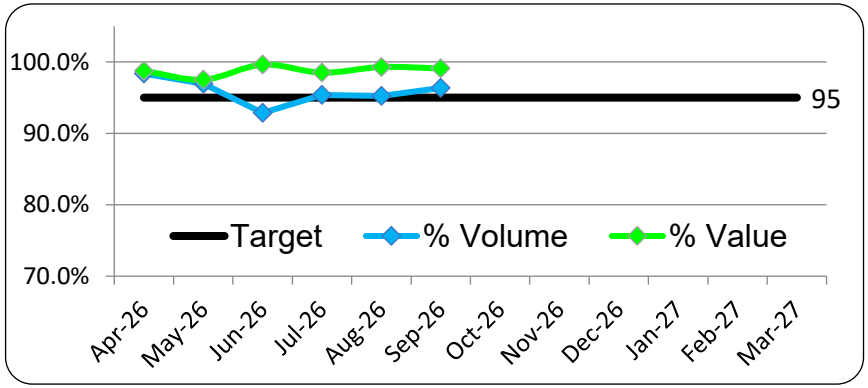
5.0 Better Payment Practice Code

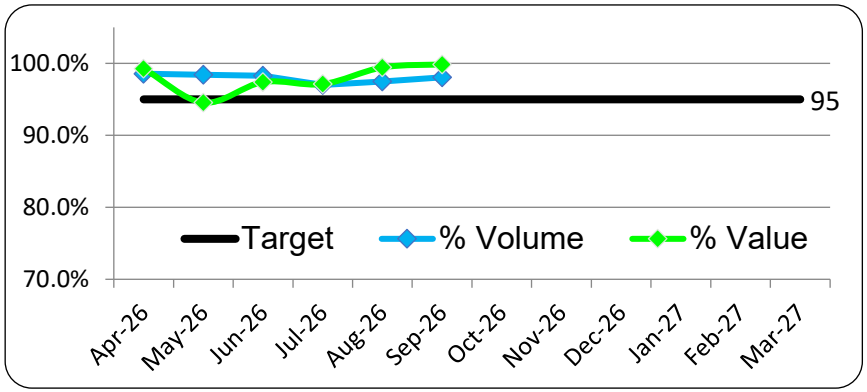
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

Performance continues to be positive although work continues to ensure that no issues remain outstanding and that systems work efficiently.

NHS	Number %	Value %
In Month	96%	99%
Cumulative Year to Date	96%	99%

Non NHS	Number %	Value %
In Month	98%	100%
Cumulative Year to Date	98%	98%





"

5.1 Transparency Disclosure

As part of the Government's commitment to greater transparency on how public funds are used the Trust makes a monthly Transparency Disclosure highlighting expenditure greater than £25,000 (including VAT where applicable).

This is for non-pay expenditure; however, organisations can exclude any information that would not be disclosed under a Freedom of Information request as being Commercial in Confidence or information which is personally sensitive.

At the current time NHS Improvement has not mandated that Foundation Trusts disclose this information but the Trust has decided to comply with the request.

The transparency information for the current month is shown in the table below.

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
08-Sep-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1008154	700,396
12-Sep-26	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	2000033984	698,025
24-Sep-26	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	207231	670,994
12-Sep-26	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	2000033985	656,909
19-Sep-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS74	400,000
02-Sep-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510011535	391,192
01-Sep-26	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000002512	346,580
21-Sep-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS51	240,000
07-Sep-26	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HONHSLS321	231,566
11-Sep-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC052INV	205,322
08-Sep-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34081070	147,527
10-Sep-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS072INV	141,868
08-Sep-26	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400004898	136,217
17-Sep-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34081824	120,000
02-Sep-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510011531	118,127
03-Sep-26	IT Services	Trustwide	Wavenet Ltd	1595262	108,300
16-Sep-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34080937	91,531
23-Sep-26	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400012613	77,894
25-Sep-26	NHS Recharge	Kirklees	Mid Yorkshire Hospitals NHS Trust	1600041658	77,269
01-Sep-26	Vaccines	Trustwide	Aventis Pharma T/A Sanofi	931771950	68,633
08-Sep-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1008153	68,231
10-Sep-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS072SN	67,846
17-Sep-26	Lease Cars	Trustwide	Athlon Mobility Services Uk Ltd	202680027652	67,065
29-Sep-26	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trust	333933	66,984
03-Sep-26	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400004891	64,727
14-Sep-26	Rent	Barnsley	Dr A D Mellor And Partners	400003	63,586
30-Sep-26	Drugs	Trustwide	Rowlands Pharmacy	1800007099	63,570
23-Sep-26	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400012613	61,630
23-Sep-26	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400012613	52,105
07-Sep-26	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000002513	50,517
30-Sep-26	Purchase of Healthcare	Forensics	Sheffield Childrens NHS Foundation Trust	2400012821	48,819
22-Sep-26	Purchase of Healthcare	Kirklees	Northumbria University	1047062	46,000

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
23-Sep-26	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400012613	44,854
14-Sep-26	Drugs	Trustwide	NHS Business Services Authority	1000089235	43,076
25-Sep-26	Purchase of Healthcare	Kirklees	Invictus Wellbeing Services Cic	676	42,433
04-Sep-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001633EPC	41,813
16-Sep-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34080243	41,321
08-Sep-26	Purchase of Healthcare	Trustwide	Bradford District Care NHS Foundation Trust	206999	38,836
08-Sep-26	Purchase of Healthcare	Forensics	Humber Teaching NHS Foundation Trust	59898974	37,014
16-Sep-26	NHS Recharge	Barnsley	Barnsley Hospital NHS Foundation Trust	6030022	35,377
01-Sep-26	Rent	Kirklees	Bradbury Investments Ltd	20000	32,589
01-Sep-26	Purchase of Healthcare	Trustwide	Priory Group Ltd	3900022139	31,682
07-Sep-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC035DINV	30,000
09-Sep-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D5100115351	29,512
29-Sep-26	Purchase of Healthcare	Forensics	Change Grow Live	IN17915	28,974
08-Sep-26	Continence Products	Barnsley	Supply Chain Coordination Limited	328585	27,888
27-Sep-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59899042	26,259
28-Sep-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59899040	26,259
28-Sep-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59899041	26,259
28-Sep-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59899043	26,259
23-Sep-26	Computer Software / Licenc	Trustwide	Bionical Solutions Ltd	9340	25,725

5.2 Glossary

* Recurrent - an action or decision that has a continuing financial effect.

* Non-Recurrent - an action or decision that has a one off or time limited effect.

* Full Year Effect (FYE) - quantification of the effect of an action, decision, or event for a full financial year.

* Part Year Effect (PYE) - quantification of the effect of an action, decision, or event for the financial year concerned. So if a post / new investment were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year.

* Surplus - Trust income is greater than costs.

* Deficit - Trust costs are greater than income.

* Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.

* Forecast Surplus / Deficit - This is the surplus or deficit we expect to make for the financial year.

* Target Surplus / Deficit - This is the surplus or deficit the Board said it wanted to achieve for the year (including non-recurrent actions). This is set in advance of the year and before all variables are known.

* Value for Money / Cost Savings - The Trust priority of Value For Money is intrinsically linked to the ability to maintain financial sustainability. In addition to value for money this are also called savings, efficiencies, and Cost Improvement Programmes (CIP). In each case this is the identification of schemes to increase efficiency, reduce expenditure or increase income.

* CDEL - Capital Departmental Expenditure Limit. This refers to the amount of capital set by Her Majesty's Treasury each year which the whole of the NHS must remain within for capital expenditure.

* ICS - Integrated Care System. ICB - Integrated Care Board.

* EBITDA - earnings before interest, tax, depreciation and amortisation. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of it's services.

Appendix 2 - Statistical Process Control (SPC) Charts Explained

Variation/Performance Icons			
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

Assurance Icons			
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix 2 - Statistical Process Control (SPC) Charts Explained

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: (none)
H	**Excellent** — Celebrate and Learn • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** — Celebrate and Understand • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — Celebrate but Take Action • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** — Celebrate • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent** — Celebrate and Learn • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** — Celebrate and Understand • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — Celebrate but Take Action • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** — Celebrate • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
(none)	**Good** — Celebrate and Understand • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** — Investigate and Understand • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — Investigate and Take Action • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average** — Understand • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H	**Concerning** — Investigate and Understand • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** — Investigate • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.
L	**Concerning** — Investigate and Understand • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** — Investigate • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
↗				**Unsure** — Investigate and Understand • This metric is showing a statistically significant variation. • There has been a one off event above the upper process limits; a continued upward trend or shift above the mean. • There is no target set for this metric.
↘				**Unsure** — Investigate and Understand • This metric is showing a statistically significant variation. • There has been a one off event below the lower process limits; a continued downward trend or shift below the mean. • There is no target set for this metric.
(none)				**Unknown** — Watch and Learn • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 11.2

Private/Public paper:	**Public**		
Title:	**CAMHS Care Group Performance Report**		
Lead Director:	**Adele Fox - Chief Operating Officer**		
Mission/values:	Supports the Trust mission and values through oversight of safe, effective, person-centred and equitable care for children and young people, with explicit focus on access, workforce sustainability, patient safety and reducing inequalities.		
Purpose:	To provide the Board with assurance on Children and Young People Mental Health (C&YPMH) Care Group performance as at August 2026; highlight material risks and variation; and set out the actions requiring continued executive oversight.		
Strategic aims:	Live Our Values - Yes	✓	Maintains focus on reducing long waits, improving access and addressing inequalities across four Places.
	Be the best we can be - Yes	✓ ✓ ✓ ✓	
	Be ambitious - Yes	✓	
BAF Risk(s):	Relevant operational, quality, workforce, finance, access and health inequality risks. The source report does not specify the applicable Board Assurance Framework risk number or whether the score changes; this should be confirmed before submission.		
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 performance position supports partnership objectives across Barnsley, Calderdale, Kirklees and Wakefield, including timely access, eating-disorder standards, neurodevelopmental pathways, crisis response, and equitable access. Several issues require system action, particularly neurodevelopmental demand and capacity, recruitment in crisis and secure services, and pathway equity.		
Any background papers / previously considered by:	The source document records that the CAMHS Patient Experience Survey was presented to the Children and Young People's Mental Health Service Clinical Governance Group in September 2026.		

With **all of us** in mind.

Executive summary:	Overall, the August 2026 position provides mixed assurance. There is clear evidence of improvement and operational grip across several workforce, access and quality measures. Appraisal compliance reached 92.9%; staff turnover was 9.4% and registered nurse turnover 6.3%, both below threshold. Reducing Restrictive Practice Interventions training was 91.7%, above the 80% threshold, and cardiopulmonary resuscitation training was 84.5%, also above the 80% target. Information governance training was marginally below target in August at 94.1% against 95% but subsequently improved to 95.6% in September. Sickness was 5.2%, slightly above the 5% threshold, with Wakefield at 7.4% remaining the principal area of concern. Access performance shows important improvement. The target that at least 75% of children and young people commence treatment within 18 weeks has been achieved for seven consecutive months, evidencing sustained improvement after a QI process was introduced. Crisis performance was reported as having no actual breaches in Calderdale and Kirklees. Routine eating-disorder access achieved 95.3% against the 95% national standard and urgent eating-disorder access was below standard at 85.7% against 95%, although this represented six of seven cases and the single breach followed a family-cancelled appointment. The most significant challenge remains with neurodevelopmental access. At the end of August, Calderdale had 461 children and young people waiting, with an average wait of 484 days and a longest wait of 831 days. Kirklees had 2,284 waiting, with an average wait of 681 days and a longest wait of 1,306 days. There continues to be partnership focus to identity alternative ways of working to improve access. Core CAMHS waits also vary slightly: average waits were 90 days in Barnsley, 124 in Calderdale, 164 in Kirklees and 39 in Wakefield. Quality and safety governance is established, with a waiting well procedure in place to support families while waiting, but continued oversight is required. Fifty-five incidents were reported in August: 1 red, 19 yellow and 35 green. The most frequently reported themes were safeguarding children (16), care pathway (12), self-harm (8) and information governance (4). Incidents are reviewed through weekly Patient Safety Oversight Group and related governance arrangements. Patient-experience feedback was positive where received, but coverage was limited: 97 Friends and Family Test responses were received in Quarter 1, only 52% of registered teams received feedback, and 21% received ten or more responses. Financial and workforce pressures remain. Agency costs are forecast at £441k for the year, largely covering a vacant consultant psychiatry role in Kirklees, and bank spend was £134k to the end of August, with a full-year forecast of £275k. Wakefield bank usage is expected to continue while services remain in business continuity and on the risk register. Recruitment difficulties in crisis services and Secure CAMHS, particularly Band 5 and Band

	6 roles at Wetherby Young Offenders Institution and Adel Beck, continue to drive reliance on bank staff. Inequalities analysis requires further development before firm conclusions are drawn. The report identifies over-representation of White and Mixed ethnic groups and under-representation of Asian groups in referrals, while deprivation data shows approximately 45% of referrals from Quintile 1 but under-representation of Quintile 2 and over-representation of Quintiles 4 and 5. The population comparators are not age-adjusted therefore more granular Place-level analysis is required. In summary, performance is improving in important areas and there is active management and oversight, however there remains some areas of challenge due to the of scale of neurodevelopmental waits, sickness and business-continuity pressures in Wakefield, medical and specialist nursing vacancies, limited resilience in urgent eating-disorder performance. There is senior oversight and support to improvement these areas and support services.
Recommendation:	**Trust Board members are asked to:** **NOTE** the overall CAMHS performance position and the areas of sustained improvement and challenges.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Children and Adolescent Mental Health Services (CAMHS) Care Group



August 2026

With **all of us** in mind.

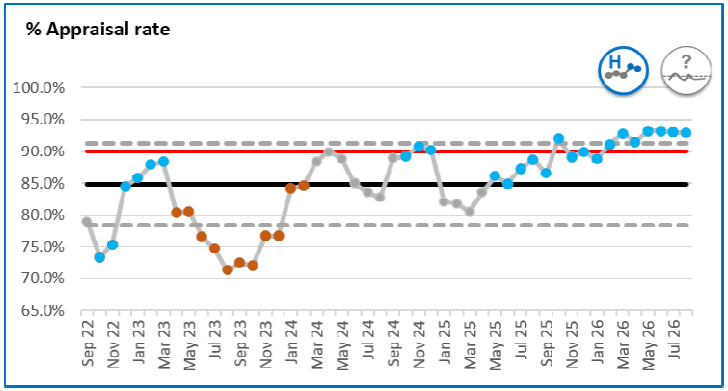
Children and Adolescent Mental Health Services (CAMHS)

The Children and Young People's Care Group provides Child and Adolescent Mental Health Services (C&YPMH) in Barnsley, Calderdale, Kirklees and Wakefield. The Care Group also provides a CAHMS Secure Service for Children and Young People across 3 settings in Wetherby Sheffield and Leeds i.e. Wetherby Young Offenders Institute, Adel Beck Secure Residential Home in Leeds and Aldine Secure Children's Home (in Sheffield) C &YPMH offers support and treatment for children and young people, aged up to 18 years (and up to 25 for children with Special Educational Needs and Disabilities) who are experiencing difficulties with their mental health and wellbeing and also support the parents, carers and families of these children and young people.

