NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 27 September 2022 at 9.00
Large Conference Room – Wellbeing and Development Centre
Fieldhead Hospital Wakefield

AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	**9.00**	**Welcome, introductions and apologies**	Chair	**Verbal item**	1	To receive
2.	**9.01**	**Declarations of interest**	Chair	**Verbal item**	2	To receive
3.	**9.03**	**Questions from the public**				
		(received in advance in writing by e:mail to membership@swyt.nhs.uk)	Chair	**Verbal item**	7	To receive
4.	**9.10**	**Minutes from previous Trust Board meeting held 26 July 2022**	Chair	**Paper**	2	To approve
5.	**9.12**	**Matters arising from previous Trust Board meeting held 26 July 2022 and board action log**	Chair	**Paper**	8	To approve
6.	**9.20**	**Service User / Staff Member / Carer Story**	Chief Operating Officer	**Verbal item**	10	To receive

With **all of us** in mind.

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
7.	**9.30**	**Chair's remarks**	Chair	**Verbal item**	3	To receive
8.	**9.33**	**Chief Executive's report**	Chief Executive	**Paper**	7	To receive
9.	**9.40**	**Performance**				
	9.40	9.1 IPR review	Director of Finance, Estates & Resources	**Paper**	5	To receive
	9.45	9.2 Integrated performance report Month 5 2022/23	Director of Finance, Estates & Resources	**Paper**	45	To receive
	10.30	*Break*			*10*	
10.	**10.40**	**Risk and Assurance**				
	10.40	10.1 Serious Incidents Quarterly report	Chief Nurse and Director of Quality and Professions	**Paper**	5	To receive
	10.45	10.2 Workforce Equality Standards Report	Chief People Officer	**Paper**	5	To receive
	10.50	10.3 Medical appraisal / revalidation annual report	Chief Medical Officer	**Paper**	5	To approve

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	10.55	10.4 Community Safer Staffing Report	Chief Nurse and Director of Quality and Professions	**Paper**	10	To receive
	11.05	10.5 Assurance and receipt of minutes from Trust Board Committees and Members' Council - Collaborative Committee 4 August 2022 - Clinical Governance & Clinical Safety Committee 13 September 2022 - Equality, Inclusion and Involvement Committee 20 September 2022 - Finance, Investment & Performance Committee 22 August/26 September 2022 - Mental Health Act Committee 16 August 2022 - Members Council 16 August 2022 - Workforce and Remuneration Committee 13 September 2022 - WYMHLDA Collaborative Committees in Common 26 September 2022	Chairs of committees/Members' Council	**Paper**	10	To receive
	11.15	*Break*			*10*	
10.	**11.25**	**11. Integrated Care Systems and Partnerships**				
	11.25	11.1 South Yorkshire update including South Yorkshire Integrated Care System (SYICS)	Chief Executive/ Director of Strategy and Change	**Paper**	10	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.35	11.2 West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update	Director of Strategy and Change and Director of Provider Development	**Paper**	10	To receive
	11.45	11.3 Provider Collaboratives and Alliances	Director of Strategy and Change and Director of Provider Development	**Paper**	5	To receive
12.	**11.50**	**Governance matters**				
	11.50	12.1 Quality Account	Chief Nurse and Director of Quality and Professions	**Paper**	5	To receive
	11.55	12.2 Equality, Inclusion and Involvement Committee Terms of Reference	Chair	**Paper**	5	To approve
	12.00	12.3 Workforce and Remuneration Committee Terms of Reference	Deputy Chair	**Paper**	5	To approve
	12.05	12.4 Internal Governance Structure	Deputy Director of Corporate Governance	**Paper**	5	To receive
	12.10	12.5 Trust Seal	Chair	**Paper**	2	To receive
13.	**12.12**	**Trust Board work programme for 2022/23**	Chair	**Paper**	3	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
14.	**12.15**	**Any other business**	Chair	**Verbal item**	3	To note
15.	**12.18**	**Date of next meeting** The next Trust Board meeting held in public will be held on Tuesday 25 October 2022	Chair	**Verbal item**	2	To note
	12.20	*Close*				

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 26 July 2022
Microsoft Teams meeting

Present:	Marie Burnham (MBu)	Chair
	Mike Ford (MF)	Senior Independent Director
	Mandy Griffin (MG)	Deputy Chair
	Erfana Mahmood (EM)	Non-Executive Director
	Natalie McMillan (NM)	Non-Executive Director
	David Webster (DW)	Non-Executive Director
	Mark Brooks (MBr)	Chief Executive
	Carol Harris (CH)	Chief Operating Officer
	Darryl Thompson (DT)	Director of Nursing, Quality and Professions
	Salma Yasmeen (SY)	Deputy Chief Executive/Director of Strategy and Change
Apologies:	Kate Quail (KQ)	Non-Executive Director
	Dr. Subha Thiyagesh (ST)	Chief Medical Officer
In attendance:	Rob Adamson (RA)	Deputy Director of Finance
	Greg Moores (GM)	Chief People Officer
	Dr. Mathen Manoj (MM)	Consultant Psychiatrist
	Sean Rayner (SR)	Executive Director of Provider Development
	Andy Lister (AL)	Company Secretary (author)
	Ashley Hambling (AH) (item 10.2)	Human Resources Business Manager
	Dr Jane Grant (item 6)	Consultant Psychologist - Calderdale Older Peoples Services
Observers:	Claire Robson (until 9:30)	Project Manager

TB/22/63 Welcome, introduction and apologies (agenda item 1)

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

MBu welcomed Dr Manoj Mathen, who was in attendance for Dr Subha Thiyagesh, and Rob Adamson, Deputy Director of Finance. Adrian Snarr, the new Director of Finance, Estates and Resources, starts with the Trust on 8 August 2022.

MBu outlined the Microsoft Teams meeting protocols and etiquette and reported this meeting was being live streamed for the purpose of inclusivity, to allow members of the public access to the meeting.

MBu informed attendees that the meeting 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.

MBu reminded the members of the public that there would be an opportunity at the beginning of the meeting for questions and comments, received in writing.

TB/22/64 Declarations of interest (agenda item 2)

It was RESOLVED to NOTE there were no further declarations of interest to those already submitted.

TB/22/65 Questions from the public (agenda item 3)

It was RESOLVED to NOTE no questions had been received from members of the public

TB/22/66 Minutes from previous Trust Board meeting held 28 June 2022 (agenda item 4)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 28 June 2022 as a true and accurate record.

TB/22/67 Matters arising from previous Trust Board meeting held 28 June 2022 and board action log (agenda item 5)

David Webster (DW) noted actions assigned to James Sabin should now be transferred to Adrian Snarr.

Action: Andy Lister

TB/22/40c – Erfana Mahmood (EM) noted the action in relation to safer staffing has been deferred and asked for a revised date for completion. Darryl Thompson (DT) reported this would go through Clinical Governance Clinical Safety (CGCS) Committee in September and then come to Board. To remain open.

TB/22/55d – MBu raised progress on quality monitoring visits. DT reported two quality monitoring visits have been booked for the summer months. To close

TB/22/42b – Mike Ford (MF) requested the action in relation to Board effectiveness surveys, and to transfer to the Audit Committee workplan needs to be allocated to Andy Lister.

It was RESOLVED to NOTE the changes to the action log and AGREED to close all actions with updates for July 2022 and any other actions where closure is proposed in the comments.

TB/22/68 Service User/Staff Member/Carer story (agenda item 6)

MBu welcomed Dr Jane Grant (JG) to the meeting.

JG reported she is a clinical psychologist and was working with the Calderdale older people's community mental health team during Covid-19.

JG stated today's story will cover what it was like to be working in an older people's community team during the pandemic. The team supports older people with social, emotional, mental health and relationship challenges and at the time this project took place, the team had been working with Covid-19 for about sixteen months.
The project speaks from many different positions, including staff that were shielding. There were many different voices included in the work, with similar feelings of isolation from colleagues, family and friends.

Although all staff worked on the same team, their experiences of Covid-19 were very different, and it was due to this sense of disconnection the project came about.

The project had two aims:

- To reconnect the team's experiences back into one place, so that the team knew what each other was going through
- To share experiences with others

JG met with the team in small groups, on Microsoft teams or in person, to interview them.

From the themes of the interviews JG wrote a collective document including experiences and quotes. It documented struggles, how people had found different ways to navigate working through the pandemic, and also how people had sustained through difficult times.

The document was read out loud to the team and this was found to be an emotional meeting. It was the first time in eighteen months people had the opportunity to reflect on what had actually happened.

Many of the team missed social connections and felt isolation. One member reported it felt like going from being in the middle of everything, to nothing, and just wanted someone to call and check everything was ok.

A number of staff noticed the impact on their own mental health and wellbeing, reporting feeling scared and anxious, overwhelmed with worry and emotion and expressed a sense of fear for themselves and their families. The pandemic was an unknown entity at this time, but people had to keep going, often feeling scared of the potential impact on them and their families.

JG reported there were a lot of management changes and at the time the team was experiencing low staff numbers. Staff reported it felt like there was no time to breathe, no time to think, it was like being on a treadmill and constantly running. Staff were doing administration in their own time and working extended shifts regularly.

The group also talked about how they sustained during the pandemic and from what the team learned, some of these changes have been embedded on a permanent basis. An example being a 9am team call on MS teams which staff have reported starts their day feeling connected to each other.

Having a safe space to talk and share worries and thoughts made staff feel like they weren't going through the pandemic alone. Commitment to clients shone through, despite feeling frightened staff knew they had to persevere for the sake of their clients.