Whilst there are some differences in the C&YPMH offer in each place the services typically support children and young people with feelings of low mood or depression; obsessive thoughts and behaviours; anxiety issues; eating disorders; self-harm and thoughts of hurting themselves and /or suicidal thoughts. Support includes individual and group therapies (such as cognitive behaviour and play therapy), medication and urgent support when an immediate mental health risk is present. Calderdale and Kirklees C&YPMH lead on delivery of the neuro-developmental pathway, diagnosing autism and ADHD. Barnsley C&YPMH is responsible for ADHD diagnosis. Wakefield and Kirklees C&YPMH are the lead providers of the mental health support teams, which provide school-based support for children and young people with low to moderate mental health needs.

Workforce

Appraisals



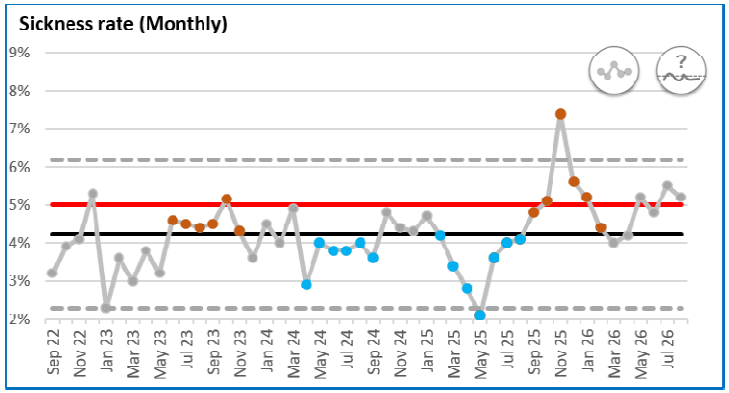
Insights

The appraisals continue to see an improvement since March 2025 with CYPMH achieving 92.9% of appraisals completed within 12 months for August 2026.

The Trust moved to an appraisal window this year and work has underway complete appraisals before the end of the appraisal window at the end of September. Focussed work is ongoing to ensure appraisals are recorded correctly and are completed within the window.

Performance information is examined at team level during the weekly Performance and Quality meeting led by the Associate Director, with the General Managers and Governance and Quality Leads. This has resulted in a marked improvement in the undertaking and recording of appraisals with a focus on continued and sustained improvement. There are specific plans at team level to ensure appraisals are completed.

Sickness



Insights

August 2026 sickness rate for the care group was 5.2% and over the 5% threshold. Trust sickness was 5.7%.

The decrease in August 26 is predominantly due to an decrease in sickness in Barnsley (1.5%) Wakefield (7.4%) and Secure CAMHS (4.7%). There was a slight increase in Calderdale & Kirklees CAMHS (4.8%) but only Wakefield CAMHS remains above threshold. This is due to both long term and short term sickness with themes of mental illness, pregnancy related illness and an increase in seasonal cold/cough/flu and gastric infections.

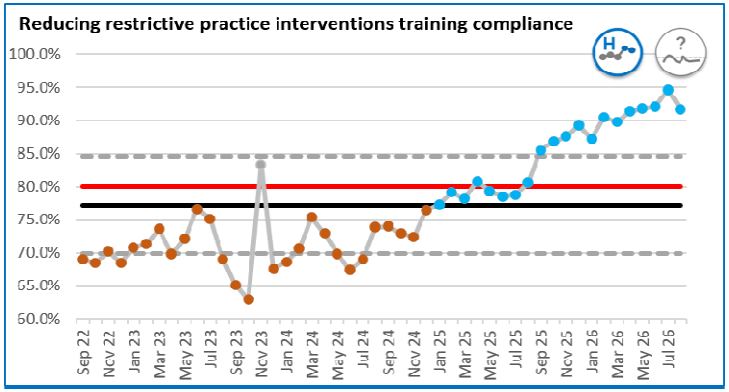
Managers are supported by People Directorate colleagues to actively manage long term sickness and timely referrals to occupational health are made.

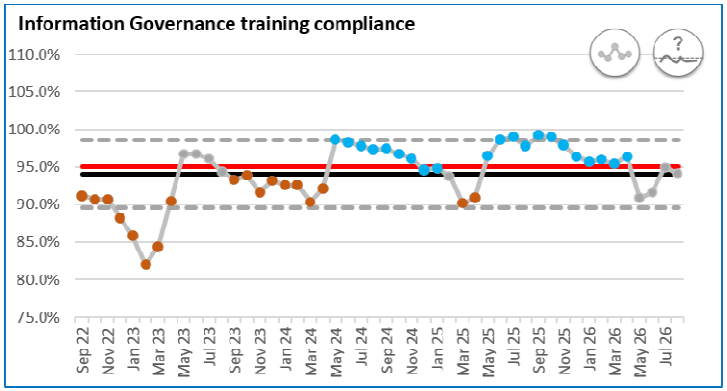
There is a continued focus on staff wellbeing within the care group . Team managers continue to implement the care group's wellbeing plan which includes local workplace improvements and the benefits of flexible working arrangements across community settings

Children and Adolescent Mental Health Services (CAMHS)

Workforce

Mandatory Training





Insights

In August 2026 performance for reducing restrictive practice interventions training for C&YPMH stands at 91.7% above the threshold of 80%.

The improvement in compliance in Barnsley and Calderdale and Kirklees is being supported by courses being made available at community bases with support from operational managers around booking and allocation of places. This approach has been beneficial in ensuring attendance to capacity and supporting overall compliance. Specific actions are in place including targeted course booking, regular contact with specialist advisor and discussions relating to how operational managers can support course bookings/attendance.

The senior leadership team maintain oversight at the weekly performance meeting with general managers and quality and Governance Leads addressing any identified actions directly with teams. The mandatory training report supports managers to monitor compliance at team level.

C&YPMH achieved a compliance of 94.1% in August 2026 for information governance training, just below the target of 95% with Trustwide performance at 95.6%.

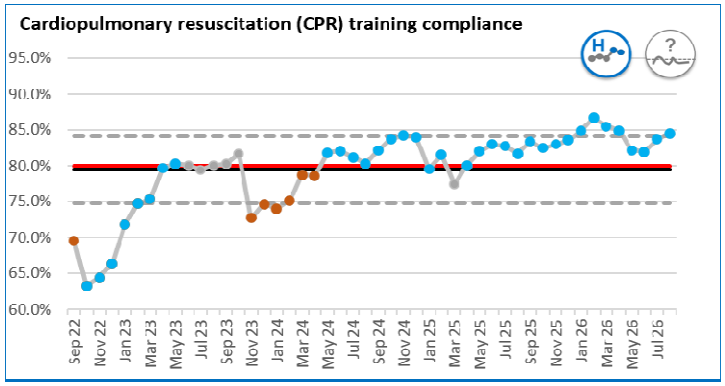
Performance information is examined at team level during the weekly Performance and Quality meeting led by the Associate Director, with the General Managers and Governance and Quality Leads. The dip in May led to focussed work to improve compliance with specific plans at team level to ensure information governance training was completed. Work is underway to anticipate the annual dip in compliance to ensure completion prior to training expiry dates.

Information Governance training compliance is now above threshold at 95.6% in September 2026.

Children and Adolescent Mental Health Services (CAMHS)

Workforce

Mandatory Training



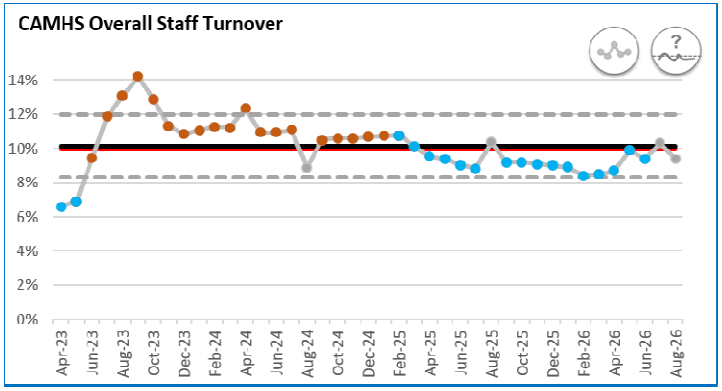
Insights

The August 2026 performance for cardiopulmonary resuscitation training stands at 84.5%, above the Trust target of 80%, with the Trustwide performance at 86.1%.

The data confirms that the care group has maintained its improvement work and special cause variation (high) performance over the 80% target since May 2025. The care group will continue to embed this work and ensure consistent and sustainable compliance.

The continued compliance is in part due to courses being made available at some community bases with operational managers involved with booking and allocation of places.

Turnover



Insights

Turnover for C&YPMH in August 2026 was 9.4% and remains below threshold.

Secure CAMHS was previously high at 17.5% due to reasons including capability dismissal, the end of FTC and staff leaving for development opportunities such as Assistant Psychologist positions however, has now decreased to 9.8% and continues on a downward trajectory.

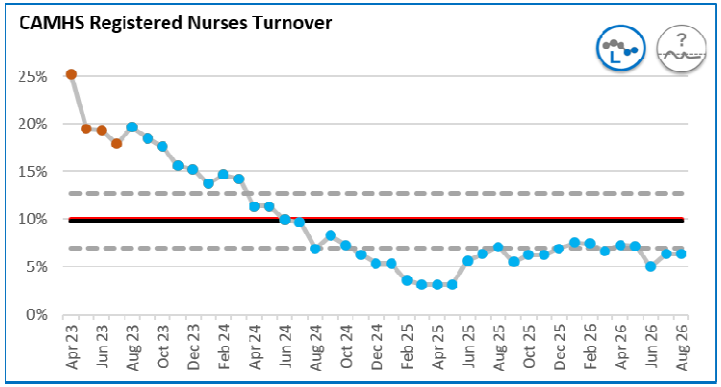
The majority of services within C&YPMH remain below the threshold with the exception of Wakefield (12%). The Wakefield Management team, which includes medical and admin staff, have the highest percentage of turnover (38.5%). This relates to 7 members of staff, 6 of which were medical staff who left due to fixed term contracts ending (completion of training and external rotation). Therefore, it is expected that this team's turnover will begin to reduce.

Calderdale are just above the threshold at 10.5%, however this only includes 2 leavers in a rolling 12 months who voluntary resigned.

Children and Adolescent Mental Health Services (CAMHS)

Workforce

Turnover



Insights

Turnover of registered nurses within C&YPMH as of August 2026 was at 6.3% (12 month rolling) and is below threshold.

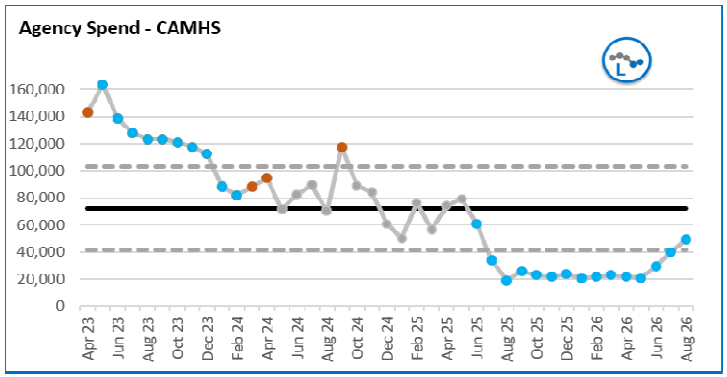
Of the 6.3%, this was 10 nurses who left for reasons including retirement, resignation due to promotion, other voluntary resignation and one leaving due to work life balance.

The data shows a fairly consistent level of low turnover over a 12 month rolling period, demonstrating that previous action plans in place have had a positive impact on turnover within registered nurses.

A review of progression pathways will be undertaken to understand whether those leaving for promotion opportunities will be undertaken to understand whether we would be able to retain Nurses in the future

Finance

Agency Spend



Insights

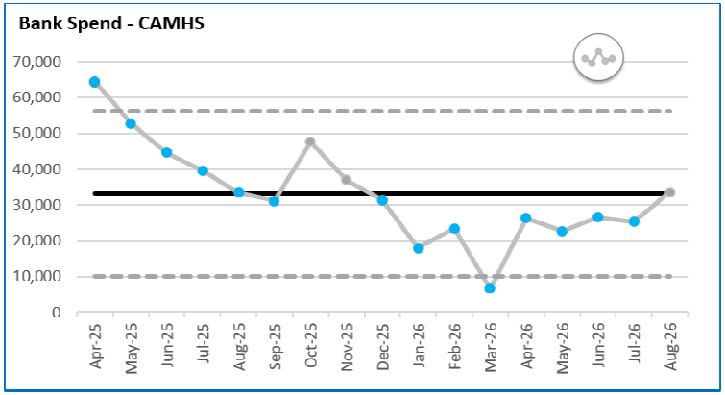
Agency costs for C&YPMH are forecast to total £441k this financial year, £14k more than actual spend last year.

Agency usage is forecast to remain at approx. 1.91wte a month for the remaining of financial year covering a vacant consultant psychiatry roles in Kirklees CAMHS. The service are actively trying to recruitment a substantive consultant into post.

Children and Adolescent Mental Health Services (CAMHS)

Finance

Bank Spend



Insights

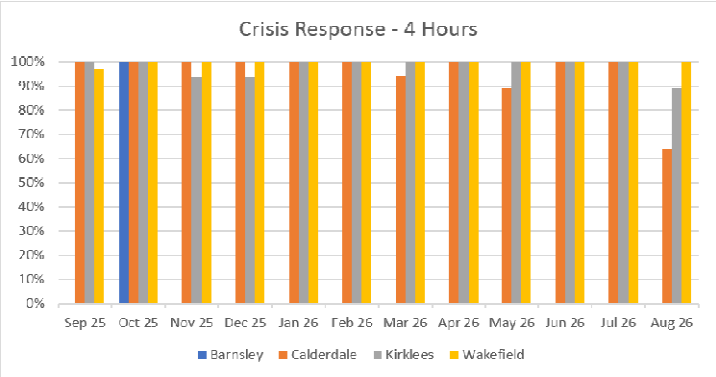
Children & Young People Mental Health Care Group bank spend totalled £134k to the end of August with an increase in costs in month attributable to staff cover in Wakefield.

Bank requirement in Wakefield is expected to continue whilst services remain in business continuity and remain on the risk register. However, the total costs will reduce going forwards with a reduction in spend expected in other areas.

Total bank costs are forecast to be £275k this financial year.

Access

CAMHS Crisis/Emergency 4 hrs



Insights

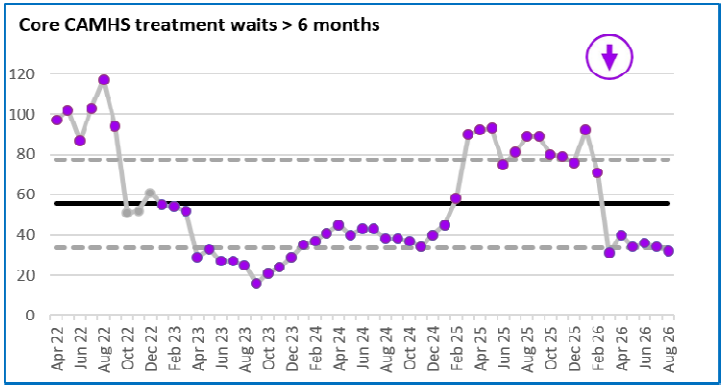
There were no actual breaches in Calderdale and Kirklees Crisis teams. The breaches shown on the bar chart are due to data quality issues which have been resolved.

Arrangements with all age liaison teams contributes towards maintaining the performance out of service hours. Where Barnsley crisis referrals are picked up through the all age liaison service, within 1 hour, they are not represented on the graph.

Children and Adolescent Mental Health Services (CAMHS)

Access

Core CAMHS treatment waits > 6 months

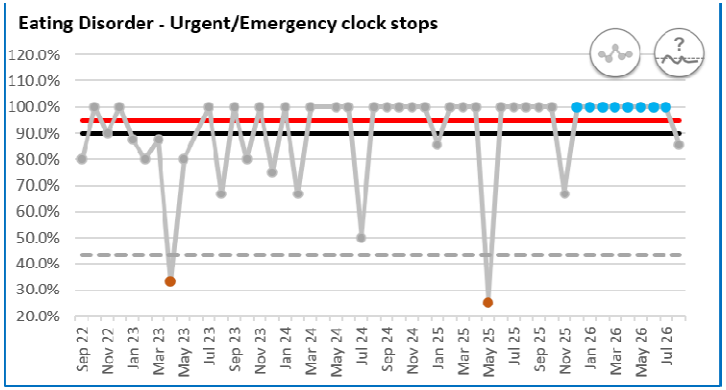


Insights

The proportion of children and young people waiting for treatment for more than 18 weeks has improved and the target of at least 75% of children and young people commencing treatment in less than 18 weeks has been achieved and above target for the last 7 months. This improvement is following rapid improvement work to reduce treatment waits and each locality has an action plan. Actions include streamlining meeting attendance, job planning reviews to increase clinical appointment capacity, streamlining clinical pathways including allocation and data quality improvement work.

While you wait offers have been developed and are being rolled out in all areas. Parent and carer sessions and general health and wellbeing advice to follow or explore further whilst waiting for an appointment. Contact numbers are provided to children, young people and families on who to contact in a crisis, which other services can support and how to contact them (such as night OWLS, Young Minds, bereavement support etc). Wakefield are piloting a 'while you wait' Creative Minds project for one year and are exploring the provision of a free course for 18 months with the Health & Wellbeing Team in Wakefield Council.

The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within one week



Insights

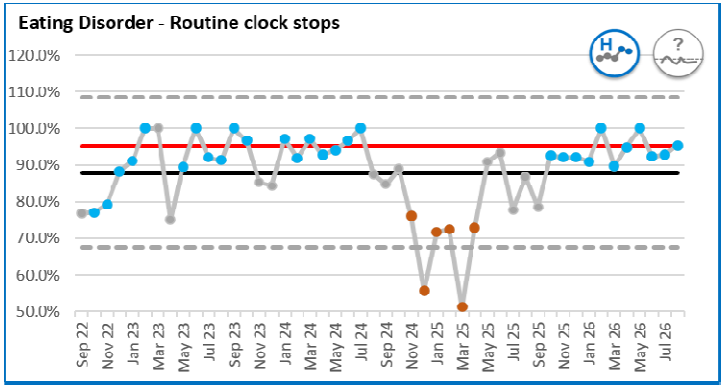
Performance for August 2026 was 85.7% against a national target of 95%. This related to 6 out of 7 cases being seen within the one week standard. Numbers referred in remain low and therefore 1 breach impacts percentage performance significantly.

The breach in August 2026 was in Calderdale & Kirklees C&YPMH Eating Disorders. The initial appointment for the young person was allocated within the timeframe, however, family cancelled the appointment which could not be rescheduled within timeframe.

Children and Adolescent Mental Health Services (CAMHS)

Access

The percentage of children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks

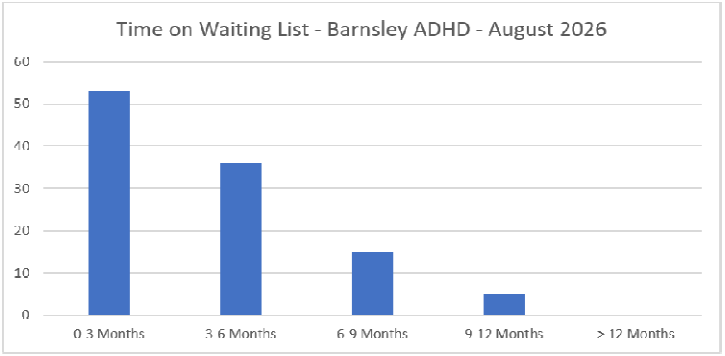


Insights

Performance for August 2026 was 95.3% against a national target of 95%. This related to 40 out of 42 children being seen within the four week standard. Following interrogation of the data and exception reporting, there was only 1 actual breach in Wakefield.

The breach in Wakefield was due to non-attendance of appointments offered within the timeframe.

Waiting Lists



Insights

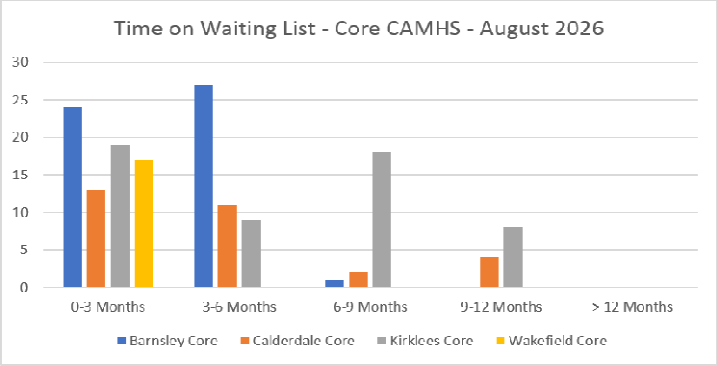
In Barnsley, C&YPMH provide ADHD assessment and treatment for children and young people, rather than a combined neurodevelopment pathway. Autism services for children and young people are provided by the acute hospital.

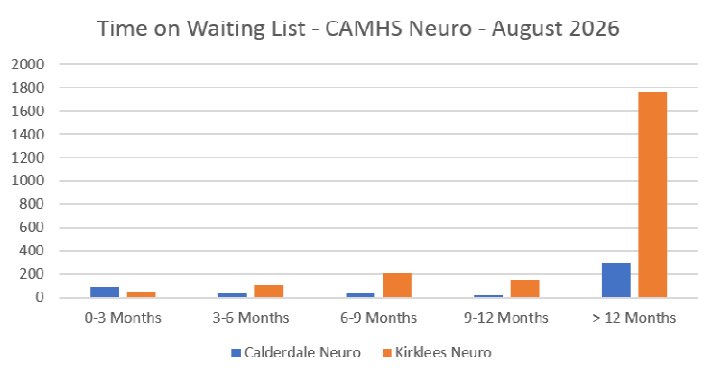
As at end August 2026, the Barnsley ADHD service had 109 people on the waiting list, the average wait was 112 days with the longest wait being 286 days.

Children and Adolescent Mental Health Services (CAMHS)

Access

Waiting Lists





Insights

As at the end of August, wait times for Core services were as follows:
Barnsley - 52 people waiting at month end, the average wait was 90 days, longest wait 208 days. The longest wait is for EMDR (Eye Movement Desensitisation and Reprocessing). Work is underway to increase capacity for EMDR within the core service existing resource.
Calderdale - 30 people waiting at month end, the average wait was 124 days, longest wait 336 days. Demand through the Single Point of Contact (SPOC) remains unpredictable. There has also been issues identified with data quality which is being addressed. Work is ongoing with Northpoint who provide the SPOC service to implement changes to support accurate screening.
Kirklees - 54 people waiting at the month end, the average wait was 164 days, the longest wait 326 days. Capacity has been impacted by urgent/priority allocations and staff absence through sickness and maternity leave. Reallocations for staff absence have reduced capacity further leading to increased waiting times for core treatment. Plans are in place to reduce waits and is forecasted have a positive effect from October
Wakefield - 17 people waiting at month end, the average wait was 39 days, longest wait 66 days. Waiting times continue to improve following recent successful recruitment and flexible allocation of resources. The longer waits are for psychology interventions and the processes and pathways for this provision are being closely monitored and reviewed.
A weekly rapid improvement group has been established to reduce treatment waits and each locality has an action plan. Actions include streamlining meeting attendance, job planning reviews to increase clinical appointment capacity, streamlining clinical pathways including allocation and data quality improvement work.

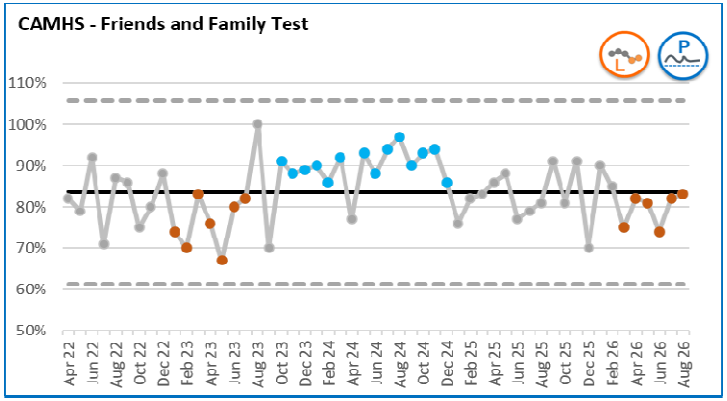
CAMHS Neuro waits relate to children and young people who have been referred for an assessment for ADHD and/or autism in Calderdale and Kirklees. The pathway was created to ensure that children could be directed to the most appropriate assessment, rather then experience a separate wait.

Calderdale: 461 people waiting at month end, the average wait was 484 days, the longest wait was 831 days. The backlog of referrals from Calderdale Single Point of Contact service in August 2024 led to approximately 300 referrals being added to the SWYFT waiting list in one day creating significantly increased waits which the service is still recovering from. The service developed a business case for funding to increase capacity and the number of commissioned assessments that the service can provide. However the business case was unsuccessful. The service has increased capacity internally through use of the Trust Bank which was funded by vacancies in the team.
Kirklees: 2284 people waiting at month end, the average wait was 681 days, the longest wait was 1306 days. Data and recording remains under review with PB&I to ensure accurate reporting of commissioned assessment activity and reported performance data. The introduction of the Kirklees ICB Right to Choose pathway has increased administrative and clinical screening requirements, generating a four-week delay for initial referrer consultations. To ensure accurate waiting list management and reflect patient choice, referrals are now added to the SWYFT ND assessment waiting list only after confirmation that families wish to proceed with assessment through SWYFT rather than an RtC provider. This change supports more accurate demand, capacity and performance reporting.

Children and Adolescent Mental Health Services (CAMHS)

Quality and Safety

Friends and Family Test



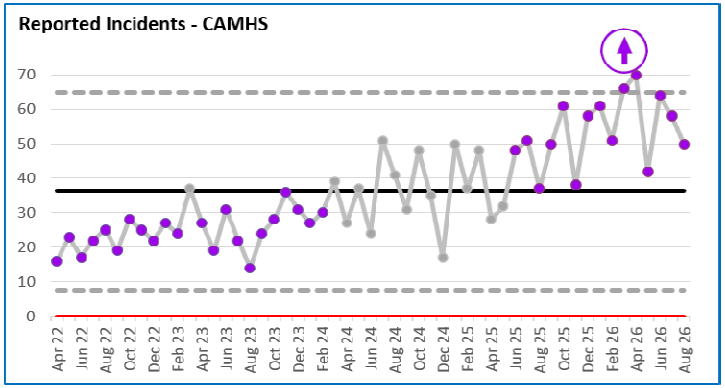
Insights

The CAMHS Patient Experience Survey was presented at the Children and Young People's Mental Health Service Clinical Governance Group in September for review, with agreement sought on the future feedback collection and reporting schedule. The experience of young people admitted to adult mental health wards was also discussed. A review of both the survey tool and the feedback collection process will be undertaken to ensure meaningful and representative feedback is captured from this cohort.

During Quarter 1:

- 97 Friends and Family Test (FFT) responses were received.
- 52% (17/33) of registered teams received FFT feedback.
- 82% (27/33) of teams receiving feedback achieved a satisfaction rating of 95% or above.
- 21% (7/33) of teams received 10 or more responses.
- Most responses were submitted by female service users, with the largest age groups being 0-20 years (13 responses) and 21-50 years. The majority of respondents identified as White British.

Incidents



Insights

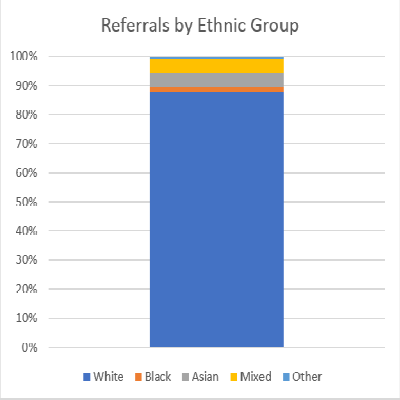
There were 55 incidents in August 2026 within the CYPMH teams, and all incidents are managed as per Trust policy.
The CYPMH Care Group includes the Community CAMHS teams across Barnsley, Wakefield, Calderdale and Kirklees and Secure CAMHS (WYOI, Adel Beck SCH and Aldine House SCH). Secure CAMHS patient safety incidents are often reported as '*External incident (not relating to SWYPFT care)*'.
There is a C&YPMH PSOG (Patient Safety Oversight Group) which meets weekly and a C&YPMH Patient Safety and Incident Monitoring Meeting (PSIMM) where incidents are reviewed and actions agreed and monitored. Each locality C&YPMH team has a local Incident Monitoring / PSOG meeting and reports on incident themes to the C&YPMH PSOG, PSIMM & Clinical Governance Meeting.