There was also a commitment to colleagues and supporting each other through difficult times.

One staff member reported she had a picture of her daughter dancing on a beach in the sunshine next to her computer and at times of feeling overwhelmed used this picture to remind herself that this will pass, and things will be ok.

Dr Subha Thiyagesh and Interim Director of HR (at the time) Lindsay Jensen were asked to witness the document and their thoughts and feelings on the document were fed directly back to the team.
As a result of the project the team are more connected and are more conscious of how to stay connected, inside and outside of work. New work routines to support each other have

been developed and new members of the team, and what they may need are fully considered.

The project identified reflection time, and its importance, to give people the opportunity the reflect when needed.

MBu thanked Jane for her story, noting it is a strong reminder of what everyone has been through.

Nat McMillan (NM) acknowledged the Trust has stretched services and asked if there are any plans to share the outcomes of JG's project across the Trust?

JG reported that looking after staff is about compassionate focussed leadership, reflective practice and acknowledging how hard things can be. In terms of recruitment to reduce pressure, work with the commissioners is ongoing, and having students on placement allows staff to share their passion and then the Trust becomes a place that people want to work.

NM noted how this work can feature in the broader organisational development strategy and look at short- and medium-term goals to support colleagues.

Greg Moores (GM) reported JG's story is timely as there is an extended Executive Management Team meeting about hybrid working soon, and GM stated he would like to catch up with JG prior to this meeting to share some of her learning.

Action: Greg Moores

Mark Brooks (MBr) queried if everyone from the team engaged in the project?

JG reported engagement was not mandatory, but everybody wanted the chance to have their say, and some found it more emotional than others. Once the project got going and people understood what its purpose was, they wanted to share their thoughts and feelings with others. The team has changed a lot since the project and newer members of staff have benefited from this.

Darryl Thompson (DT) noted there is a possibility staff have experienced trauma through the pandemic and queried if any staff from the project had accessed the West Yorkshire health and wellbeing resource for support?

JG reported she knew that staff were aware the support was there and were signposted by managers where appropriate

MF asked for more detail about a contribution to a book chapter.

JG reported group of psychologists are writing a book and one of the chapters is about working with staff teams and JG is linking with a psychologist in Manchester to share the project findings.

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

TB/22/69 Chair's remarks (agenda item 7)

MBu highlighted the following items are being presented in the afternoon's Private Board meeting:

- Private risks
- Ward 19 extra care area business case approval
- Bretton Centre contract
- IT services contract reprovisioning

- Pharmacy contract
- Complex incidents report
- CAMHS performance report

It was RESOLVED to NOTE the Chair's remarks.

TB/22/70 Chief Executive's report (agenda item 8)

Chief Executive's report

MBr asked to take his report as read and highlighted the following:

- MBr gave thanks to Trust staff for their resilience during the recent heatwave where temperatures reached close to 40 degrees, MBr noted the Trust had good plans in place and had responded well
- When temperatures escalate fire alarms can trigger, and where this had happened staff responded well and in line with protocols
- Some Covid restrictions have been reintroduced in the Trust with rising prevalence in our communities, although in the last seven days staff absence from Covid has reduced
- There is a strong prevalence of flu in Australia and New Zealand at present which may indicate a challenge in the UK for the coming winter
- Vaccination guidance has been released and for the autumn and over 50s, those that are clinically vulnerable and patient facing staff will be eligible for booster vaccinations
- The LeDeR report (review of learning disability lives and deaths) has been recently published and highlights that approximately half of the deaths of people with a learning disability last year were avoidable. This further highlights the issue of health inequalities and as an organisation that provides learning disability services we need to identify and implement the learning taken from this report
- A national women's health strategy has recently been released
- Integrated Care Boards are now statutory entities, and initial governance meetings have taken place in July, and these meetings are now looking to focus on making improvements and addressing health inequalities
- The cost of living continues to increase, and we have temporarily increased mileage rates to support high mileage staff.
- Business Delivery Units have been changed to Care Groups; a piece of work led by Carol Harris our Chief Operating Officer
- Our physical health expert Mo, is leading a piece of work for staff to look after their physical health
- A member of staff received a very touching letter of thanks from a family who lost a loved one

NM noted the LeDeR report was discussed as CGCS last week – and gave thanks to the quality team, for keeping the Committee up to date, and reported CGCS will receive a further update in September.

In reference to the LeDeR report, CH noted that work being conducted by the Trust with primary care in Wakefield has been noted as good practice.

EM asked if discussions are taking place with the unions about industrial action over pay?

GM reported this is taking place. Pay is governed by national powers, there is a risk of industrial action, but we have good relationships with unions locally.

DW asked if there is an increased risk of spreading Covid-19 now that extended sick leave has been abolished.

MBr reported the Trust has counter measures in place, such as mask wearing in clinical settings to reduce this risk.

GM reported staff still get paid sick leave if they are off with Covid-19, it is the extension past six months that has been now removed.

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

TB/22/71 Risk and assurance (agenda item 9)

TB/22/71a Board Assurance Framework (agenda item 9.1)

Julie Williams (JW) introduced the item and highlighted the following points:

- All strategic risks, controls and assurances have been reviewed
- **Risk 3.4** is a new risk- Failure to embed new ways of working and develop digital and creative innovations resulting in reduced inability to meet increasing demand and less efficient service provision – this has been given an initial grading of yellow.
- On 7 July the Executive Management Team (EMT) discussed the following risks in detail and agreed to recommend the following ratings:
  Risk 1.1 - The new NHS landscape of integrated care boards, place-based partnerships and provider collaboratives could lead to changes and variations in local priorities resulting in service inequalities, and differences in our offer in each place - To remain Amber
  Risk 2.3 - Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care – To remain Amber.
  Risk 3.3 – Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives – To remain Yellow.
  Risk 4.1 – Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user experience – To remain Amber.

MBr reported at the EMT it was noted the BAF has been subject to several areas of challenge at Board meetings in relation to workforce, the impact of acuity and demand and its impact on quality, and capacity and capability.

When we have reviewed our strategic risks, we have not seen any key changes in the position on workforce, quarter on quarter, and in a similar manner our quality metrics from the integrated performance report have showed little variation. EMT therefore recommend that risk gradings should remain the same at this time.

It was RESOLVED to NOTE the report and APPROVE the updates to the Board Assurance Framework

TB/22/71b Corporate / organisational risk register (agenda item 9.2)

Julie Williams (JW) introduced the item and highlighted the following points:

- This is the review of the organisational risk register for Q1 22-23
- Following Board in April 2022 there has been a significant review of risk controls
- Three new people risks, and one operational risk have been added

MBu asked to go through risks in turn and invite comments from Committee chairs and lead executives:

- **New risk** - Staff wellbeing continues to be a pressure in relation to physical and mental health, this has an impact on the overall workforce and related KPIs

GM reported this new risk has arisen as result of the review of Covid specific risks.
Covid risks **1536** (BAME staff health disproportionally affected by the impact of Covid-19) and **1612** (low uptake of the vaccine by staff at high risk could lead to disproportionate risk of infection across the Trust) have been merged to create this new risk. GM is looking at data

to identify whether a further risk is requires specifically in relation to BAME staff and staff with disabilities.

EM noted the Board has been hearing of continued pressures from service demand, how do we engage with staff to see what they feel about their current wellbeing?

GM reported the data suggests there is not a lot of movement in relation to sickness, amber is the right grading at this time. There is lots of good work taking place in relation to staff wellbeing and we continue to engage with staff on how to make things even better.

MBr reported as part of the system oversight framework all NHS trusts are now conducting quarterly staff surveys and so the Trust is getting regular feedback.

GM noted the Robertson Cooper staff wellbeing survey provides further comprehensive data around wellbeing.

MF queried if there is potential consequence of reduced delivery of potentially unsafe and reduced quality of services as a result of this risk?

GM agreed to review the wording of the new risk to reflect a more detailed consequence in line with risk **1614** (National clinical staff shortages resulting in vacancies which could lead to the delivery of potentially unsafe and / or reduced services, increased out of area placements and / or breaches in regulations.)

ACTION: Greg Moores

- **1614** (as above) – DT reported has been separated out to reflect the safety and quality impact of staff shortages and will be overseen by Clinical Governance Clinical Safety Committee.

MG and GM confirmed this risk had been reviewed at the Workforce and Remuneration committee (WRC) to ensure the different elements of risk 1614 and risk 1151 (Risk of being unable to recruit and retain clinical staff due to national shortages and growth in mental health investment/ commissioning which could impact on the safety and quality of current services and future development) had been clearly articulated. Risk 1151 will remain aligned to WRC.

- **1530** - Risk that demand continues to rise placing further pressure on access to services and waiting lists.

CH reported following review of the Covid risks the risk description has been updated to reflect that the new risk is demand in general, not just in relation to Covid and the action is about gaining a better understanding of how demand will increase. This is likely to result in a number of additional actions being logged for the Q2 report.

- **275** – Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners.

SY reported this risk will now move to CGCS instead of Finance Investment and Performance Committee (FIP) as the risk is more about impact, as opposed to the lack of resources. NM reported CGSC agree with the new alignment.

- **1511** – Risk that carrying out the role of lead provider for forensics across West and/ or South Yorkshire will result in financial, clinical, and other risk to the Trust.

SR reported given the delineation of Collaborative Committee (CC), it has been agreed to move this from CGCS to CC.

- **1159** - Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.

MBr reported Audit Committee (AC) has taken responsibility for Health and Safety from CGCS and this is why the risk has been aligned to AC instead of CGCS.