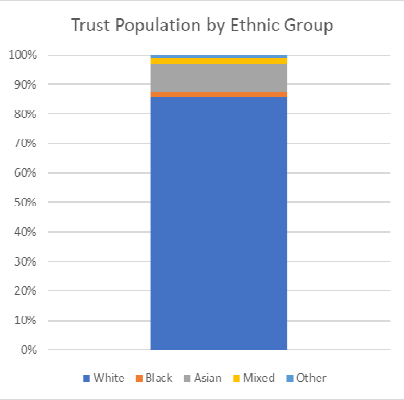
The 55 incidents reported included severity ratings of Red (1), Yellow (19), Green (35).
The four highest reported themes were: Safeguarding Children (16), Care Pathway (12), Self – Harm (8) and Information Governance Incidents (4).
Of the 8 reported Self – Harm incidents 5 were reported by Secure CAMHS and 3 by Community teams.

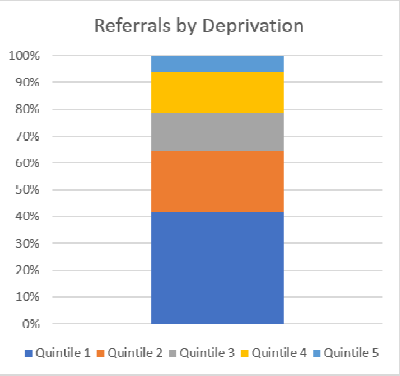
Children and Adolescent Mental Health Services (CAMHS)

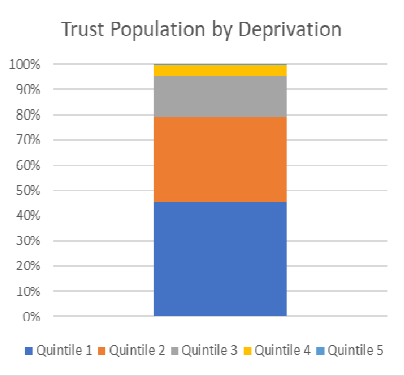
Inequalities

Referrals









Insights

Based on rolling 12 months of referrals (September 2025 - August 2026) referrals for people from a white and mixed ethnic group are over represented against the Trust's population, and referrals for people from an Asian ethnic group are under represented. More detailed analysis is required to enable better understanding of this data and actions needed to address it. Studies have suggested that young people from a South Asian background are more likely to revert to faith when coping with Mental Illness [Ali et al 2017]. However, this will need to be considered in the context of individual place populations and the fact that the census data has not been age-adjusted and is therefore a general population statistic rather than one which is directly comparable to the population likely to be accessing C&YPMH services.

The care group has ensured prioritisation of Equality Impact Assessment with the Quality and Governance Leads working with team managers to facilitate their completion and to ensure that action plans are meaningful. A number of care group leaders have also attended the enhanced Equality, Diversity and Inclusion training, further strengthening understanding of the wider equality agenda.
Focus on improving the data collection for protected characteristics.

The care group is involved in the embedding of the NHSE Patient Carer Race Equality Framework (PCREF) and a mapping exercise to identify areas for improvement work and actions is underway. PCREF will inform our equality impact assessments and is a golden thread in our priority programme work.

Based on rolling 12 months of referrals (September 2025 - August 2026) approximately 45% of referrals were received from our most deprived communities in Quintile 1, which mirrors the profile of our Trust footprint. Referrals from Quintile 2 are under-represented and referrals from Quintiles 4 and 5 are over-represented.

More detailed analysis is required to better understand this data and what needs to be done to address it. Since our Trust services covers 4 Places which each have distinct population demographics, a more granular investigation may be beneficial to fully understand any disparities at Place and in line with our 6 step Quality Improvement methodology. The population data is not currently age adjusted for a direct comparison, and therefore the findings should not be considered confirmation of a social gradient in access at this time.

There is work underway to address health inequalities through understanding the impact and barriers experienced by the most deprived areas served by community mental health services to ensure involvement and access is equitable and representative.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Statistical Process Control (SPC) Charts Explained

	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

	Assurance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Statistical Process Control (SPC) Charts Explained

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	**Excellent** — Celebrate and Learn • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** — Celebrate and Understand • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — Celebrate but Take Action • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** — Celebrate • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent** — Celebrate and Learn • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** — Celebrate and Understand • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — Celebrate but Take Action • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** — Celebrate • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
~	**Good** — Celebrate and Understand • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** — Investigate and Understand • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — Investigate and Take Action • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average** — Understand • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H	**Concerning** — Investigate and Understand • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** — Investigate • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.
L	**Concerning** — Investigate and Understand • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** — Investigate • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
↗				**Unsure** — Investigate and Understand • This metric is showing a statistically significant variation. • There has been a one off event above the upper process limits; a continued upward trend or shift above the mean. • There is no target set for this metric.
↘				**Unsure** — Investigate and Understand • This metric is showing a statistically significant variation. • There has been a one off event below the lower process limits; a continued downward trend or shift below the mean. • There is no target set for this metric.
○				**Unknown** — Watch and Learn • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 12.1

Private/Public paper:	**Public**		
Title:	**South Yorkshire Integrated Care System (SY ICS) Update including Mental Health, Learning Disability and Autism Provider Collaborative (MHLDA)**		
Lead Director:	**Mark Brooks - Chief Executive** **Dawn Lawson – Executive Director of Strategy, Inclusion and Change/ Deputy Chief Executive**		
Mission/values:	The development of joined-up care through Place and system working is central to the Trust's strategy and is supportive of our mission to help people reach their potential and live well in their community. The Trust values are central to our approach to partnership working.		
Purpose:	The purpose of this paper is: • To update the Trust Board on key developments in SY ICS and the SY MHLDA provider collaborative and linked programmes. • To update on partnership developments in Barnsley.		
Strategic aims:	Live Our Values	✓	The Trust's partnership working at system and Place supports it to be the 'Best Partner' and to achieve its ambitions.
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓	
	Be ambitious	✓	
BAF Risk(s):	4.1 Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place' 4.2 Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust. 4.3 Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve 6.2 System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience. 6.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.		

With all of us in mind.

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships.	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through Place-based partnership arrangements and provider collaboratives, and also developments and discussions in progress where relevant.
Any background papers / previously considered by:	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 29 September 2026.
Executive summary:	The Trust is an active participant in the South Yorkshire Integrated Care System and this report provides a summary of key points from the main meetings and forums which have taken place in that system during the reporting period. Work continues with our partners in Barnsley to evolve and develop place-based partnership governance arrangements and neighbourhood health. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register and will need to be kept in view as the SY ICS and MHLDA Provider Collaborative develops. New risks may emerge.
Recommendation:	**Trust Board members are asked to:** • **NOTE** the SY ICS and Barnsley Place updates.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
27 October 2026
Agenda item – 12.1
South Yorkshire update including South Yorkshire Integrated Care System (SY ICS)

1. Introduction

The purpose of this paper is to update the Trust Board on key developments in the South Yorkshire Integrated Care System (SY ICS) and the South Yorkshire Mental Health, Learning Disability & Autism Provider Collaborative (SY MHLDA) and linked programmes, and also on partnership developments in Barnsley.

Regarding partnership development in Barnsley, meetings are taking place with partners to develop a place provider partnership and determine its role and deliver against its agreed year one priorities given the changes that are taking place with the Integrated Care Board. The Trust is well represented in these discussions.

The paper summarises key developments from recent Integrated Care Board (ICB) and place-based meetings.

2. South Yorkshire Integrated Care Board

South Yorkshire Integrated Care Board

Member	Chief Executive
Items discussed	There has been no further meeting in public of the South Yorkshire Integrated Care Board (ICB) since the last report to Trust Board. The annual general meeting for the ICB took place on October 7th which was followed by a meeting in private and development session. This was largely focused on the future role and ways of working of the ICB.
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	There has been no further meeting of the South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative Board since the last report to Trust Board.
Date of next meeting	Next meeting to be confirmed.

4. South Yorkshire Eating Disorder Joint Committee (EDJC)

Member	Director of Strategy, Inclusion and Change/ Deputy Chief Executive
Items discussed	There has been no further meeting of the South Yorkshire Eating Disorder Joint Committee (EDJC) since the last update to Trust Board.
Date of next meeting	Next meeting November 2026

5. Barnsley Place

Barnsley Provider Partnership (BPP)

Member	Chief Executive
Items discussed	<u>Update from meeting on 24th September 2026</u> Key agenda items included: • Notes of the previous meeting and actions on 20th August 2026. o Matters arising. o Alignment and interface of the place provider partnership with the South Yorkshire Health Commissioner when that role is appointed to. o Response to Multi/Single Neighbourhood contract consultation. • Agenda for Barnsley Leaders Session 28th September 2026. An event was held with close to 40 system leaders to focus on delivery of the three identified priorities of the place provider partnership and effective working between organisations. • Update on Provider Partnership Priority workstreams o Hospital at Home- Heart Failure. o Neighbourhoods. o Discharge. o Managing progress on priorities. • Update on Urgent and Emergency Care Group. • Health and Wellbeing Board update.
Date of next meeting	Next meeting 29th October 2026

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	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
27 October 2026
Agenda item 12.2

Private/Public paper:	**Public**		
Title:	**West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update.**		
Lead Director:	**Mark Brooks - Chief Executive**		
Mission/values:	The development of joined-up care through Place and system working is central to the Trust's strategy and is supportive of our mission to help people reach their potential and live well in their community. The Trust values are central to our approach to partnership working.		
Purpose:	The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire Health and Care Partnership focusing on developments that are of importance or relevance to the Trust. The paper also includes an update on key developments in the three districts in West Yorkshire where the Trust provides services (Calderdale, Wakefield, Kirklees).		
Strategic aims:	Live Our Values		The Trust's partnership working at system and Place supports being the 'Best Partner' and the Trust to achieve our ambitions.
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓	
	Be ambitious	✓	
BAF Risk(s):	4.1 Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place 4.2 Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust. 4.3 Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve 6.2 System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience. 6.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.		
Contribution to the objectives of the Integrated Care System/Integrated	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through Place based partnership arrangements and provider collaboratives, and also developments and discussions in progress where relevant.		

With **all of us** in mind.

Care Board/Place based partnerships.	
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 29 September 2026.
Executive summary:	West Yorkshire Health and Care Partnership is an 'Integrated Care System'. It works in partnership with NHS organisations, councils, Healthwatch, hospices, charities and the voluntary community and social enterprise sector to improve the health and wellbeing of people living in West Yorkshire's five districts. NHS West Yorkshire Integrated Care Board (ICB) became a statutory organisation on 1 July 2022. The ICB has responsibility to commission the majority of NHS services for the West Yorkshire (WY) population. Each of the five place-based partnerships in WY has an integrated care board committee to make decisions, similar to the NHS West Yorkshire Integrated Care Board. Work continues in each of the Trust's three districts' partnerships to evolve and develop place-based partnership governance arrangements. The Trust has continued to work with partners in each of its places to support the development of place-based arrangements. Meetings of Place Provider Partnerships in shadow form commenced April 2026 in Calderdale, Kirklees and Wakefield. The paper summarises key developments from recent ICB and place-based partnership meetings. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register.
Recommendation:	**Trust Board members are asked to:** • **NOTE** the update on the development of Integrated Care Systems and collaborations: ○ West Yorkshire Health and Care Partnership. ○ Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees. • **NOTE** the minutes of relevant partnership boards/committees.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 12.2

West Yorkshire Health & Care Partnership (WYHCP) - including the Mental Health, Learning Disability and Autism Collaborative and Place-Based Partnerships Update

1. Introduction

The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire Health and Care Partnership (WYHCP), focusing on developments that are of importance or relevance to the Trust. The paper also includes an update on key developments in the three districts in West Yorkshire (WY) where the Trust provides services (Calderdale, Wakefield, Kirklees).

West Yorkshire Health and Care Partnership is an 'Integrated Care System'. It works in partnership with NHS organisations, councils, Healthwatch, hospices, charities and the voluntary community and social enterprise sector to improve the health and wellbeing of people living in West Yorkshire's five districts.

The ICB has responsibility to commission the majority of NHS services for the WY population. Each of the five place-based partnerships in WY has an integrated care board committee to make decisions, in line with the delegations provided to it by the NHS West Yorkshire Integrated Care Board. The role of these committees has changed given the reorganisation of the ICB in 26/27 and there will only be one meeting per quarter for decision-making purposes.

Work continues in each of the Trust's three districts' partnerships to evolve and develop place-based provider partnership governance arrangements. The Trust has continued to work with partners in each of its places to support the development of place-based arrangements. Meetings of Place Provider Partnerships in shadow form commenced April 2026 in Calderdale, Kirklees and Wakefield.

This paper summarises key developments from recent ICB and place-based partnership meetings. A key focus of system discussions has been the organisational change in each of our ICBs, and the role ICBs play in the future as strategic commissioners.

2. West Yorkshire Health and Care Partnership

Updates from key recent meetings of the West Yorkshire Health and Care Partnership are summarised below.

West Yorkshire Integrated Care Board

Member	Mental Health, Learning Disability and Autism services are represented by Sara Munro, Chief Executive of Leeds and York Partnership NHS Foundation Trust, as partner member of the Integrated Care Board.
Items discussed	There has been no further meeting of the West Yorkshire Integrated Care Board since the last update to Trust Board.

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 Operating Officer
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	Update from meeting on 13th October 2026 Key agenda items included: • Adult In-Patient Mental Health/Secure. ○ Out of Area. ○ RCRP (Right Care Right Person). • MHST (Mental Health Support Teams). ○ Delivery Audit. ○ Finances. • West Yorkshire Rehabilitation Framework. • Mental Health Support for Survivors of Sexual Violence. • Planning and Performance. • Eating Disorders Physical Health Monitoring. • Oliver McGowan Mandatory Training. • Escalation of AAA.
Date of next meeting	Next meeting scheduled for 10th November 2026

Wakefield

The Trust continues to be a pro-active partner in the Wakefield District Health and Care Partnership (WDHCP) and associated work, leading in specific areas, for example, the Wakefield Mental Health Alliance. Since the last report to Board, the initial meeting of the Wakefield Place Provider Partnership has taken place.

Wakefield District Health and Care Partnership Committee

Member	Chief Executive
Items discussed	There has been no further meeting of the Wakefield District Health and Care Partnership Committee since the last update to Trust Board.
Date of next meeting	Next meeting scheduled for 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 23 September 2026 Key agenda items included: • Wakefield Mental Health Day / World Mental Health Day event- an update was provided on the planned Wakefield Mental Health Day event. The event has developed from a small-scale event in 2023 to a wider partnership event, with around 60 organisations now in attendance. • Mental Health Alliance dashboard- it was noted that four key performance indicators were currently behind target- these related to children and young people's services, talking therapies and older adult average length of stay and adult acute length of stay. It was acknowledged that PICU bed pressures continued to reflect wider system strain. • My Mental Health Wakefield website- an update was provided on the introduction of the My Mental Health Wakefield website. • Adult Population Health Survey 2027- an overview of the survey was provided. This is expected to run every four years and aims to understand population-level health behaviours, risk factors, local needs and inequalities. • Mental Health Personalised Care Framework guidance- SWYPFT presented an overview of the Mental Health Personalised Care Framework. The framework replaces the Care Programme Approach and applies across secondary mental health services, with a broader ambition to support multi-agency working. It was agreed the Trust will work with voluntary and community sector colleagues to explore examples of how the new framework will operate.
Date of next meeting	Next meeting scheduled for 21st October 2026

Wakefield Health and Wellbeing Board

Member	Assistant Director Business Development and Contracting
Items discussed	There has been no further meeting of the Wakefield District Health and Wellbeing Board since the last update to Trust Board.
Date of next meeting	Next meeting scheduled for 24th November 2026
Further information	Papers and draft minutes are available at: www.wakefield.gov.uk: Browse meetings - Health and Wellbeing Board

Calderdale

SWYPFT is a partner in delivering Calderdale Cares. We have continued to work with partners to develop a place-based approach.

Calderdale Cares Partnership Board

Member	Chief Executive
Items discussed	There has been no further meeting of the Calderdale Cares Partnership Board since the last 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.
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	Update from meeting on 23 September 2026 Key agenda items included: • Developing Well - SEND in Calderdale.

	• Winter Planning 2026/27. • Refreshing Calderdale's Health and Wellbeing Strategy. • Health and Wellbeing Board Forward Plan.
Date of next meeting	Next meeting is scheduled for 13th January 2027
Further information	Papers and minutes are available at: https://calderdale.moderngov.co.uk/ieListMeetings.aspx?CId=148&Year=0

Kirklees

Kirklees ICB Committee

Member	Chief Executive
Items discussed	There has been no further meeting of the Kirklees ICB Committee since the last meeting of Trust Board.
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	Update from meeting on 24 September 2026 Key agenda items included: • Director of Public Health Annual Report 2025/2026 - Women's Voices, Advocacy, and Reducing Inequalities ○ The report aims to inform local people about the health of their community as well as inform decision-makers on health gaps and priorities that need to be addressed. ○ This year the focus was women's voices with a focus on experience of maternity care. • 2025 CLiK Survey report- the Board was presented with the key findings from the latest Current Living in Kirklees (CLiK) Survey, carried out between October 2025 and January 2026. Three key messages were: perceptions of local area and relationships with others now more negative than in 2021 when the previous survey was carried out, financial pressures are being experienced, and improvements have been seen in health-related behaviours. • Kirklees Neighbourhood Health Plan- an update on the development of the neighbourhood health plan for Kirklees was shared. • Changes to the Integrated Care Board Landscape Update.
Date of next meeting	Next meeting scheduled for 28th January 2027

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	There has been no further meeting of the Kirklees Partnership Executive since the last update to Board
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. 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
27 October 2026
Agenda item 12.3

Private/Public paper:	**Public**		
Title:	**Specialised NHS-Led Provider Collaboratives and Alliances - Update**		
Lead Director:	**Adrian Snarr, Director of Finance, Estates 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 the Specialised NHS-Led Provider Collaboratives, focusing on developments that are of importance or relevance to the Trust. It provides distinct updates on the West Yorkshire and South Yorkshire and Bassetlaw Adult Secure Provider Collaboratives, followed by progress on the shared Yorkshire and Humber regional workstreams.		
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	The paper provides an update on the work of the Provider Collaboratives and their relationship to Integrated Care Board and Place-based organisations.		

With all of us in mind.

Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	It describes regional work to improve pathways, capacity planning, repatriation, data and intelligence, learning disability and autism pathways, and Single Point of Access arrangements. The paper highlights demand and capacity pressures, out-of-area placements, patient flow and discharge, quality assurance and the financial position of the West Yorkshire and South Yorkshire and Bassetlaw Adult Secure Provider Collaboratives.
Any background papers / previously considered by:	None
Executive summary:	The paper provides separate updates on the West Yorkshire and South Yorkshire and Bassetlaw Adult Secure Provider Collaboratives, together with progress on the shared Yorkshire and Humber regional workstreams. • In West Yorkshire, demand remains concentrated in male secure pathways. Out-of-area placements and discharge performance continue to affect capacity and flow, and the Provider Collaborative is forecasting a £1.2m deficit for 2026/27. All commissioned providers remain on routine quality surveillance. • In South Yorkshire and Bassetlaw, activity remains above planned levels. Out-of-area placements, long lengths of stay and discharge delays continue to require focused oversight. The month 5 forecast is a £1.534m deficit. Quality oversight arrangements are in place, although full assurance has not been provided in all areas. • Across Yorkshire and Humber, joint work is progressing on executive oversight, regional data and capacity information, out-of-area placements and repatriation, learning disability and autism pathways, and Single Point of Access arrangements.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** the updates provided within the paper

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
27 October 2026
Agenda Item 12.3

Specialised NHS-Led Provider Collaboratives and Alliances – Update

1. Introduction

The purpose of this paper is to provide Trust Board with an update on the Specialised NHS-Led Provider Collaboratives, focusing on developments that are of importance or relevance to the Trust. The paper provides distinct updates on West Yorkshire and South Yorkshire and Bassetlaw, followed by progress on the shared Yorkshire and Humber regional workstreams.

2. Background

The Trust is the Co-ordinating Provider for Adult Low and Medium Secure Services in West Yorkshire and South Yorkshire and Bassetlaw. It is also a partner in the West Yorkshire Adult Eating Disorder and Children and Young People Mental Health inpatient Provider Collaboratives.

3. West Yorkshire

3.1 West Yorkshire Adult Secure Provider Collaborative

The West Yorkshire Adult Secure Provider Collaborative commissions 254 secure beds across NHS and independent sector providers. During July and August 2026, 46 referrals were received, including 36 relating to male pathways. Eight new cases were waiting for admission at the end of the reporting period, with continued pressure in medium secure male mental illness services.

As at 1 September 2026, 272 West Yorkshire patients were receiving secure care. Of these, 215 were accommodated within West Yorkshire and 57 were placed out of area. Twenty-eight of the out-of-area patients were placed elsewhere within Yorkshire and Humber and 29 were outside the region.

Discharge activity remains below the level required to support effective flow. Nine discharges were completed during the two-month reporting period and 14 patients were reported as clinically ready for discharge. Further assurance is required regarding the consistency of clinically ready for discharge reporting across providers.

The financial forecast remains a £1.2m deficit for 2026/27, with a year-to-date deficit of £497k. The principal pressures continue to be out-of-area placements and high-cost Exceptional Packages of Care.

All West Yorkshire commissioned providers remain on routine quality surveillance. The West Yorkshire Adult Secure Provider Collaborative Board received assurance that the Commissioning Hub continues to fulfil its delegated quality oversight and assurance responsibilities.

4. South Yorkshire and Bassetlaw

4.1 Adult Secure Provider Collaborative

During the reporting period from 1 July to 31 August 2026, the South Yorkshire and Bassetlaw Adult Secure Provider Collaborative received 13 referrals and recorded nine admissions. Three patients were admitted out of area, including two where no low secure bed was available within the area.

Activity remained above planned levels. The assurance report records 20 patients placed out of area, of whom four were identified as appropriate for repatriation. A staged clinical review process is in place, supported by weekly discussions between case managers and clinicians, to progress repatriation where clinically appropriate and suitable capacity is available.

Patient flow and discharge remain areas of concern. Twenty-seven patients had a length of stay exceeding five years, and focused work is underway to review longer-stay patients and address barriers to discharge. While delayed discharges have clinical oversight, full assurance has not been provided that all patients are receiving care in the least restrictive setting.

The month 5 financial forecast is a deficit of £1.534m, principally reflecting higher-than-planned inpatient activity and additional pressure from provider uplifts. Assurance has been provided regarding financial oversight, although the available Lead Provider budget is not expected to support a year-end breakeven position at the current level of demand.

All providers remain subject to routine quality monitoring. The report provides assurance regarding the oversight arrangements but does not provide full assurance that all South Yorkshire and Bassetlaw patients are receiving adequate, safe and effective care. Completion of annual quality review action plans and continued scrutiny of restrictive practices and safeguarding remain necessary to support full assurance.

The Trust is also exploring closer alignment between the West Yorkshire and South Yorkshire Single Point of Access arrangements as part of the wider regional programme.

5. Yorkshire and Humber regional workstreams

The three Adult Secure Provider Collaboratives across Yorkshire and Humber are progressing joint work to improve collaboration, make better use of capacity, support care closer to home and strengthen consistency in commissioning decisions.

5.1 Executive oversight and governance

An executive oversight committee has been proposed to strengthen governance, sponsorship and collaboration across the regional footprint. The first meeting is scheduled for 12 October 2026 and will be jointly chaired by executive leads from South West Yorkshire Partnership NHS Foundation Trust and Humber Teaching NHS Foundation Trust.

Delivery has at times been constrained by inconsistent engagement, uncertainty about future contract arrangements and differences in governance structures. NHS England has indicated a contract renewal process, with submissions due by 19 October 2026.

5.2 Data and intelligence collaboration

The regional data collaborative is progressing positively. Terms of reference have been developed and data leads are meeting regularly to establish a core dataset that can provide a consistent regional view of bed use and capacity.

- A weekly Secure Care capacity situation report has been developed and is expected to be piloted from the beginning of October.

- The pilot will draw on weekly returns from Single Point of Access functions and collate regional bed availability.

- The initial approach will be evaluated, including comparison with an alternative collection method being developed by Humber and North Yorkshire colleagues.

5.3 Out-of-area placements and repatriation

The regional tracker identified 68 patients placed outside the region, almost half of whom were from West Yorkshire. Two referrals have been received and are being progressed. Current challenges include changes to patients repatriation status following further review and limited case manager attendance because of capacity constraints.

Variation in regional bed-day prices has also been identified as a commissioning concern. Immediate price alignment may not be achievable, but greater transparency and a consistent regional approach should form part of the programme.

5.4 Learning disability and autism pathways

Further analysis is required to understand regional demand, referral patterns, occupancy, capacity and the impact of admission thresholds before decisions are made about bed reductions, service conversion or future investment. Learning disability and autism pathways will need to be considered separately within the regional programme.

A regional improvement forum involving providers and clinical leaders has been proposed to examine length of stay, barriers to progression, prevention of admission, quality, clinical models and pathway improvement. The final paper will be presented to the executive oversight committee for approval.

5.5 Single Point of Access

A staged proposal has been developed to map current models and reduce unwarranted variation, establish a regional escalation process for complex cases, develop regional pathways where coordination could improve access and flow, and use evidence from the earlier stages to assess whether a regional Single Point of Access would be beneficial.

6. Overall position

The strategic direction remains sound and there is a shared intention to improve the use of regional capacity, keep people closer to home where clinically appropriate, identify pressures earlier, reduce unnecessary variation and strengthen collective management of financial and clinical risk. Clear executive sponsorship, consistent participation and defined authority will be important to maintain progress.

South West Yorkshire Partnership Teaching
NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 13.1

Private/Public paper:	**Public**		
Title:	**Internal Governance Structure**		
Lead Director:	**Dawn Lawson – Deputy Chief Executive/Director of Strategy, Inclusion and Change**		
Values:	The Trust governance structures support delivery of the Trust's strategy, and our mission to help people reach their potential and live well in their community. The Trust values are central to our approach to how we operate.		
Purpose:	To review the Trust's internal meeting governance structure to ensure it supports the delivery of the Trust's mission and values, strategic objectives and legal requirements and provides the Trust Board and committees of the Board with the required levels of assurance.		
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. The internal meetings governance framework provides a structure through which the Trust delivers its strategic objectives and provides evidence of key controls as mitigation for strategic risks in the Board Assurance Framework (BAF).		
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.	A clear internal governance framework reflects the Trust's lines of assurance, demonstrating that the Trust operates effectively and efficiently to ensure it delivers quality healthcare over the long term, and contributes to the objectives of the integrated care partnerships (ICP), integrated care boards (ICB), and place-based partnerships, through robust governance arrangements.		

With **all of us** in mind.

Any background papers / previously considered by:	The governance structure was discussed by Trust Board in March 2026.
Executive summary:	The Trust internal governance framework illustrates the relationship between Board governance and corporate/clinical governance, providing the systems, processes, and framework to enable Board decision making. The internal governance framework identifies key lines of assurance reporting into the formal committees of the Board. In April 2026 the Trust took the decision to step down the Equality, Inclusion and Involvement Committee to make equality, diversity and inclusion part of everything we do, and the Trust has been developing the appropriate governance arrangements to support this aim, as summarised below. The All of us in Mind Insight Group has now been established to support delivery of the Trust's Equality, Diversity and Inclusion (EDI) Strategy through the development of insight, understanding, engagement and influence. The Group provides a forum where colleagues and communities can bring together lived experience, evidence, intelligence and data to deepen understanding of EDI issues and inform organisational decision making. The Equality, Diversity and Inclusion (EDI) Operational Group has been established to provide operational leadership, oversight, coordination and assurance for the delivery of the Trust's Equality, Diversity and Inclusion Strategy and associated action plans. The Group operates under delegated authority from the Executive Management Team (EMT) and has no executive powers other than those specifically delegated through Trust governance arrangements. The group reports into Quality and Safety Committee and People and Remuneration Committee as required. The framework has therefore been updated to reflect the following changes: <u>Operational level (green)</u> The All of us in Mind Insight Group has been added, reporting into the EDI Operations Group. <u>Oversight of management activity (blue)</u> • The Digital Program Group has been added, reporting into The Transformation, Innovation and Sustainability Committee. • The EDI Operations Group has been added, reporting into EMT, Quality and Safety Committee and People and Remuneration Committee. • The Freedom to Speak Up Oversight Group has been added, reporting into Audit Committee. • The Finance, Performance, Quality and Workforce Care Group meetings have been added, reporting into Finance, Investment and Performance Committee <u>Objective oversight and scrutiny (purple)</u>

	• The Equality, Inclusion and Involvement Committee and sub-committee have been removed. • The Transformation, Innovation and Sustainability Committee has been added. The internal meetings' governance framework provides Trust Board with assurance that EMT have in place a clear organisational structure with defined and consistent lines of responsibility, effective risk management processes, and control mechanisms that support the board assurance framework, and meet the requirements of the code of governance for NHS Provider Trusts (2022). **Next steps** To ensure there is a clear line of sight on how the Board hear the voice of our colleagues and our communities, the EDI Ops group will map where the voice of our communities and colleagues are heard within the groups identified on the governance structure.
Recommendation:	**Trust Board members are asked to:** • **REVIEW** and **APPROVE** the updates to the internal governance structure**.** • **APPROVE** the proposal of mapping of how voice feeds into the groups of our internal governance structure.