- **522** – Risk that the Trust's financial viability will be affected because of changes to national funding arrangements

MBr reported financial risk is low for this financial year, but this may change from 2023-24. The proposal is to move the risk to a local risk register and escalate back to the ORR should the risk increase in the future.

- **1077** Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.

MBr reported this risk shows the historic position when tendering for business was regular practice. With the development of Integrated Care Systems there is a duty of collaboration and partnership working and therefore less likelihood of tendering.

- **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

MBr reported given the current financial position of the Trust the risk is significantly reduced for the current year, hence the scoring moved from possible to unlikely

- **1368** – Risk that given demand and capacity issues across West Yorkshire and nationally, children and younger people requiring admission to hospital will be unable to access a CAMHS bed. This could result in quality of care being compromised and places additional pressure on staff when young people are cared for on adult wards in the secure CAMHS estate or in acute hospitals supported by the Trust's CAMHS service

CH reported the service had initially recommended reducing the risk as a result of access to Red Kite View beds and a low number of children being placed on adult wards. Since this review demand has gone back up.

CH will therefore review the risk further and reconsider the grading of this risk and report into EMT.

ACTION: Carol Harris

- **1585** – The current NHS capital regime could result in the Trust not having sufficient allocation to complete all its capital plans in any one year adversely impacting on ability to meet its strategic objectives and priorities.

MBr reported the Trust is constrained by the ICS capital limit as to how much capital it can spend. For 2022-23 we are fine, but there may be a challenge for next year 2023-24. In the short term we will reduce the risk, but it will likely increase next year.

- **1615** - non-delivery of the actions identified to make SWYPFT a Great Place to Work leading to higher turnover of staff, increased absence, lower quality of care and resistance to change and innovation.

GM reported the risk likelihood has reduced from 4 to 3 and MG agreed, noting it was supported by WRC.

- **1527** – Risk that the Covid-19 testing regime is delayed or inadequate leading to sub-optimal utilisation of staff and sub-optimal care.

DT reported the testing regime for staff is now through lateral flow and so the recommendation is for the risk to be closed.

- **1432** – Risk of lack of succession planning and talent management may lead to gaps in key roles and fail to promote diversity.

GM reported the wording has been amended and is presented for approval.

- **1528** – Risk that new models of care arising from Covid-19 are not adequately tested, leading to a deterioration in the quality of care.

DT reported as part of living with covid there are existing processes where new models of care are presented to the Operational Management Group (OMG) and Executive Management Team (EMT) for approval. Recommended to close.

- **1531** - Service users with protected characteristics and specifically from a BAME background and people with a learning disability may be disproportionately affected by Covid-19.

DT reported the consequence score has reduced but likelihood remains the same. Processes are in place to identify those that are clinically vulnerable. There are also processes in place to recognise those that have come into our care who haven't been vaccinated.

- **1545** – Increased risk of legal action as a result of decisions taken or events that have taken place during Covid-19

JW reported the terms of reference for the Covid-19 inquiry and the scheduling of different stages of the review. The Trust is not impacted by stage 1, but by stages 2 and 3. The risk needs to remain as we don't yet know the outcome of the enquiry. MBr also noted there is a case potentially going to an employment tribunal in October 2022. Recommendation to retain.

- **1567** – Inability to meet the competing demand of responding to current waves of the pandemic, the regulatory reporting and restoration drives.

MBr reported this risk related to responding to continuing waves of the pandemic. The Trust now has established processes for dealing with future waves and is now part of how we operate. Recommendation to close.

- **1536** – BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus.

GM reported this risk has been merged with 1612 (below) to create a new risk as cited at the start of this item and as such these will both be closed.

- **1612** - Lower uptake of the Covid 19 vaccination by those staff identified as more at risk could lead to a disproportionate risk of infection across the Trust workforce, service users, patients, and carers.

MF commented the new risk needs to have actions that will reduce the risk to be within its risk appetite. 1536 was one of the few risks where the target score remained outside of risk appetite.

GM reported the actions have been transferred into the new risk.

MF noted the risk heat map was missing from this set of Board papers.

Action: Julie Williams

It was RESOLVED to REVIEW and COMMENT on the risk register and;

- **AGREE the new risk scorings for risks 1614, 1151, 1114, 1368, 1585, 1615, 1531**
- **AGREE the new risk description following the merging of covid specific risks 1536 and 1612**
- **AGREE the new risk description of 1530 which was previously a covid specific risk**
- **AGREE the amended risk description of risk 1432**
- **AGREE to move risk 275 from FIP to CG&CSC**
- **AGREE to move risk 1511 from CG&CSC to the new Collaborative Committee**
- **AGREE to move risk 1159 from CG&CSC to the AC as it is a health and safety risk and as per terms presented to the June Board.**
- **AGREE for covid risk 1545 to remain due to ongoing legal action.**
- **AGREE to the removal of risks 522, 1077, 1527, 1528, 1567, 1536, 1612**

TB/22/71c Patient Experience annual report (agenda item 9.3)

DT asked to take the item as read and highlighted the following points:

- The annual report has been discussed in depth at CGCS
- It is acknowledged the report is data heavy and a review process is being discussed so that future reports include more analysis of the data
- For the financial year 2021/22 the customer services team received and dealt with 777 items of feedback in the form of complaints, concerns, and comments (excluding compliments). This is an 8% increase compared to 2020/21.
- Re-opened complaints have reduced to 6% (normally 12-13%)
- The report explains contact with the Parliamentary ombudsman
- 76% of 370 complaints were dealt with by way of local resolution
- Delays in sign off have been acknowledged and an action plan is being presented to EMT

NM reported as Chair of CGCS there is lot of work taking place to improve annual reports following feedback from the Committee and they are evolving. This is our patient experience report but has a real focus on complaints and we want to look at how we can broaden the report to take account of the whole experience.

Action: Darryl Thompson

MBr noted the Trust needs to consider how it uses this report. Feedback, complaints, and compliments need to be used to help the Trust improve. An improvement and inclusion lens to all reports will help them develop. MBr queried the 40-day response rate, which is more challenging than the national target and needs to be reviewed to see what is achievable.

Action: Darryl Thompson

MF noted formal complaints involving staff attitude are not meeting performance targets but queried how many staff interactions are there in a year? Do we need to review this target as the number of complaints involving staff attitude seems very low next to the number of contacts staff will have with service uses and carers during a twelve-month period? In the compliments section staff attitude is nearly always the top positive.

Action: Darryl Thompson

MF noted the data regarding the 40-day target but queried if the Trust has missed the six-month target as this is the national target?

MBr confirmed some complaints have gone past the six-month target.

MBu asked that all points raised should be dealt with through CGCS and then DT can consider what targets may be appropriate. It is not always about the complaint answer but whether the complaint has been resolved. Timescales for complaints need to be carefully considered as does the quality of the complaint response.

DW raised family and friends' feedback and Attention Deficit and Hyperactivity Disorder (ADHD) stands out.

CH reported this is often because of waiting times, but sometimes people are unhappy when they have waited for a diagnostic assessment and are told they haven't got the diagnosis. An invited review of the ADHD and Autism Spectrum Service (ASD) is taking place, conducted by the Royal College of Psychiatry.

It was RESOLVED to APPROVE the Patient Experience - Customer services annual report 2021/22

TB/22/71d Health and Safety Annual report (agenda item 9.4)

Nick Phillips (NP) introduced the item and highlighted the following points:

- This the annual safety services report to the Trust
- It documents what has taken place in 21/22 and what plans are in place for 22/23
- It includes all safety services teams - Health and Safety, Fire Safety, Emergency Preparedness Resilience and Response (EPRR) and Security
- It makes sure the Board and Trust are discharging their duties under the Health and Safety Act and Fire Reform Order
- The report has been reviewed by EMT and the Audit Committee (AC) and was recommended to progress to Trust Board for approval
- Covid had a large impact last year
- Despite this fire training has remained high at 91.7 %
- The Health and Safety audit received its highest return figures yet
- Key priorities for 22/23 are for fire training to return to face to face where most appropriate
- EPRR core standards are resuming and will change, and the Integrated Care Board will take on new responsibilities

NP explained the context of the rolling ligature audit. The environmental safety group has been through a process to pick a door for bedrooms bringing in the latest technology for ligature risk reduction. The Trust is moving towards the end of the installation process, and the technology brings increased assurance for the safety of patients in our wards.

NM asked to see the progress regarding the ligature audit and progress of the programme. It was agreed progress should be reported into both AC (audit actions) and CGCS (clinical risk)

Action: Adrian Snarr/Darryl Thompson

DT reported there is a summary of incidents including the door ligature programme going to CGCS in September.

MF reported on a recent quality monitoring visit to Kirklees Intensive Home-Based Treatment Team (IHBTT), and staff were noted not to be using lone worker devices

NP reported the Trust is less prescriptive about which lone worker devices are used now, as long as there is a process used by the team that can be demonstrated to be effective.

It was RESOLVED to APPROVE the safety services annual report 2022/23 including the action plans for the year for all the safety services teams.

TB/22/71e Premises Assurance Model (PAM) annual report (agenda item 9.5)

Nick Phillips (NP) presented the item and highlighted the following points:

- This is an NHS England submission we make annually
- The submission covers contract management (including value given), health and safety, compliance around food etc.
- This all has to be evidence based, with interviews by assessors
- NP then assesses the outcomes to provide assurance before submission

MBu reported she has seen the document, which is comprehensive and is assured by it.

NP reminded the Board it is being asked to approve the submission, not the actual report.

EM noted the size of the report and asked how it is checked?

NP reported each individual item is checked and then NP performs random sample checking with the managers for each area.

MF queried if is it credible the Trust has nothing that requires minimal improvement.