Internal Governance Structure

Board are required to ensure appropriate risk management processes are in place.
The Executive Management Team are responsible for the delivery of the strategy and plans within the organisation which are managed through the 1st line (green)

South West Yorkshire Partnership Teaching NHS Foundation Trust

- Members Council
  - Nominations Committee
  - Quality Group
  - Co-ordination Group
- Trust Board
  - Quality and Safety Committee
    - Complex Case Meeting
    - Executive Management Team
      - Clinical Policy Review and Ratification Group
      - Operational Management Group
        - Extended EMT
        - Improving Clinical Information Group
        - IM&T TAG
        - Estates TAG
        - Benchmarking Group
        - Education Training Governance Group
        - Value for Money Group
        - EDI Operations Group
      - Transformation, Improvement and Priority Programme Boards
      - Bids and Tenders Meeting
      - Clinical Record Keeping Improvement Group
      - Trust Planning Group
      - Trust Co-ordination of feedback from input into place
      - All of us in Mind Group
      - Operational Governance Group
      - Barnsley Physical Health and Wellbeing Group
      - Children & Families Care Group
      - LD, Adult ASD, ADHD Care Group
      - Forensic Care Group
      - Mental Health Care Group
    - Drug & Therapeutic Sub-Committee
      - Resus & Oxygen TAG ECT TAG Non medical prescribing steering group
      - Patient Safety Oversight Group
        - Mortality Review Group
        - Corporate Policy, Procedure and Risk Group
      - Physical Health Operational Steering Group
      - Safe Medicines Practice Group
        - Clozapine Special Interest Group
        - ECT Group
      - Safeguarding Link Practitioner Forum
      - Prevent Action Group
    - Clinical Governance Group
      - Clinical Ethics Advisory Group
      - Nursing Quality Group
      - AHP Advisory Group
      - Safeguarding Strategic Group
      - Physical Health Optimisation Group
      - Trust Research and Innovation Group
      - Nutrition Steering Group
      - Safer Staffing Group
      - Allied Health Professionals Professional Network Groups
      - Temporary Staffing Management Group
      - Infection prevention and control TAG
      - Quality Improvement Group
      - Patient Safety Improvement Group (inc Suicide Prevention Group)
      - NICE Steering & Overview Group
      - Clinical Policy Review and Ratification Group
      - Medical Devices & Safety Alerts Group
      - Care Group governance groups
      - Clinical Safety Design Group
      - Clinical Environmental Safety Group
      - New Roles Group
      - Care Plan Risk Assessment Improvement Group
      - Care Group Patient Safety Oversight Group
      - Reducing Restrictive Physical Intervention TAG
      - Falls Group
      - Patient Safety Clinical Reference Group
      - Clinical Risk Training Group
      - Care Group Clinical Governance Group
    - JLNC BMA Staff side
      - eRostering Group
      - Trust Partnership Forum (+Finance)
    - Finance, Investment & Performance Committee
    - People and Remuneration Committee
    - Transformation, Innovation and Sustainability Committee
      - Digital Programme Group
      - Finance, Performance, Quality, Workforce Care Group
    - Mental Health Act Committee
      - Hospital Managers
      - MHA and MCA Code of Practice Group
      - Equality and Involvement Care Group Meetings
      - Medical Education TAG
      - Undergraduate Non Medical Education Group
      - Medical Staff Committee
      - Training Governance Group
      - Specialist Advisors Training Group
      - Staff Side Comms Group
      - Trust Partnership Forums
      - Individual Care Groups
      - Corporate Services
  - Corporate Trustee
    - Charitable Funds Committee
      - Linked Charities Governance Group
      - Linked Charities Operational Group
      - Poverty Response Network
    - Audit Committee
      - EyUp! Operational Group
      - Safety TAG
      - Water Safety Group
    - West Yorkshire Mental Health, Learning Disability & Autism Services Collaborative (WYMHLDA) Committee in Common
    - South Yorkshire MHLDA Provider Collaborative Board
    - Commissioning Committee
      - Freedom to Speak Up Oversight Group
      - West Yorkshire AS Provider Collaborative Board
        - AS Patient Safety & Quality Group
        - AS Clinical & Operational Group
      - Yorkshire AS Provider Collaborative Oversight
        - AS Operational Delivery Group
        - AS Patient Safety & Quality Group
    - Teaching Trust Joint Partnership Board with University of Leeds

Key

- front line, specialists, operational, policy, KPIs, risk registers, reports on system, controls
- oversight of management activity, compliance, reviews
- objective, oversight and scrutiny
- --- report as required on an exception basis

South West Yorkshire Partnership Teaching
NHS Foundation Trust

Trust Board
27 October 2026
Agenda item 14.1

Title:	**Trust Board Fit and Proper Persons Test, Declarations of interest and independence policy**		
Lead Director:	**Dawn Lawson – Deputy Chief Executive/Director of Strategy and Change**		
Mission/values:	To be relevant today and ready for tomorrow		
Purpose:	To provide Executive Management Team with the updates to the above policy for review prior to submission to Trust Board for approval.		
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.	Having a Trust policy aligned to the NHS England Fit and Proper Person Test (FPPT) Framework supports the objectives of Integrated Care Systems (ICSs), Integrated Care Boards (ICBs), Place-Based Partnerships and partner organisations by ensuring that board members and senior leaders demonstrate the integrity, competence, capability and values required to lead effectively. By promoting robust governance, accountability and transparency, the policy strengthens public confidence in leadership and decision-making across the health and care system. It also supports collaborative working by ensuring that organisations have appropriately qualified leaders who can work in partnership to improve quality, safety, population health outcomes and the effective use of resources.		
Any background papers / previously considered by:	Previous policy versions submitted on a three yearly basis		
Executive summary:	Following the fit and proper person test internal audit it was identified that the Trust Board policy for Fit and Proper Persons Test, Declarations of interest and independence could be improved to be definitive about the processes followed on director appointments and annual review. The policy has therefore been substantially re-written to include the following:		

With all of us in mind.

	• Now aligns to the Trust policy format including equality impact assessment • Has strong alignment to the NHSE FPPT framework. • Outlines processed to be followed on appointment and on annual review • Has a new section documenting key criteria related to the Board member reference process and management. • Documents what should be recorded on ESR • Documents the declarations of interest requirements • Documents non-executive director declaration of independence requirements The policy has been reviewed by Non-Executive Director Celia Weldon, the Chief People Officer and Director of Finance, Estates and Resources. All comments raised in review have been addressed and the policy updated. The policy is submitted to Trust Board for final review and approval.
Recommendation:	**Trust Board members are asked to:** **APPROVE** the attached policy.

South West Yorkshire Partnership Teaching
NHS Foundation Trust

Document name:	Trust Board fit and proper persons test policy, including declarations of interest and independence
Document type:	Policy
What does this policy replace?	Trust Board declaration and register of FPPT, interests and independence policy 2023
Staff group to whom it applies:	Trust Board members and those acting up to Board level for more than six weeks
Distribution:	The whole of the Trust
How to access:	Intranet
Issue date:	October 2026
Next review:	October 2029
Approved by:	Executive Management Team on Trust Board on (date)
Developed by:	Head of Corporate Governance (Company Secretary)
Director lead:	Director of Strategy, Inclusion and Change/Deputy Chief Executive
Contact for advice:	Head of Corporate Governance (Company Secretary)

Contents

1.	**Introduction**	**3**
2.	**Purpose and scope of the policy**	**3**
3.	**Definitions**	**4**
4.	**Principles**	**5**
5.	**Duties**	**9**
6.	**Equality Impact Assessment**	**11**
7.	**Dissemination and implementation arrangements (including training)**	**26**
8.	**Process for monitoring compliance and effectiveness**	**26**
9.	**Review and revision arrangements**	**27**
10.	**References**	**28**
11.	**Associated documents**	**28**
12.	**Appendices**	**28**
	Appendix A - Checklist for the review and approval	**28**
	Appendix B - Version control sheet	

1. Introduction

This policy sets out the Trust's arrangements for compliance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which requires directors and those performing equivalent or similar functions to be fit and proper persons.

It incorporates the NHS England Fit and Proper Person Test Framework for board members, effective from 30 September 2023 and updated on 16 April 2025, including requirements for appointment checks, annual assessment and self-attestation, appraisal and leadership competency assessment, board member references, Electronic Staff Record (ESR) information, local record retention, annual assurance and periodic independent review.

The policy also maintains the Trust's arrangements for board member declarations of interests and, for Non-Executive Directors, assessment of independence, supporting transparent, accountable and effective governance.

2. Purpose and scope of the policy

2.1 Purpose

The purpose of this policy is to provide a consistent, fair, proportionate and auditable process through which the Trust can obtain and retain assurance that each person in scope is fit and proper on appointment and throughout their tenure, and that declared interests and Non-Executive Director independence are appropriately recorded, assessed, managed and reported.

Through this policy the Trust will:

- Meet the statutory requirements of Regulation 5 and Schedule 4 of the 2014 Regulations.
- Apply the NHS England FPPT Framework to recruitment, appointment, promotion, annual assessment and departure from board level roles.
- State the process for assessment, decision-making, record keeping, reporting, review and escalation.
- Ensure the timely declaration, recording and management of interests.
- Support the Board's annual assessment of the independence of Non-Executive Directors.
- Protect personal and special category data in accordance with data protection law and records management requirements.

2.2 Scope

The mandatory NHS England Framework applies to all voting and non-voting Executive and Non-Executive Board Members, whether permanent or interim, and to persons who are directors for the purposes of Regulation 5. Temporary board appointments lasting more than six weeks are subject to the board member reference requirements.

Professional registration does not remove a Board Member from scope.

3. Definitions

Term	Meaning
Board Member	An Executive Director or Non-Executive Director, with or without voting rights, including a permanent or interim appointment, and any person treated as a director under Regulation 5.
Chair	The Chair of the Trust Board, who holds ultimate accountability for ensuring that effective FPPT systems and processes are in place and for reaching or overseeing conclusions on fitness and propriety.
Fit and Proper Person Test (FPPT)	The statutory and national framework used to assess whether a person satisfies the requirements for good character, qualifications, competence, skills and experience, health, conduct and the absence of grounds of unfitness.
Framework	The NHS England Fit and Proper Person Test Framework for board members and associated national guidance and templates.
Annual assessment	The yearly validation of relevant FPPT information, annual self-attestation, appraisal and competency evidence, followed by an explicit conclusion on whether the Board Member remains fit and proper.
Board member reference	The standard NHS England reference used for relevant appointments and completed and retained when a Board Member leaves, whether or not another employer has requested it.
ESR	The NHS Electronic Staff Record, including the restricted FPPT data fields.
Interest	Any actual, potential or perceived interest that could affect, or reasonably be seen to affect, a Board Member's judgement or actions in the Trust's interests.
Independence	Independence in character and judgement, assessed by the Board for each Non-Executive Director in accordance with the Code of Governance for NHS provider trusts and the Trust Constitution.
Serious misconduct or mismanagement	Conduct or management failings assessed in context against the meaning and examples within the NHS England Framework and Regulation 5.

4. Principles

4.1 Statutory criteria

A person may be appointed, or continue, as a Board Member only where the Chair is satisfied that the person:

- is of good character;
- has the qualifications, competence, skills and experience necessary for the role;
- is able, by reason of health and after reasonable adjustments, to perform the tasks intrinsic to the role;
- has not been responsible for, contributed to or facilitated serious misconduct or mismanagement while carrying on a regulated activity or providing an equivalent service; and
- is not subject to any ground of unfitness in Part 1 of Schedule 4 to the Regulations.

Good character includes consideration of relevant criminal convictions and whether a person has been erased, removed or struck off a register maintained by a healthcare or social work professional regulator. Schedule 4 also includes specified insolvency restrictions, barred-list status and legal prohibition from holding the relevant office.

4.2 Fair and individual assessment

Each assessment will be evidence-based, considered on its individual facts, proportionate to the role and completed in accordance with equality, employment and data protection law.

Health or disability information will be considered only to the extent relevant and necessary to determining capability after reasonable adjustments.

Board Members will be given a reasonable opportunity to respond to information that may adversely affect an assessment or reference.

4.3 Appointment and promotion

No Board Member will commence in post until the Employability and Retention Lead has completed the required pre-appointment checks, obtained the appropriate references and reached a documented FPPT conclusion, approved by the Chair.

Any unresolved gap, discrepancy or mitigation must be expressly recorded and approved through the decision-making arrangements in this policy.

4.4 Initial FPPT assessment

The initial assessment will use the current NHS England checklist and will, as applicable, verify identity and employment history; qualifications, competence and development; references; appraisal information; relevant disciplinary, grievance, speaking-up and employee behaviour findings or investigations; DBS status in line with local policy; professional registration; occupational health clearance; director, insolvency and charity trustee disqualification checks; settlement agreement

information where relevant; social media and employment tribunal judgement checks; annual/new starter self-attestation; and Chair or Chief Executive sign-off.

The Chair will consider substantiated findings from disciplinary processes, Freedom to Speak Up investigations, patient safety investigations, regulatory reviews, CQC inspections, external investigations and other relevant sources when assessing fitness and propriety.

Required information will be recorded in ESR and supporting evidence filed and retained securely in individual Board member folders in both paper and digital formats.

4.5 Annual FPPT cycle

Every Board Member will complete an annual self-attestation and annual FPPT assessment. The assessment should be aligned with annual appraisal and with consideration of competence and development against the NHS Leadership Competency Framework.

Relevant ESR fields will be validated and updated, supporting evidence retained locally and an explicit conclusion recorded.

The Chair will also complete a self-attestation. The Senior Independent Director will provide the appropriate oversight for the Chair's assessment.

Documented evidence demonstrating compliance with the NHS Leadership Competency Framework shall be maintained as part of each board member's FPPT record

4.6 Changes in circumstances and concerns

Board Members must notify the Chair and Head of Corporate Governance (Company Secretary) without delay of any change that may affect fitness or propriety, professional registration, an interest or, for a Non-Executive Director, independence.

Concerns may arise through regulatory notification, recruitment information, appraisal, employment processes, speaking-up routes, public information or other credible sources.

Concerns will be assessed promptly, fairly and confidentially by the Chair, with appropriate professional advice and an opportunity for the individual concerned to respond.

4.7 Outcomes, mitigations and escalation

The conclusion will state whether the person is fit and proper. Where concerns, information gaps or mitigations exist, the rationale, evidence, action, responsible person and review date will be documented and approved by the Chair.

Where a person is assessed as unfit by the Chair on behalf of the Trust, or continuation is exceptionally proposed despite a failed element, the Trust will act in accordance with Regulation 5, employment or appointment arrangements, the Trust Constitution and the NHS England Framework, including notification or submission to NHS England and engagement with the CQC where required.

Where concerns indicate a potential failure of the FPPT, the Chair shall determine whether notification to NHS England, the Care Quality Commission or other relevant bodies is required and ensure this is undertaken without undue delay.

4.8 Board member references

- The NHS England board member reference template will be used on all occasions to establish the primary facts as required by the board member reference template.
- For new board member appointments:
  - If the person to be appointed is from outside the NHS, the Trust should obtain a minimum of two references covering a minimum of six years' employment history.
  - If the person to be appointed is from within the NHS but moving into a Board role for the first time, the Trust should obtain a minimum of two references covering a minimum of six years' employment history.
  - The two references should come from different employers, where possible.
- For an individual who moves from an NHS board level role to the Trust Board:
  - A reference should be obtained from the previous/current NHS organisation, and, in addition, wherever possible, a further reference from a separate organisation should be obtained, covering a minimum of six years' employment history.
- References will be obtained before appointment, be validated as bona fide, and be assessed alongside the wider evidence rather than as the sole basis for a decision.
- A complete board member reference will be prepared, approved and retained when a Board Member leaves, including retirement or movement to a non-board or non-NHS role, whether or not a request has been received.
- References supplied by the Trust will be accurate, complete, open, honest and fair, based on established and documented facts, signed off by the Chair and normally provided within the national timeframe.
- Where subsequently discovered information would materially change a reference, the Trust will consider and, where required, issue an updated reference in accordance with the Framework.

4.9 ESR, local records and data protection

Restricted FPPT information will be recorded accurately and promptly in ESR by authorised staff. Supporting documents will be retained securely in individual Board member folders in both paper and digital formats.

Access will be limited to those who require it for a legitimate function. Processing will comply with the UK General Data Protection Regulation, Data Protection Act 2018, the Trust's privacy information and the NHS Records Management Code of Practice.

Local staff records will normally be retained for at least six years, subject to longer retention where justified by the seriousness and relevance of a case; ESR FPPT information and accompanying references will be retained on the career-long basis set out in the Framework.

4.10 Declarations and management of interests

Board Members must declare relevant and material actual, potential or perceived interests on appointment, annually, when circumstances change and at the start of any meeting where an agenda item creates a relevant interest. This includes, where relevant, directorships, employment, consultancy, ownership and shareholdings, positions of authority in charities or voluntary bodies, connections with organisations commissioning or providing NHS services, gifts, hospitality, sponsorship, clinical private practice and relevant interests of close family or associates.

The Chair, advised by the Head of Corporate Governance (Company Secretary), will determine appropriate management. This may include recording the interest, restricting access to information, withdrawal from discussion, exclusion from decision-making or voting, or other proportionate action.

The declaration and action taken will be recorded in the Board minutes and Register of Interests. Board Members must also comply with the Trust's Standards of Business Conduct and Conflicts of Interest requirements.

4.11 Register of Interests

The Head of Corporate Governance (Company Secretary) will maintain the Board Register of Interests, update it following changes, arrange annual review by the Board and publish or make it available as required by legislation, the Trust Constitution and applicable NHS guidance. Personal information that is not necessary for transparency will not be published.

4.12 Non-Executive Director independence

Each Non-Executive Director will declare information relevant to independence on appointment, annually and when circumstances change.

The Board will identify in the annual report which Non-Executive Directors it considers independent in character and judgement and will explain any relevant relationships or circumstances, including recent Trust employment, material business relationships, additional remuneration, close family ties, cross-directorships or significant links with other directors, and length of service.

The assessment will be made against the Code of Governance for NHS Provider Trusts and the Trust Constitution.

5. Duties

Role	Duties
Trust Board	Approve the policy; receive annual public assurance that FPPT requirements have been satisfied; consider the Register of Interests and Non-Executive Director independence; oversee actions arising from audit or review.
Chair	Hold ultimate accountability for effective FPPT systems; ensure appointment and annual assessments and self-attestations are complete; oversee appraisal and development; conclude or approve FPPT outcomes; sign relevant references and annual submissions; ensure concerns and mitigations are documented and acted on.
Senior Independent Director / Deputy Chair	Provide independent oversight of the Chair's FPPT assessment and appraisal arrangements, and undertake escalated responsibilities where the Chair has a conflict or is the subject of a concern.
Chief Executive	Support the Chair; ensure Executive Director accountability and organisational resources; declare concerns relevant to Board Member fitness; complete own annual requirements.
Chief People Officer	Ensure robust recruitment, employment, occupational health, regulatory, reference and appraisal processes for Executive Board Members; support ESR accuracy and secure local records; advise on employment, equality and due process.
Head of Corporate Governance (Company Secretary)	Coordinate policy implementation; maintain the Board Member scope list, declarations, registers, evidence matrix and governance records; support annual and appointment assessments; coordinate Board, Audit Committee and Council of Governors reporting; maintain procedural guidance and liaise with NHS England and CQC as required.
Line managers / appraisers	Complete evidence-based appraisal and leadership competency assessment, identify development needs, review self-attestation and promptly raise relevant concerns.
Board Members	Provide complete, accurate and timely information; participate in appointment and annual

Role	Duties
	checks, appraisal and development; declare interests and changes in circumstances; cooperate with review; comply with conduct, confidentiality and conflict-management requirements.
Audit Committee	Receive assurance from internal or external review, monitor agreed actions and advise the Board on the adequacy of controls.
Council of Governors	Exercise statutory and constitutional responsibilities relating to appointment, appraisal and removal of the Chair and Non-Executive Directors and receive relevant assurance.
Internal Audit or independent reviewer	At least every three years, assess FPPT processes, controls and compliance, including sample testing of assessments and associated documentation, and report findings through the agreed governance route.

The Trust shall complete the NHS England Annual FPPT Submission in accordance with nationally prescribed requirements. The annual submission will be coordinated by the Head of Corporate Governance (Company Secretary), reviewed by the Chair and approved by the Trust Board prior to submission. Evidence supporting all declarations shall be retained in accordance with the Framework and Records Management Code of Practice.

Records of annual appraisals, competency assessments, self-attestations and FPPT conclusions shall be retained as part of the Board Member's FPPT record.

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?**	**SWYPFT - Trust Board Fit and Proper Persons Test Policy, including declarations of interest and independence.** Updated following internal audit report including strengthened aligned to the NHS England FPPT Framework.
2	**Description of the document:** *Prompt: what is the aim of the document?*	The policy establishes a consistent, fair, proportionate and auditable process for assessing whether Board Members are fit and proper on appointment to the Board and demonstrates the process to be undertaken throughout their tenure by means of annual checks. It includes declarations of interests and independence for Non-Executive Directors.
3	**Lead contact person for the Equality Impact Assessment**	Name: Andrew Lister Job title: Head of Corporate Governance (Company Secretary)
4	**Who else is involved in undertaking this Equality Impact Assessment** *Prompt: list all people involved by name and job title*	Policy development involved the Head of Corporate Governance and People Directorate. Trust Equality Representative
5	**Sources of information used to identify gaps and barriers** *Prompt: local, regional, national research/reports/journals & profession updates. Complaints and compliments data.*	**Source: Census 2021 data** **Workforce data:** Trust Board Equality Profile dated 15 September 2026 (Board and headline workforce sex and ethnicity data); workforce data 2025 and the Trust Board Fit and Proper Persons Test, Declaration of Interests and Independence Policy 2026. The Board profile provides Board-level information only for sex and ethnicity. The detailed workforce report provides wider information on age, disability, race, religion or belief, marital status, sex and sexual orientation. Data for Board members on these characteristics is not publicly available due to Board numbers being small, and therefore there is a risk of identifiable information and breaches of confidentiality. Data sets do not report pregnancy and maternity, gender reassignment or caring status.

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.

Source: Census 2021 data
Workforce data: 2025

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%

	No	Not Declared	Prefer Not to Answer	Yes
Employees	4736	184	52	561
Percentage	85.60%	3.33%	0.94%	10.14%

Impact: Potential adverse impact could arise if the health element of FPPT is treated as a diagnosis-based test rather than an assessment of ability to perform intrinsic duties after reasonable adjustments. The policy mitigates this by limiting health information

<table>
<tr><td></td><td></td><td>to what is relevant and necessary. This requires reasonable adjustments where necessary for individual circumstances. Assessment information and meetings should be provided in accessible formats.
Assessment: Possible impact, mitigated through reasonable adjustments, confidentiality, accessible information and monitoring.</td></tr>
<tr><td></td><td>QUESTIONS</td><td>ANSWERS AND ACTIONS</td></tr>
<tr><td>5b</td><td>Gender:

Prompt: Female & Male issues should be considered</td><td>Source: Census 2021 data
Workforce data:2025

<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>

<table>
<tr><th></th><th>Female</th><th>Male</th></tr>
<tr><td>Employees</td><td>4329</td><td>1204</td></tr>
<tr><td>Percentage</td><td>78.24%</td><td>21.76%</td></tr>
</table>

Impact: FPPT criteria apply equally but there is the possibility of unequal access to senior career opportunities.
Decision-makers must assess competence against the role, avoid sex-based assumptions and ensure appraisal, reference and concern processes are consistently evidenced.
Pregnancy-related absence must not be treated as a competence, conduct or commitment concern.
Assessment: No direct negative impact is identified from the policy if equality monitoring of Board recruitment, appointment and annual FPPT process and outcomes are adhered to and monitored.</td></tr>
<tr><td>5c</td><td>Age:

Prompt: Older people & Young People issues should be considered</td><td>Source: Census 2021 data
Workforce data:2025</td></tr>
</table>

Area	Under 18	18-39	40-59	60-79	Over 80
England	11,774,609 20.8%	16,161,002 28.6%	14,897,132 26.4%	10,858,911 19.2%	2,798,379 5%
Barnsley	50,068 20.5%	65,448 26.8%	65,850 26.9%	51,606 21.1%	11,595 4.7%
Calderdale	45,122 21.8%	51,990 25.2%	57,280 27.7%	42,548 20.6%	9,694 4.7%
Kirklees	98,029 22.6%	11,9116 27.5%	114,735 26.5%	81,845 18.9%	19,484 4.5%
Wakefield	73,625 20.8%	96,756 27.4%	94,822 26.8%	71,717 20.3%	16,440 4.7%

Workforce data: Trust data as at December 2025

Row Labels	Distinct Count of Employee Number	Percentage %
<=20 Years	16	0.36%
>=71 Years	32	0.49%
21-25	235	5.13%
26-30	623	13.10%
31-35	697	14.06%
36-40	749	14.43%
41-45	678	12.09%
46-50	681	11.29%
51-55	706	10.76%
56-60	682	10.24%
61-65	444	6.57%
66-70	94	1.48%
Grand Total	**5637**	**100.00%**

		Impact: Experience and competence must be assessed against objective role requirements without assumptions about age, length of service, digital capability or retirement proximity. Information and assessment methods should be accessible and flexible. Assessment: No negative impact identified; monitor Board recruitment and FPPT outcomes by age where numbers allow and confidentiality can be protected.
5d	**Sexual Orientation:** *Prompt: Heterosexual, Bisexual, Gay, Lesbian groups should be considered*	**Source: Census 2021 data** **Workforce data:2025** **Workforce data: Trust data as at December 2025**

Area	Straight or heterosexual	Gay or lesbian	Bisexual	Other sexual orientation	Not answered
England	43,403,110 89.37%	747,805 1.54%	623,504 1.29%	165,305 0.34%	3,626,649 7.46%
Barnsley	182,948 91.57%	2,990 1.5%	1,817 0.91%	396 0.2%	11,638 5.83%
Calderdale	149,815 89.91%	2,811 1.69%	1,968 1.18%	550 0.33%	11,488 6.89%
Kirklees	311,501 89.96%	4,340 1.25%	3,697 1.07%	998 0.29%	25,742 7.43%
Wakefield	261,615 90.98%	4,321 1.50%	2,968 1.03%	689 0.24%	17,945 6.24%

Row Labels	Count of Employee Number	Percentage %
Bisexual	103	1.83%
Gay or Lesbian	140	2.49%
Heterosexual or Straight	4804	85.36%
Not stated (person asked but declined to provide a response)	521	9.26%
Other sexual orientation not listed	11	0.20%
Undecided	7	0.12%
Unspecified	42	0.75%
Grand Total	**5637**	**100.00%**

		Impact: Sexual orientation is not relevant to fitness or propriety. Declarations of interests do require generalised disclosure of personal relationships i.e spouse not named, and records must be handled confidentially. References, conduct concerns and public-source checks must be assessed objectively without stereotyping. Assessment: No adverse impact expected if data protection and confidentiality safeguards are followed.
5e	**Religion or Belief:** *Prompt: Main faith groups and people with no belief or philosophical belief issues should be considered*	**Source: Census 2021 data** **Workforce data:2025** **Workforce data: Trust data as at December 2025** Impact: Religion or belief is not a criterion of FPPT framework. Assessment: Any potential impact is mitigated through consistent evidence standards, opportunity to respond and equality-aware decision-making.