NP reported it is credible, there were areas last year where we required minimal improvement and cross checking against other organisations has taken place.

MBu thanked NP and his team for the all the work carried out.

It was RESOLVED to NOTE that the Trust has rated itself "good" using the Premises Assurance Model and APPROVE the full submission being uploaded to the NHS England portal.

TB/22/71f Assurance and receipt of minutes from Trust Board Committees and Members' Council (agenda item 9.6)

Audit Committee 12 July 2022

MF highlighted the following:

- The Audit Committee has taken over responsibility for Health and Safety
- EMT are going to review risks aligned to the Committee
- The Risk management procedure was reviewed
- The review of Standing Financial Instructions and Scheme of Delegation have been deferred pending the arrival of the Director of Finance, Estates and Resources
- Risk triangulation report received
- Substantial assurance for the Data Security and Protection Toolkit

Clinical Governance & Clinical Safety Committee 19 July 2022

Nat McMillan (NM) reported the following:

- The Committee was unable to recommend the drugs and therapeutic annual report this time due to the absence of the Chief Medical Officer at the meeting
- The Patient Safety strategy update was received, showcasing the excellent work that has taken place

- Learning Disability waiting lists were considered and a lot of work is taking place to improve waiting times
- Sancus report – the Committee was assured about the new process put in place regarding serious incidents (SIs)and CGCS will now monitor SI action plans
- Pressure ulcers update was received

Finance, Investment & Performance Committee 27 July 2022
David Webster (DW) highlighted the following:

- Agency spend is high and agency caps may come in at ICB level, but this shouldn't present an issue
- The forecast currently is a growing surplus
- An underspend on the Bretton Centre in year is now expected, which is a potential risk for next year
- There may be calls on our surplus from other areas and this is being reviewed by the Deputy Director of Finance

NM reported the surplus we have, is not the surplus we want as we would prefer to be spending monies on increased staffing, and this is discussed regularly at the committee.

Workforce and Remuneration Committee 5 July 2022
Mandy Griffin (MG) highlighted the following:

- Recruitment and retention were considered
- Approved the clinical excellence awards
- Supported the recruitment of the primary care executive advisor
- Good discussion took place around the four allocated risks

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

TB/22/72 Performance (item 10)

TB/22/72a Integrated Performance Report (IPR) Month 3 2022-23 (agenda item 10.1)

SY introduced the summary dashboards and priority programmes:

- This month's IPR reflects the updated metrics and priority programmes agreed by Trust Board for 2022/23.
- A small number remain in development and some metrics are reported quarterly – these are specified in the report.
- For some metrics we recognise that it will take time for the improvement work taking place to take effect and as such work is being carried out to determine if having phased targets during the course of the year will be more appropriate.

Priority programmes

- Progress is being made to enable a reduction in the number of out of area placements.
- The inpatient improvement programme is aiming to address many of the workforce challenges specific to inpatient wards.
- Systems are being put in place to manage and unblock barriers to discharge as well as effective coordination of out of area placements so that people can be repatriated as quickly as possible.
- A programme of work has commenced on improving access to care, with a specific focus on creating a framework and improvement plans for reducing waiting times and providing support for people while they wait.
- Recruitment and retention work is ongoing in all places and services

- A project has been mobilised to oversee and facilitate the introduction, configuration, and development of digital personal health record capabilities for our service users through the portal Patient Knows Best (PKB).
- Work continues to scope out the details of programmes and areas of focus. This section of the IPR is continuing to evolve.
- Community transformation work continues

Inequalities

- The Trust led a discussion in a regional event hosted by Health Education England around the use of lived experience as part of the workforce including peer support workers.
- A key priority for the Trust is to improve the recording and collection of protected characteristics across all services - this will be monitored by the Trust's Equality, Inclusion and Involvement Committee.
- Work in places to address health inequalities continues, in particular those with serious mental illness and learning disabilities
- The Equality, Inclusion and Engagement Committee (EIIC) and Mental Health Act Committee (MHA) reports have been received which highlight the use of our services by people with protected characteristics through means of access and location. This is being fed in through Equality Impact Assessments (EIAs) into community transformation projects and improvement programmes

Quality

- The Trust continues to perform well despite challenges
- A focus remains on documentation – care planning and risk assessments - and improvement plans are in place and ongoing
- Information Governance (IG) breaches have increased, and this remains an ongoing priority

People

- We continue to work on recruitment and retention challenges

NHSI Metrics

- We continue to perform well against national metrics

MBu thanked SY for her summary and asked individual directors to raise salient points.

Covid-19

DT highlighted the following:

- There has been one Covid-19 outbreak on Newhaven, but given the level of prevalence in the community this helps illustrate our controls and processes are largely working well
- There is a current challenge regarding patients being required to isolate when testing positive

Quality

DT gave the highlights from the report:

- IG breaches have been higher in month than normal. Further examination has revealed information shared has typically been to other health sector organisations, with their own data protection processes, and the level of risk is therefore reduced
- The communications team are sending out reminders regarding the importance of IG
- Performance against risk assessments in inpatient and community settings remains below target but action plans are in place to address

- Care planning is also under target. A review of the metric is taking place with an interim metric being considered. A timeframe for the final metric is to be confirmed to Board.

Action: Darryl Thompson

A discussion followed in respect of the challenges regarding care planning. It was agreed that this would be discussed with the ward managers' meeting before private board in the afternoon and a presentation about the care planning process through SystmOne could be given to a CGCS and then fed back to Board.

Action: Darryl Thompson

A further discussion followed about SystmOne and multiple care plans being in existence. All required sign off in order to perform against the metric. SY reported there is an improvement programme in place for care planning, which will include all aspects of the work and this overview should be used to feedback. DT agreed and stated this work will be used to feed back through CGCS as actioned above.

DT continued the quality highlights:

- One pressure ulcer has been defined as attributable and there are no lapses in care identified
- People dying in a place of their choosing is back on target
- Falls have moved back to be within common cause variation
- On Elmdale ward there has been a sickness and diahorrea outbreak

NM asked for a of review pressure ulcers to be taken through CGCS

Action: CGCS

NHSI national Indicators

MBr reported performance against national targets remains stable and largely positive:

- In line with national targets
- There is one red metric, which refers to pediatric audiology and relates to a small number of patients. This is affected by Covid outbreaks and is improving.
- OOA bed placements are high, we have a revised trajectory and CH, ST and MBr are meeting with West Yorkshire colleagues and NHSE/I to review various performance and discuss improvement plans.
- Children and young people eating disorders, this metric is also based on very low numbers
- We had been through a recent period of not using any adult beds for children/young people, but we did use 16 days for children/young people in adult beds in June.

Locality

CH highlighted the following points:

- There is a focus on supervision and mandatory training in all areas with a focus on targeted hotspots
- Recruitment remains challenging
- The reset and recovery operational priority programme has been moved into improving access to our services and addressing inequalities. This work is being aligned into data quality work.

Child and adolescent mental health services (CAMHS)

- Waiting numbers for neurodevelopmental services remain problematic with increased capacity reducing waiting lists marginally
- Calderdale and Kirklees crisis teams are under pressure and staff are being moved from Core CAMHS to support demand, which in turn places pressure on Core CAMHS
- Core CAMHS in Wakefield is a current concern in relation to waiting lists
- Staffing pressures are present in Adel Beck and Wetherby

- Autism Spectrum Disorder (ASD) and Attention Deficit and Hyperactivity Disorder (ADHD) services have had an increase in referrals, and we are working with commissioners to resolve this
- Dr Marios Adamou has been asked to contribute to the development of national autism standards

Barnsley general community services

- There are staffing challenges in neurorehabilitation
- Rotherham commissioners have been looking for other providers to take on elements of their neuro rehab provision
- Barnsley commissioners have provided a new specification that we are configuring
- Children's speech and language therapy waiting times have gone up. There are increased levels of referrals across all children's services
- A new risk is emerging in relation to "vacation cosmetic surgery" where people are going abroad to have cosmetic surgery and then presenting issues to our tissue viability services

Barnsley community mental health

- Communication issues between inpatient services and community services means discharges have been affected, including performance against the 72hr follow up target,
- Focused work has taken place to identify the issues causing this and actions have been put in place to address.
- A return to face to face to training for aggression and violence has caused some initial issues, in relation to staff attendance but this has now been successfully resolved
- There is the development of an all age eating disorder services
- Neighbourhood hubs are developing in Barnsley including Trust staff and primary care staff at Wellington house

Forensics, Learning Disability (LD), Autistic Spectrum Disorder (ASD) and Attention Deficit and Hyperactivity Disorder (ADHD)

- NM has already provided assurance from CGSC regarding LD waiting lists
- A review of long-term segregation arrangements has taken place and identified people are not getting sufficient access to outside space. There are also challenges around reviews from external medics and work is taking place to address these points
- In forensics, vacancies and turnover remain high but we have recruitment taking place
- We have newly qualified staff waiting to start in September
- Consideration is being given to setting up a forum for new starters to meet the operational leads and discuss any issues that are coming to light with a view on retention.
- Johnson ward report – whistleblowing report – the final draft has been received and is being reviewed and we are working on an action plan to deal with the issues raised.

Inpatient Services (Barnsley, Calderdale, Kirklees and Wakefield)

- High activity continues
- OOA have reduced slightly
- The seven-day leadership team is working well to manage services out of hours
- There has been success in recruitment into inpatients
- Single Point of Access teams remain under pressure and additional staff have had to be used.

EM queried if community services are under more pressure in certain areas of the Trust and noted supervision is still behind in many places.