Area	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other	No religion	Not answered
England	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%	3,400,548 6.0%
Barnsley	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%	1,2728 5.2%
Calderdale	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%	11,129 5.4%
Kirklees	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%	23,949 5.5%
Wakefield	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%	18,972 5.4%

Row Labels	Distinct Count of Employee Number	Percentage %
Atheism	1453	27.33%
Buddhism	27	0.50%
Christianity	2594	45.56%
Hinduism	62	1.08%
I do not wish to disclose my religion/belief	780	12.48%
Islam	273	5.27%
Jainism	1	0.01%
Judaism	9	0.17%
Other	412	7.11%
Sikhism	24	0.47%
Unspecified	2	0.03%
Grand Total	**5637**	**100.00%**

5f	**Marriage and Civil Partnerships** *Prompt: Single, Married, Co-habiting, Widowed, Civil Partnership status should be considered*	**Source: Census 2021 data** **Workforce data:2025**

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%

Workforce data: Trust data as at December 2025

Row Labels	Distinct Count of Employee Number	Percentage %
No data input	3	0.07%
Civil Partnership	97	1.81%
Divorced	448	7.28%
Legally Separated	52	0.84%
Married	2790	47.51%
Single	2110	40.29%
Unknown	71	1.22%
Widowed	66	0.98%
Grand Total	**5637**	**100.00%**

<table>
<tr><td></td><td></td><td>Impact: Marriage or civil partnership is not relevant to FPPT. Interest declarations may properly capture relevant interests involving close family or associates, but only information necessary to identify and manage an actual, potential or perceived conflict should be collected or published.
Assessment: No adverse impact expected, subject to proportionality, confidentiality and data minimisation.</td></tr>
<tr><td>5g</td><td>Pregnancy and Maternity

Prompt: Currently pregnant or have been pregnant in the last 12 months should be considered</td><td>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

<table><tr><th>Area</th><th>Number of live births 2021</th><th>Percentage of Total fertility rate (TFR)</th></tr><tr><td>England</td><td>595,948</td><td>1.55%</td></tr><tr><td>Barnsley</td><td>2,521</td><td>1.63%</td></tr><tr><td>Calderdale</td><td>2,143</td><td>1.71%</td></tr><tr><td>Kirklees</td><td>4,826</td><td>1.72%</td></tr><tr><td>Wakefield</td><td>3,857</td><td>1.68%</td></tr></table>Workforce data: Trust data as at December 2025 – Not held in relation to Trust data or absence process

Impact: Pregnancy, maternity leave or related absence must not be interpreted as evidence about competence, attendance commitment, health suitability or propriety. Reasonable flexibility should be provided for assessment, appraisal and evidence deadlines, and only role-relevant information should be retained.
Assessment: There should not be any material impact if the above protocols are adhered to. The Trust has an up-to-date family leave policy in place.</td></tr>
<tr><td>5h</td><td>Gender Re-assignment

Prompt: Transgender issues should be considered</td><td>Source: Census 2021 data
NB: Percentages are calculated from the total usual resident population aged 16 years and over

<table><tr><th>Area</th><th>Gender identity the same as sex registered at birth</th><th>Gender identity different from sex registered at birth</th><th>Not answered</th></tr><tr><td>England</td><td>43,002,331
93.47%</td><td>251,844
0.55%</td><td>2,752,783
5.98%</td></tr><tr><td>Barnsley</td><td>189,640
94.92%</td><td>803
0.74%</td><td>9,389
4.70%</td></tr><tr><td>Calderdale</td><td>156,893
94.16%</td><td>829
0.89%</td><td>8,966
5.38%</td></tr><tr><td>Kirklees</td><td>323,432
93.40%</td><td>1,725
0.9%</td><td>21,214
6.13%</td></tr><tr><td>Wakefield</td><td>271,795
94.52%</td><td>1,280
0.81%</td><td>14,539
5.06%</td></tr></table></td></tr>
</table>

		Workforce data: Trust data as at December 2025 – Not held in relation to Trust data or absence process Impact: Gender reassignment is not relevant to the FPPT framework. Identity checking, ESR entries, references and historic records must be handled sensitively, lawfully and confidentially, including where names or documents have changed. No unnecessary disclosure should occur. Assessment: No adverse impact expected if privacy, dignity and accurate-record safeguards are applied.
5l	**Carers** *Prompt: Caring responsibilities paid or unpaid should be considered*	**Source: Census 2021 data** *NB: Missing values account for 'N/A' or 'not answered'* **Workforce data:2025** **Workforce data: Trust data as at December 2025**

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%

Row Labels	Distinct Count of Employee Number	Percentage %
Not Recorded	5386	95.98%
Working Carer	251	4.02%
Grand Total	**5637**	**100.00%**

		Impact: Caring responsibilities are not relevant to the FPPT framework. Assessment and appraisal arrangements should allow reasonable scheduling flexibility. Availability assumptions should not influence competence or conduct judgements. Assessment: No adverse impact expected, with flexible administration and objective role-based assessment.
5j	**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)*	**Source: Census 2021 data** **Workforce data:2025**

Area	White	Asian	Black	Mixed	Chinese & other
England	45,783,401 81%	5,426,392 9.6%	2,381,724 4.2%	1,669,378 3%	1,229,153 2.1%
Barnsley	236,964 (96.6%)	2,297 (0.9%)	1,715 (0.7%)	2,293 (0.9%)	1,333 (0.5%)
Calderdale	177,836 (86.1%)	21,726 (10.5%)	1,439 (0.7%)	4,027 (1.9%)	1,603 (0.8%)
Kirklees	318,969 (73.6%)	84,202 (19.4%)	9,948 (2.3%)	13,588 (3.1%)	6,506 (1.5%)
Wakefield	328,742 (93%)	12,633 (3.6%)	4,516 (1.3%)	4,938 (1.4%)	2,541 (0.7%)

Workforce data: Trust data as at December 2025

Row Labels	Distinct Count of Employee Number	Percentage %
A White - British	4377	74.99%
B White - Irish	22	0.38%
C White - Any other White background	99	1.90%
CA White English	2	0.04%
CD White Cornish	1	0.02%
CP White Polish	1	0.02%
CX White Mixed	3	0.06%
D Mixed - White & Black Caribbean	42	0.84%
E Mixed - White & Black African	19	0.41%
F Mixed - White & Asian	22	0.38%
G Mixed - Any other mixed background	22	0.38%

GA Mixed - Black & Asian	1	0.02%
GC Mixed - Black & White	1	0.02%
GF Mixed - Other/Unspecified	2	0.04%
H Asian or Asian British - Indian	169	3.11%
J Asian or Asian British - Pakistani	147	2.76%
K Asian or Asian British - Bangladeshi	15	0.31%
L Asian or Asian British - Any other Asian background	38	0.72%
LD Asian East African	1	0.02%
LH Asian British	1	0.02%
M Black or Black British - Caribbean	41	0.71%
N Black or Black British - African	472	9.99%
P Black or Black British - Any other Black background	9	0.16%
PC Black Nigerian	13	0.29%
PD Black British	3	0.05%
R Chinese	13	0.25%
S Any Other Ethnic Group	30	0.60%
SE Other Specified	1	0.02%
Unspecified	2	0.05%
Z Not Stated	68	1.45%
Grand Total	**5637**	**100.00%**

Impact: FPPT uses recruitment, appraisal, reference, disciplinary and other conduct information, so historic or process bias could be carried into decisions unless evidence is scrutinised.

The Trust should continue to have panel diversity, consistent decision records, an opportunity to respond and review of adverse outcomes are important safeguards.

PCREF is service-facing and is not directly engaged by this Board employment policy, although its anti-racist principles are consistent with fair governance.

Assessment: Potential impact identified. Board recruitment and appointment processed and outcomes, FPPT decisions, and use of adverse information should be monitored by ethnicity where data and confidentiality allow, with periodic independent review and escalation of recurring patterns.

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?*

Due to the fact that this policy is applicable to Board members only, review has been sought by all executive board members via the executive management team meeting.

In addition, a newly appointed non-executive director who was part of the team that implemented the Kark review findings in 2023 that resulted in the new national FPPT framework has also been engaged in the development of this policy.

The policy cannot be approved until signed off by all Board members on 28 September 2026. All Board members will have the opportunity to read and review this policy prior to sign off on 28 September 2026.

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

1. No EIA previously in place

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	☒	Use the 15 September 2026 Trust Board equality profile as the baseline for sex and ethnicity. Ensure equality remains high priority for the purpose of Board recruitment, appointment and annual FPPT outcomes, and where necessary any use of mitigations, concerns and decision timeliness by protected characteristic where data quality and small-number confidentiality permit. Compare future Board composition with the wider workforce only as contextual evidence. Escalate recurring differential patterns for review.	Head of Corporate Governance	From 2026/27 annual cycle	Evidence reported through annual FPPT assurance and periodic independent review (every 3 years).	
Disability	☒					
Gender reassignment	☒					
Marriage and civil partnership	☒					
Race	☒					

Religion or belief	☒					
Sex	☒					
Sexual Orientation	☒					
Pregnancy maternity	☒					
Carers	☒					

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	☐	Include equality and bias checks within the three-yearly independent review of FPPT controls. Sampling should test whether references, disciplinary or speaking-up information, public-source searches and competency judgements were relevant, corroborated, consistently weighed and free from stereotyping. Findings and actions should be reported to Audit Committee and Trust Board.	Head of Corporate Governance /Internal Audit or independent reviewer	Every three years	Evidence reported through annual FPPT assurance and periodic independent review.	
Disability	☒					
Gender reassignment	☒					
Marriage and civil partnership	☐					
Race	☐					
Religion or belief	☒					

Sex	☐					
Sexual Orientation	☐					
Pregnancy maternity	☒					
Carers	☒					

Methods of monitoring actions: Actions will be monitored and updated as per stipulated policy review periods and should any technical policy changes be implemented as a result of national guidance.

Publication

The completed EIA will be submitted to the Equality and Engagement team for review and grading. Following sign-off, it may be published with the policy on the Trust intranet and, where appropriate, the public website. Any workforce or Board-level data published will be aggregated and subject to small-number confidentiality controls.

7 EIA assessment by

Name: Iffath Hussain Diversity Inclusion & Belonging Lead

Date: 17 September 2026

Rating: Achieving

Recommendations: 5 or more workforce and Sensus data has been used to complete EIA. Important to review policy as per review date to ensure intended actions are delivered and monitored as recorded in the EIA.

7. Dissemination and implementation arrangements (including training)

The approved policy will be published on the Trust intranet and, where appropriate, the public website. Superseded versions will be archived in accordance with document-control arrangements.

No general Trust-wide classroom training is required. Targeted briefing and procedural support will be provided when the Framework, legislation, ESR requirements or local processes change.

8. Process for monitoring compliance and effectiveness

Control	Standard	Lead	Frequency	Reported to
Board Member scope list	Complete and current list of posts and people in scope	Head of Corporate Governance	On appointment/change and annual review	Chair
New appointment assessment	100% completion before commencement, with documented conclusion and	Chief People Officer / Head of Corporate Governance	Each appointment	Chair / appointing body

Control	Standard	Lead	Frequency	Reported to
	required evidence			
Annual self-attestation and FPPT assessment	100% completion for Board Members, with documented conclusion	Head of Corporate Governance	Annually	Trust Board
Appraisal and competency assessment	Completion and development needs recorded	Relevant appraiser / Chief People Officer	Annually	Chair
ESR and local records	Required fields updated; evidence securely retained; access controlled	Chief People Officer / authorised ESR lead	On change and annual validation	Chair
Board member references	Required incoming references obtained; departing reference completed and retained	Chief People Officer / Head of Corporate Governance	Each appointment/departure	Chair
Interests and independence	Declarations current; conflicts managed; register reviewed and published as required	Head of Corporate Governance	Ongoing and annual	Trust Board
Annual assurance submission	Board assurance and NHS England regional submission completed	Chair / Head of Corporate Governance	Annually	Trust Board
Independent assurance	FPPT process, controls and compliance reviewed with sample testing	Internal Audit / independent reviewer	At least every three years	Audit Committee and Trust Board

9. Review and revision arrangements

The Head of Corporate Governance (Company Secretary), working with the Chief People Officer, will review this policy at least every three years and sooner where legislation, Regulation 5, the NHS England Framework, CQC expectations, ESR arrangements, the Trust Constitution, governance codes, audit findings or organisational responsibilities change.

Material amendments will be subject to stakeholder consultation, an updated Equality Impact Assessment and approval through the route shown on the document-control page. Minor administrative amendments may be made under the Trust's policy governance arrangements, with the version-control record updated.

10. References

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 5 and Schedule 4
- NHS England Fit and Proper Person Test Framework for board members
- NHS England associated FPPT guidance documents and templates
- NHS Leadership Competency Framework for board members
- NHS Constitution for England
- NHS Records Management Code of Practice
- Data Protection Act 2018
- UK General Data Protection Regulation
- Equality Act 2010
- Bribery Act 2010

11. Associated documents

This section should list any other documents to be read in association with the policy. This could include other policies, procedures and guidance documents.

12. Appendices

Appendix A: Checklist for the review and approval of policy document
Appendix B: Version control sheet

Appendix A - Checklist for the review and approval of policy document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		

	Is the method described in brief?	Yes	
	Are people involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	Reviewed by the Chief People Officer and Director of Finance, Estates and Resources and one Non-Executive Director with experience of the FPPT process.
	Is there evidence that a trauma-informed 'lens' has been applied? e.g. through use of language etc.	N/A	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint People Directorate Human Resources/staff side committee (or equivalent) approved the document?	N/A	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		

	Is the policy written on the Policy template, including all headings as outlined in the Policy on Polices at appendix E.	Yes	
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	Annual FPPT process and FPPT process for Board level appointments and relevant documentation and folders.
	Is there a plan to review or audit compliance with the document?	Yes	Three yearly internal audit review.
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	Yes	

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)	✘		✘	✘		✘	✘	✘		✘		✘

Agenda item / issue	28 Apr	26 May	30 June	28 July	25 Aug	29 Sep	27 Oct	1 Dec (Nov)	15 Dec	26 Jan	23 Feb	30 Mar
Any other business (public and private)	✘		✘	✘		✘	✘	✘		✘		✘
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)		✘				✘
Learning from healthcare deaths report			✘			✘ (annual)	✘	✘				✘
Guardian of safe working hours annual report								✘				
Workforce Equality Standards						✘						
Medical appraisal / revalidation annual report						✘						
Ligature Annual Report								✘				
Drugs and Therapeutics Annual Report						✘						
Safeguarding 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		✘	✘									

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
(delegated authority required for submission for 30 June)												
Cyber Board security update (private)	✘						✘					
Annual report and accounts (private)		✘	✘									
Quality Account			✘									
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												

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
South Yorkshire update including the South Yorkshire Integrated Care System (SY ICS)	✘		✘	✘		✘	✘	✘		✘		✘
West Yorkshire update including the West Yorkshire & Health & Care Partnership (WYHCP)	✘		✘	✘		✘	✘	✘		✘		✘
Provider Collaboratives and Alliances	✘		✘	✘		✘	✘	✘		✘		✘
Performance reports												
Integrated Performance Report (IPR)	✘		✘	✘		✘	✘	✘		✘		✘
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	✘											

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
Assessment against NHS Constitution				✘								
Audit Committee annual report including committee annual reports and terms of reference	✘											
Use of Trust Seal			✘			✘		✘				✘
Internal governance structure review												✘
Strategies and Policies												
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						✘						
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 *(September 2026)*