CH reported pressures in community services and there are still a number of vacancies. GM is developing a report highlighting where community staff move to when they leave community services. Some staff have moved to new primary care roles, but it should be noted that in the long term these primary care roles will help with demand.

GM reported movement of staff from inpatients to community is now happening in the first twelve months as opposed to after a number of years, which was the previous experience

DT reported the knock-on effect of this is band 6 staff with less experience are now our gatekeepers, noting this is a national picture.

EM queried if Trust data is sufficient to highlight areas of risk in relation to community services.

CH reported risk assessment are broken down into community and inpatients.

MBr reported serious incident date is aggregated as are many of the indicators in the IPR.

EM asked if more data should be reviewed as community data to show trends. It was agreed this would be part of the IPR development to be led by CH and DT.
Action: Carol Harris/Darryl Thompson

DT reported incidents are reviewed through Committee and if there is a trend change it would go to CGCS and then to Board. JW noted incidents are also discussed in detail at OMG.

Communications, Engagement and Involvement
SY reported:

- The comms team remain busy with internal work, priority programmes including focused work around recruitment and retention, and supporting staff through the heatwave
- They continue to work with partners in places to work through how we will communicate through place

GM noted there is good work going on between Human Resources and Communications teams about reshaping Cheryl Watterston's previous role (Workforce Race Equality Standard Organisational Development Lead) and how this can be reshaped to promote the health inequalities agenda.

Finance and Contracts
Rob Adamson (RA) highlighted the following points:

- The Trust has a financial plan for a surplus of £3.2m. The first quarter had a predicted surplus of £2.3m and has achieved £2.7m as a result of additional income and vacancies
- National inflationary cost pressures are starting to emerge
- There is increased forecast spend for the rest of the year, the Trust is trying to utilise all the money it has to support service access and improvement, which relies on a growing and expanding workforce
- The agency cap is coming back via integrated care systems as part of the system oversight framework

MBu expressed concern about the agency cap and MBr noted the need to get staff in place to fill vacancies so that the Trust is not as dependent on agency.

Workforce
Greg Moores (GM) highlighted the following points:

- The people section of the IPR is a work in progress and he would welcome feedback from board
- Employee relations information has not progressed due to national ESR issues
- GM will continue to review targets to ensure they are appropriate
- Vacancies – our overall vacancy rate is c16%
- There is variation, Calderdale Kirklees and Wakefield vacancy rates are between 7-8%, inpatients and forensics are around 19%

- Turnover, overall is at 15.8%
- Again there is variation, in LD services it is 23% and in IT services 6%
- Sickness absence is 4.6%, on target, but in forensics and inpatients this is higher
- Appraisals - GM has asked for in date appraisals to be considered as a new metric
- A new overall training figure is 89.3.%, with best performing 91% and worst performing 80%

MF noted an increase of breaches of working time directives and queried if there is any impact or penalty for the Trust.

GM reported under junior doctors' terms and conditions there can be penalties but will check for any corporate penalty

Action: Greg Moores

NM asked to note the quality of service the Trust delivers given the pressure and demand the Trust is under. Thanks need to be given to the staff and recognition for their work.

EM questioned if there was any information on international recruits in terms of numbers and successful transition through the process. In relation to vacancies is there more detail about doctors or nurses and which care groups are affected.

GM reported he is taking the detail to WRC rather than Board and is happy to be challenged on this.

MG reported this is being reviewed in detail in WRC and should there be any need to report by exception this will be drawn out in the AAA report.

SY commented that the Trust has committed to ensuring equality and inclusion is a golden thread through everything. We need to have two or three indicators in the workforce section for Board focus.
GM agrees and will review this.

Action: Greg Moores

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

TB/22/72b NHS Staff Survey Update (agenda item 10.2)

GM introduced Ashley Hambling who highlighted the following points:

- The paper reflects the NHS staff survey results from October/November 2021
- The survey was redesigned in 2021 around the NHS People promise indicators
- This limits comparison to previous years
- Overall at a Trust-wide level our results are positive
- Five of the nine key themes are better than the national average benchmark score for similar NHS providers
- Health and wellbeing – we had the highest score in W Yorkshire
- Staff engagement – we retained our score in this field
- Morale – is 0.2 above the national average
- The Trust is considered to be compassionate and inclusive
- "We each have a voice that counts" – received an average national score
- "We work flexibly" also received an average national score
- "We are always learning" received a lower-than-average score as did "We are a team"
- The report provides more detail around care group level results and there is variation across these results from our different services
- CAMHS Wakefield and support services had very positive results
- Menta Health inpatient services and forensic services were less positive

- Staff group feedback – there is also variation here, colleagues in lower bands have lower staff satisfaction and medical staff have the highest
- Workforce Disability Equality Standard (WDES) and WRES results improved significantly on last year
- Action planning – we have shared the results in various forums and taken feedback into WRC and EIIC and EMT.
- A request has been made of local services to review their results and formulate key actions for improvement
- An update report is being taken into WRC in September to monitor progress

GM noted this will tie in with the wider Organisational Development (OD) approach and we need to use these types of surveys to test our OD approach. We need to rethink how we use our resources. This level detail will be going to WRC in September.

MBr noted when compared with neighbouring Trusts we are doing well.

NM supported working on the development of the OD strategy and approach and move away from surveys.

CH noted inpatients and forensics and had been mentioned in the same way with the IPR – forensics is an inpatient service. They share similar issues because they are inpatient services.

A discussion followed that "we are a team" refers to individual teams rather than the wider "SWYPFT team". AH clarified that the "we are always learning" results are very positive for staff groups such as qualified nurses but are considerably lower for lower banded staff.

GM reported it is possible to a draw a line between some of the feedback and information from other sources, particularly exit questionnaires. There are themes from exit data regarding career development, flexible working and access to training. This is helpful because they are tangible, and we can do something about them.

DW noted we are getting a good representation of the workforce in our results.

AH noted there has been a decline in response rate but we run other surveys and so we have to look at the broader picture.

EM queried the workforce race and equality data; it does say that BAME colleagues are suffering less bullying but more discrimination and harassment.

AH noted the report is quite brief for Board in this area and will happily pick this is up with EM outside of the meeting.

Action: Greg Moores

It was RESOLVED to NOTE the report and the high-level actions and next steps.

TB/22/73 Integrated Care Systems and Partnerships (agenda item 11)

TB/22/73a South Yorkshire update including South Yorkshire Integrated Care System (SY ICS) (agenda item 11.1)

SY reported this is the new structure to the integrated care systems and partnerships section. There are three sections, South Yorkshire report, West Yorkshire report, and provider collaboratives and alliances. Presenting the report in this way shows the amount of work taking place and how many meetings there are for Board members to attend.

Feedback from the Board is that the new format is much easier to digest.

MBr and SY asked to take the paper as read including the updates for Barnsley:

There were no questions.

It was RESOLVED to NOTE the South Yorkshire ICS update

TB/22/73b West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnership update (agenda item 11.2)

SR asked for the paper to be taken as read, highlighting the following points:

- On 19 July 2022, the first public Wakefield Health and Care District partnership meeting was held. The focus for one of the items was on the Mental Health Alliance. Amanda Miller from the Trust's Wakefield community mental health services presented the community transformation work the Trust is carrying out in Wakefield and it was very well received.

SY reported at the System Executive Leadership meeting for West Yorkshire, the Trust and its partners in Calderdale shared a presentation on creativity and health. The learning from Calderdale was shared including being a catalyst for change, by shaping a creative health offer in mental health, community, learning disability and autism services.

The ICS has been completing work through the national centre for creative health and the Trust has led on this work on behalf of the ICS. This has involved talking to places about what they are doing in terms of their creative health offer, to map out what is in place with a view to developing a West Yorkshire ICS hub for creative health. This was well received, and the Trust will continue to play a strong role in shaping his work.

As a related point there are conversations taking place with Huddersfield University considering an academic health innovation hub.

It was RESOLVED to RECEIVE and NOTE the update on the development of Integrated Care Systems and collaborations:

- **West Yorkshire Health and Care Partnership;**
- **Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees**
- **Receive the minutes of relevant partnership boards/committees**

TB/22/73c Provider Collaboratives and Alliances (agenda item 11.3)

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

- The report is structured to reflect the delineation of the provider collaboratives from Trust business as a provider
- South Yorkshire and Bassetlaw name is still relevant for the adult secure provider collaborative, even though the Bassetlaw element has been dropped from the ICS
- Phase 2 (national context phrasing) of the next provider collaboratives for South and West Yorkshire will be forensic CAMHS and perinatal services

Mbu asked to discuss these two items with MBr outside of the meeting

Action: Marie Burnham/ Mark Brooks

A discussion followed about the NHSE taking consultation about phase 2 and deciding whether it should be a provider collaborative or not, and whether this decision is down to NHSE or the providers.

SR explained provider collaboratives in this context refer to NHSE delegating its specialised commissioning responsibilities to an entity such as a provider collaborative and so NHSE hold the power to make that decision.

EM queried now that ICS has a statutory footing and our required attendance at more meetings, are we now having to report more Key Performance Indicator's (KPIs) and do we have capacity to manage this?

MBu reported this is for MBr to discuss with the executive team to look at capacity and the Non-Executive Director portfolio's as well. There is also a role for governors to review.

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

TB/22/74 Governance (agenda item 12)

TB/22/74a Assessment against NHS Constitution (agenda item 12.1)

JW read the statement to be agreed by Board:

- This is the required annual self-assessment of the Trust as to whether we meet the rights and pledges set out in the NHS constitution and clearly identifies this in our annual report and annual governance statement for 21-22.
- The Trust Board is therefore asked to review and approve this annual assessment of compliance with the NHS Constitution.

It was RESOLVED to APPROVE the paper, which demonstrates how the Trust is meeting the requirements of the Constitution.

TB/22/75 Strategies and Policies (agenda item 13)

TB/22/75a Social Responsibility and Sustainability Strategy update (agenda item 12.2)

SY asked to take the paper as read and reported this is the final draft of the strategy for final approval and comments.

The Board agreed this was an excellent strategy.

MF queried where the strategy should report in terms of Board committee.

SY reported this would be EIIC in the first instance with similar people being present working on this agenda.

MG reported a discussion had taken place; we need a twice-yearly update to Board but the monitoring will go through EIIC.

MBr reported it can be reviewed through the committee effectiveness process.

AL noted the EIIC terms of reference need updating to include this in its duties.

Action: Andy Lister

It was RESOLVED to APPROVE the strategy, AGREE the preferred method of governance and CONSIDER the alignment description.

TB/22/76 Trust Board work programme 2022/23 (agenda item 14)

AL reported all requested changes from last months board meeting have been implemented.

It was RESOLVED to APPROVE the updates to the work programme.

TB/22/77 Date of next meeting (agenda item 15)

The next public Trust Board meeting will be held on 27 September 2022

TB/22/78 Any other business (agenda item 16)

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 26 July 2022 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 26 July

Min reference	Action	Lead	Timescale	Progress
TB/22/67	Actions assigned to James Sabin should be transferred to Adrian Snarr	Andy Lister	September 2022	Complete as per action log
TB/22/68	GM to speak to Dr Jane Grant about hybrid working	Greg Moores	September 2022	Complete Conversation took place and was reported into discussion regarding hybrid working at Executive Management Team.
TB/22/71b	GM agreed to review the wording of the new risk to reflect a more detailed consequence in line with risk **1614** (National clinical staff shortages resulting in vacancies which could lead to the delivery of potentially unsafe and / or reduced services, increased out of area placements and / or breaches in regulations.)	Greg Moores	October 2022	Complete Included in updated Organisational Risk Register which has been presented to Executive Management Team.
TB/22/71b	In relation to risk 1368 CH reported since this risk was reviewed, demand has gone back up and there is also the CAMHS performance report to consider. CH will therefore review the risk further and reconsider the grading of this risk and report into EMT.	Carol Harris	October 2022	

With all of us in mind.

TB/22/71b	Heat map to be included with the quarterly risk papers	Julie Williams	October 2022	
TB/22/71c	The patient experience report is very focussed on complaints and its scope needs to be broadened to include a fuller view of service users experience of the Trust	Darryl Thompson	March 2023	
TB/22/71c	In relation to the patient experience annual report DT to review 40 day response complaint target	Darryl Thompson	September 2022	This is being reviewed as part of a current review of our broader complaints response. This review is being overseen by EMT
TB/22/71c	MF asked for a discussion outside of the meeting with DT to look at complaints involving staff attitude in the context of how many staff interactions there are with carers and service users in a year. MF noted staff attitude is also one of the Trusts top compliments	Darryl Thompson	September 2022	Still to be arranged.
TB/22/71d	It was agreed progress against the ligature audit should be taken to both Audit Committee (aduti actions) and CGCS (clinical risk)	Adrian Snarr/ Darryl Thompson	October 2022	
TB/22/72a	Care planning metric for the IPR is under review with an interim metric being considered. DT to provide a timeline for when final metric will be confirmed to Board	Darryl Thompson	September 2022	Verbal update to be provided
TB/22/72a	A discussion in respect of the challenges regarding care planning took place. It was agreed that a presentation about the care planning process through SystmOne should be given to CGCS and then fed back to Board.	Darryl Thompson	September 2022	This is being navigated through the CGCSC workplan prior to feedback to Board.
TB/22/72a	NM asked for a of review pressure ulcers to be taken through CGCS	Darryl Thompson	October 2022	

TB/22/72a	MF noted an increase of breaches of working time directives and queried if there is any impact or penalty for the Trust. GM reported under junior doctors' terms and conditions there can be penalties but will check for any corporate penalty	Greg Moores	September 2022	GM confirms there are contractual penalties depending on the breach/seriousness/regularity.
TB/22/72a	SY commented that the Trust has committed to ensuring equality and inclusion is a golden thread through everything. We need to have two or three indicators in the workforce section of the IPR for Board focus. GM agrees and will review this.	Greg Moores	October 2022	
TB/22/72b	In relation to the staff survey update EM queried the workforce race and equality data; it does say that BAME colleagues are suffering less bullying but more discrimination and harassment. AH noted the report is quite brief for Board in this area and will happily pick this is up with EM outside of the meeting.	Greg Moores	October 2022	
TB/22/73c	MBu asked to discuss future provider collaboratives of forensic CAMHS and perinatal services with MBr and the fact that the South Yorkshire Adult Secure Provider collaborative is retaining the Bassetlaw element of its name despite it being removed from the South Yorkshire ICS name.	Mark Brooks/Marie Burnham	September 2022	MBu to provide verbal update
TB/22/75a	EIIC terms of reference to be updated for next public Board meeting to include sustainability	Andy Lister	September 2022	On September agenda

Actions from 28 June 2022

Min reference	Action	Lead	Timescale	Progress

TB/22/54a	CAMHS Mental Health Support teams to present their work to Trust Board	Carol Harris/Subha Thiyagesh/Andy Lister	October/November 2022	Logged on the Board story register
TB/22/54a	GM to look into how accessible the creative approaches offer is for staff who are really busy.	Greg Moores	September 2022	Paper going to WRC in November
TB/22/57b	EMT to consider which Trust Board committee will oversee sustainability or whether a further TB committee is required.	EMT	September 2022	Sustainability has been aligned to EIIC and updated terms of reference are on the agenda.

Actions from 26 April 2022

Min reference	Action	Lead	Timescale	Progress
TB/22/40a	The executive summary of the IPR needs to identify key areas of concern and performance risks associated with clinical practice.	Adrian Snarr	September 2022	June update: Section of Care Groups reporting improved and deep dive reports also presented in private. Updated as requested for September.
TB/22/40c	In reference to the safer staffing report discussions on the impact on quality are taking place and work is needed to reflect this correctly in the report.	Darryl Thompson	November 2022	This will be incorporated into the next six-monthly Safer Staffing Report that will come to Board after it has gone to CGCSC in November
TB/22/40c	EM asked about safer staffing in the community and queried what progress has been made. DT reported the community safer staffing group need to consider what the deliverables are. Progress needs to be made and measured and then reported back to Board.	Darryl Thompson	September 2022	A Brief report has been requested for July Board Request that this report is deferred, to enable the group to report first into the Clinical Governance Group. The group are due to meet in July and will be reviewing how to engage with the centralised recruitment process and utilise international recruitment opportunities. Community Safer Staffing report on September agenda. To close

TB/22/42c	Clinical Ethics Group to ensure its terms of reference align to best practice	Clinical Ethics Group	November 2022	Clinical Ethics Group needs to meet and establish terms of reference are aligned to best practice before returning to Board. Updated terms of reference included as an appendix to the action log.
TB/22/43c	MBr suggested the scheme of delegation should be updated to reflect MF's comments about approval.	Adrian Snarr	January 2023	<u>June 2022 update</u> The SFI and Scheme of delegation is due for review during July following the formation of the ICB and some further material changes needed linked to Provider Collaboratives. This request will be incorporated into the wider review. This will flow via AC before coming into Board for final approval. Deadline to be adjusted to reflect governance route. September 2022. <u>September 2022 update</u> In order to give time to conduct a full and proper review as a result of formation of ICB's and new financial governance routes this will now be presented in January 2023.

<u>Actions from November 2021</u>

TB/21/121c	The internal meeting framework schematic - MB reported it was likely this schematic would need further review in April 2022 following the development of ICS and partnership arrangements and it should come back to Board in April/May 2022.	Andy Lister	September 2022	July update - A full review and re-work of the internal governance framework has been completed and is being scheduled to go through EMT before coming to Board in September for approval. On September's agenda.

South West Yorkshire Partnership NHS Foundation Trust

SWYPFT Clinical Ethics Advisory Group (CEAG)

1) Purpose

The purpose of the CEAG is to:

- Provide a forum for discussion on ethical issues relating to clinical issues within SWYPFT.
- Raise the general awareness of clinical ethical issues within the Trust.
- Provide advice and guidance to the Trust Board, Executive Management Team (EMT) and care groups on ethical issues to facilitate the development of standards and policies, and improve the quality of care.
- Provide "real time" support to individual clinicians/practitioners.
- To assist the education of staff, service users and carers in ethical matters.

The CEAG will not:

- Provide legal advice.
- Undertake risk management.
- Provide advice on research matters.
- Consider any issue not primarily of an ethical nature.

The CEAG will be advisory and not executive. It is important to note that the accountability for issues brought to the CEAG remain with the services, whether this be policy/practice development which would be under the auspices of the relevant director, or clinical matters in which this accountability remains with the relevant clinical staff.

Collaboration with others, particularly within the geography of the Trust footprint, is essential, and the CEAG will link into the West Yorkshire and Harrogate Clinical Senate ethics group and relevant South Yorkshire groups.

The Terms of Reference for the CEAG will be formally reviewed within 12 months of the initial meeting.

2) Membership principles

Initially members of the group will be appointed by the Interim Clinical Ethics Group. The balance of the membership and appointment process will then be reviewed by the CEAG. The Chair will be appointed by the group and serve for a term of three years, at the end of which the filling of the position will be reviewed. There will be a Vice Chair appointed by the group, who will serve as above.

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Members will serve for a period of three years which may be renewable. Places shall be made available to new members where members retire from the group.

Where no new members are ready to join the group, periods of service may be renewed. NB: care will be taken to ensure that periods of service are staggered to avoid significant problems of retirement from the group.

The CEAG will be quorate, when either the Chair or Vice Chair and 5 members are present.

Membership of the CEAG

Membership will be limited to 12 individuals. There is a need for the membership of the CEAG to instil confidence in staff and service users and carers that a wide range of experience and expertise is available.

- Members should be appointed on the basis of reputation, performance, skill and knowledge.
- Lay representation is essential and care must be taken to ensure sufficient support is in place for this to be effective. Following advice the lay member will not be a non-executive director of the Trust.
- Members should be clear that they are present for their personal attributes and not as representatives of any given body, group, profession or organisation.
- Conflicts of interests will be declared and noted, care will be taken to avoid systemic conflicts of interests arising from the governance and reporting processes of the group.
- Co-opting of members in addition to a core membership for specific issues will take place as required.
- Members will be willing to participate in ethical educational activities, including links with other Ethics Groups and the UK Clinical Ethics Network. This will require developing familiarity with principles, concepts and theory as well as relevant cases, legislation and policies.
- It is proposed that the group will include members from a range of clinical backgrounds (medical, nursing, allied health professionals, psychological services, pharmacy and non-professionally registered care workers) and representation from legal services and pastoral care. At least one member of the group will have an academic background in ethics and at least one member will have specific knowledge and experience in equality and diversity issues. There must be at least one lay member.
- Administrative support will be provided by the relevant lead director's team.

3) Place within the Trust infrastructure

CEAG is a formally constituted group, ratified by the Clinical Governance and Clinical Safety Committee (CGCSC).

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The CEAG will prepare a summary report on the activities of the group on an annual basis and will submit the report to the CGCSC.

4) Meetings

- There will be a formal agenda, issued not later than seven working days before each meeting. Agenda items/papers to be submitted to the Chair not less than ten working days before each meeting. Items of urgent business arising after this time will be accommodated with the agreement of the meeting.
- Notes of the meeting will be taken, recording key discussion points, actions agreed and any advice/guidance agreed by the group. Notes will be issued to members not later than 14 working days following meetings.
- Meetings will take place initially at a frequency of every two months (to be reviewed in the light of experience).
- In order to provide consideration for urgent issues the Chair or Deputy Chair may convene a virtual meeting with a minimum of four other members. Any output from this will be subsequently reviewed by the CEAG.

5) Process of clinical ethics consultation

Any Trust employee can seek ethical advice from the CEAG by contacting a member of the committee and completing a brief written referral. It is expected that staff will already have escalated these issues within their appropriate line management structures, including the trio of General Manager, Clinical Lead and Practice Governance Coach within the care groups. Normally the person referring the case would attend the meeting to discuss the case in detail and hear the discussion. Where advice involves consideration of individual clinical cases, the cases should be anonymised as far as is practical to preserve patient confidentiality.

Patients/carers can seek ethical advice from the CEAG with support from the customer services team.

Issues referred should relate to patient care, whether at management or clinical level. Issues relating solely to staff issues, such as employment disputes, are not appropriate for this group.

The Chair may decide to invite a patient/carer, or an advisor with particular expertise (e.g. lawyer) to attend the meeting.

The discussion and any specific advice which emerges will be documented as a letter to the referring clinician. Where the discussion relates to a particular patient, this will usually be expected to form part of the patient record. In order to maintain patient confidentiality discussions about specific cases will not be referenced in the annual report, areas of learning and development may be included.

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Where advice relates to the development of policy or procedure, a referral should be made from the relevant director's office.

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South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 September 2022
Agenda item 8

Private/Public paper:	**Public**		
Title:	**Chief Executive's Report**		
Paper presented by:	Chief Executive		
Paper prepared by:	Chief Executive		
Purpose:	To provide the strategic context for the Trust Board conversation.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	N/A.		
Any background papers / previously considered by:	This cover paper provides context to several of the papers in the public and private parts of the meeting and also external papers and links.		
Executive summary:	**Following the sad passing of the Queen, the Trust observed the 10-day period of mourning.** Bank holiday arrangements were put in place for the day of the funeral, allowing as many staff as possible to pay their respects whilst also ensuring appropriate service provision was in place. **We have seen an improvement in the prevalence of Covid-19 in the community and in the Trust**. At the time of writing this report, staff absence due to Covid-19 is as low as it has been since the pandemic began. Whilst this is a more positive position, we have experienced some outbreaks on our wards. Following feedback from staff and analysis of our current position, we are pleased to have been able to fully remove the requirement for mask wearing in non-clinical areas. For the time being, we are retaining the need in clinical areas to ensure patients are protected. There have also been national changes which reduce the requirement for testing for Covid-19. These have been considered internally with updated internal processes now in operation. We will continue to monitor prevalence and guidance and will act accordingly should the circumstances change. The UK's Covid-19 alert level has been downgraded to level 2, meaning the virus is in "general circulation" but healthcare pressures and transmission are "declining or stable." **Following the successful roll out of our COVID staff vaccination programme last year, we were pleased to inform staff that the national booking system for the winter booster is now open.** Along with the flu vaccination programme, this forms part of our planning for winter. The Trust is		

	fully engaged in winter planning within integrated care systems and in our local places. Guidance has been issued regarding winter planning, including the vaccination programme, and the Trust has an internal group established to oversee its delivery and communication. **Therese Coffey has been appointed as Secretary of State for Health and Social Care.** Her priorities for the NHS have been described as A, B, C, D – ambulances, backlogs, care and doctors & dentists. The new Prime Minister, Liz Truss, has outlined her main three priorities as being tax cuts, the energy crisis and the NHS. **We are supporting our staff and our service users in response to the cost of living crisis.** Whilst some measures have been announced by the Government, cost inflation remains high and energy bills are expected to be high too. A Trust wide working group has been established to share information and coordinate support across all areas and services. Useful information and signposting for staff has been compiled and resources to help support service users is in development. To further support staff, we have temporarily implemented higher mileage payments for fuel as well as introducing a mechanism enabling staff to draw down an element of their salary earlier in the month (called WageStream). We will continue to work internally and with partners to identify any actions we can take to improve the situation for our service users and staff. **Staff in all areas played an important role in ensuring continuity of service provision and showed great resilience during the heatwaves we experienced over the Summer.** Measures were also taken to support staff wellbeing such as provision of cold drinks and free ice creams. **Whilst the Trust was not directly affected, several NHS provider organisations suffered from the impact of a cyber-attack** on the supplier, Advanced. This is a salient reminder of the importance of cyber awareness in the Trust and also the measures we take to protect our systems and information. Once any learning is available from this incident, we will review it and adopt as appropriate. **A national meeting for Chief Executives of NHS providers of mental health services took place during the early part of September.** This provided an opportunity for the Chief Executives to come together and discuss the sector approach to managing winter, recognise achievements and influence future direction. Achievements recognised include a reduction in bed occupancy by people with a learning disability, increased access to physical health checks for people with a learning disability, higher numbers of children and young people accessing mental health services, meeting higher demand for IAPT and increasing the total workforce numbers. **System working continues to develop and evolve.** Integrated Care Boards, Place Committees and other forums have all met since the Health and Care Bill went live in July. The focus is shifting more towards how improvements to care can be made and how health inequalities can be addressed. There are more detailed update reports in the Board papers that cover this. **Operationally there continues to be significant challenge.** Positively, through much hard work and commitment, the number of out of area bed

	placements has reduced and, as can be seen by the integrated performance report, many of our key metrics continue to be achieved, however, demand for inpatient beds remains high and staffing challenges remain in a number of areas, particularly inpatient wards. **The Trust's early intervention in psychosis teams have been named as some of the best performing in the country.** The National Clinical Audit of Psychosis (NCAP) is an audit programme that measures the quality of care that NHS mental health trusts provide to people with psychosis. This year the target was for 70% of EIP teams in England to achieve 'Performing well' or better. All five of our EIP teams (spanning Barnsley, Wakefield, Calderdale and North and South Kirklees) achieved this, with two of our teams achieving 'Top performing.' **The Board papers include reference to the most recent LeDeR report (learning from lives and deaths of someone with a learning disability).** We were pleased to see that our Wakefield learning disability ACE project, 'Achieving Change through Engagement', was named as a model of good practice. The report takes learning from learning disability services to promote change and improve LD services nationally. As a Trust, we are committed to improving the lives of people with a learning disability. At a recent executive management session, we considered how the Trust can further use its role and influence in the wider system to benefit our learning disability service users and their families & carers. **A new 'Discovery College' has launched in Wakefield offering free health and wellbeing courses to young people.** Part of Wakefield's Recovery and Wellbeing College, the Discovery College will offer courses and workshops developed and delivered with young people to support the mental health and wellbeing of people aged 16 – 25 years old. **The pay award for 2022/23 has been received and being paid to staff.** We are aware that trade unions are balloting their members regarding industrial action. This report updates The Brief attached at **[ANNEX 1]** which itself outlines priorities and actions for all Trust staff. The Brief provides continuity of communications alongside The View, the most recent Coronavirus update and the weekly Headlines.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The Brief

25 August 2022

Monthly briefing for staff, including feedback from Trust Board and executive management team (EMT) meetings

With **all of us** in mind.

Our mission and values

During challenging times is it important we focus on our values.

We exist to help people reach their potential and live well in their community.

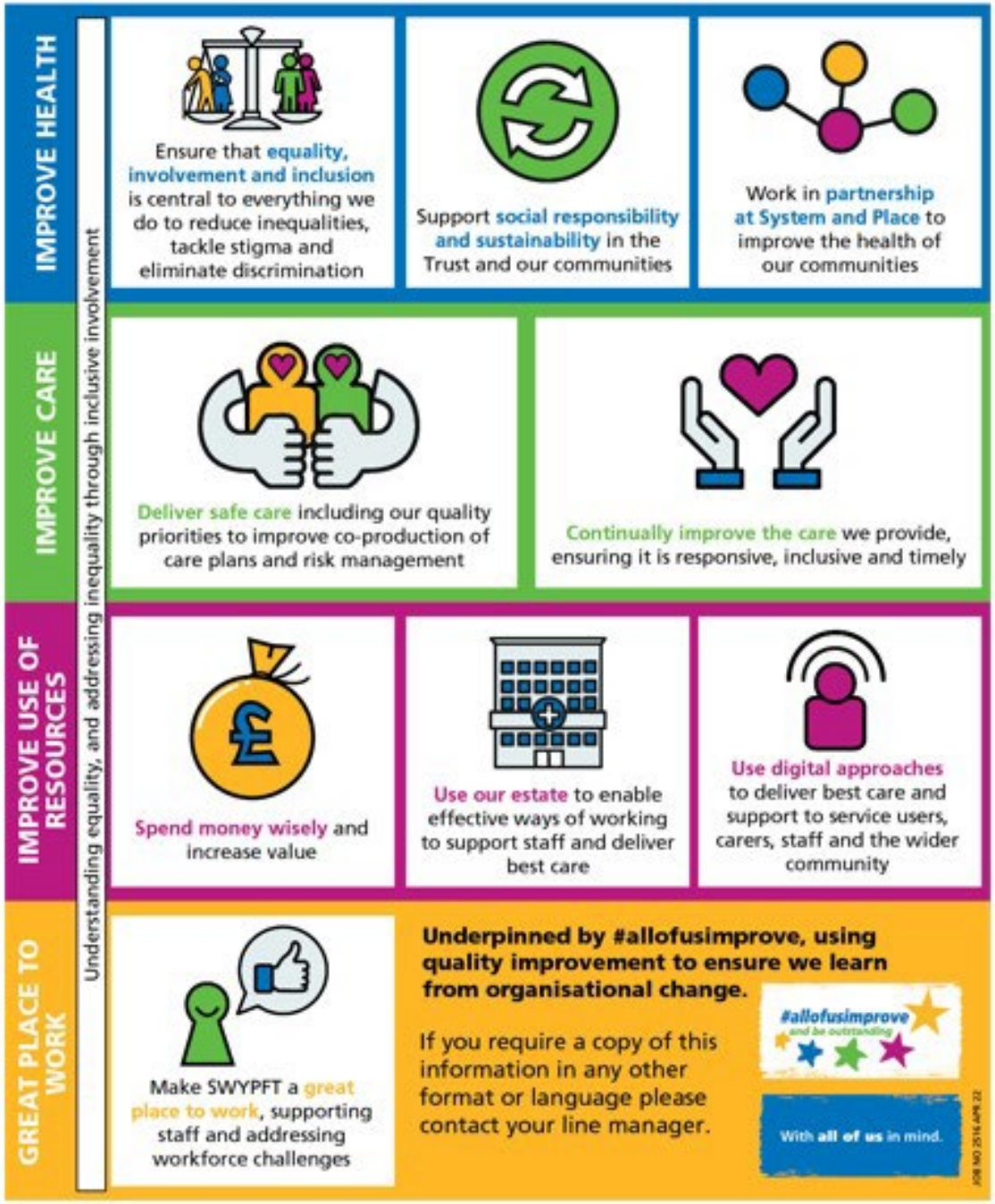
To achieve our mission we have a strong set of values:

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

Our Wakefield recovery and wellbeing college attended Wakefield Pride to showcase their support for LGBT+ communities, and share information about the courses and support they have on offer.

Well done also to occupational therapist Lizzie Hart, who received a compliment from a local GP: "You have been able to support the patient, tackling numerous medical and cognitive issues as well as dealing with some of the social challenges. Thank you for your hard work and dedication to our patients "

Our priorities 2022-23



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Ongoing progress is being made to reduce out of area placements. The Trust had 13 people placed in out of area beds at the end of July, a reduction from our peak of 20 in recent months.

A Trust sustainability change manager has been appointed. Tony Wright will lead and co-ordinate the social responsibility and sustainability work from 1st September.

The national, regional and local context

South West Yorkshire Partnership NHS Foundation Trust

We are continuing to work with our partners in each of our places, ensuring a smooth transition to new arrangements, and building on the local progress we have already made.

Integrated Care Systems are now statutory bodies. We are involved in two ICSs, in the West Yorkshire Health and Care Partnership and South Yorkshire ICS. We are also a part of the Place Committees which have been set up in all of our local areas. You can find out more about how the system works on our intranet, including links to the ICS websites.

Nick Balac has been appointed as the primary care executive adviser for the **Barnsley Community Health and Care Alliance**. He will work for our Trust and help build the alliance between us and the Barnsley Healthcare Federation.

A new collaboration between local mental health support teams (MHST) and our child and adolescent mental health services (CAMHS) has launched in Barnsley. Branching Minds Barnsley brings together both services under one roof, helping children, young people and their families get the right support at the right time, whilst providing more seamless care.

West Yorkshire Health and Care Partnership has launched a 'Healthier Together' website to support babies, children, young people and families with their health and wellbeing. It has health resources for people to access as well as resources for professionals to share with those they are working with.

Creative Minds is supporting the Kirklees Year of Music by teaming up with Locala and Hoot Creative Arts with a new funding opportunity for local groups. Details are on their website.

Coronavirus updates

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As of 24 August there were **31** members of staff absent or working from home due to coronavirus. This is a reduction compared to what we reported in last month's Brief.

The Trust policy on the wearing of face masks has not changed. However, the COVID Moving Forward group is looking at the issue, taking into account feedback from staff, our current COVID outbreaks and the fact that some of our service users are currently being treated in our acute hospitals. A review exploring all options is taking place and we will update as soon as we can.

We are still fully supporting hybrid ways of working so you should continue to work either from home or from a Trust base, as required by your role and agreed with your line manager.

COVID booster vaccines are being rolled out for front line health and care workers this Autumn. Along with the flu vaccine it will help to keep everyone safe over the winter period.

We need to remember that COVID is still with us, and impacting on people's lives. We currently have some outbreaks in our Trust and service users with COVID receiving care in acute trusts.

Remember you should report a new COVID infection on ESR or Healthroster, as appropriate. **SharePoint must also be completed for our Trust figures.** Reasons need to be recorded, and for Test and Trace purposes, which is continuing. A new flow chart is available on the intranet so you can see the process laid out in full.

West Yorkshire Health and Care Partnership Staff Mental Health and Wellbeing Hub are running a focus group to engage staff with lived experiences of long COVID.

With **all of us** in mind.

Remember there is support available if you need.it. Your wellbeing is important to us.

Improving Health
Our performance in July

NHS
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- **56.2%** of people completing IAPT treatment and moving into recovery
- **100%** of IAPT referrals beginning treatment within 18 week. **97.6%** within 6 weeks.
- **91.3%** of service users followed up within 72 hours of discharge from inpatient care
- **78%** records with up-to-date risk assessment in inpatient and **51.4%** in community
- **80.4%** of learning disability referrals have had a completed assessment, care package and commenced service delivery within 18 weeks (provisional)
- **100%** of people died in a place of their choosing
- **2.6%** delayed transfer of care
- **57.4%** in CAMHS services waiting less than 18 weeks for treatment

We're continuing to review how we provide mental health care for older people within our inpatient wards. The Trust will be hosting a stakeholder and staff event in September 2022 which will update on the next steps in the transformation programme, including the timeline and info on the process we will follow.

Can you help us to fight flu? We're looking for peer to peer vaccinators to help us ensure all of us are protected from flu. If you're a qualified nurse who gives injections and would like to help find out more.

Congratulations to our Barnsley Children's Speech and Language Therapy for being nominated in the CAHPO Awards 2022. They are nominated for the fantastic digital tools produced to help children, young people and families access support. Give them a follow on social media to find out more about the support available.

Congratulations also to our tissue viability team in Barnsley who, in partnership with Lohman and Rauscher have been shortlisted in the HSJ Awards for their fantastic partnership work on wound care

Improving Care
Our performance in July

NHS
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NHS Foundation Trust

- **326** inappropriate out of area bed days
- **0** young people under 18 admitted onto adult inpatient wards
- **90.2%** waiting list referral to assessment within 2 weeks
- **93.7%** waiting list assessment to treatment within 6 weeks
- **45** days is the average length of stay on adult acute mental health wards
- **36.1%** of service users on CPA offered a copy of their care plan
- **70.1%** of our mental health service users have their equality data recorded

93% of respondents in the friends and family test rated our general community services either good or very good; **88%** in our mental health services; **-71%** would recommend CAMHS; and **80%** our LD services.

Support our #AllofYou campaign and share your personal equality data on ESR. This helps us to make sure that services meet the needs of us all. And don't forget to ask our service users if they are happy to share their own equality information as this helps to ensure the services we provide meet the requirements of our local communities.

EyUp! Charity is implementing an additional funding route from Monday 5 Sept. The new funding route will support colleagues wishing to apply for charitable funding up to £300. These applications will be assessed every 2 weeks providing services with a quicker access to available charitable funds. For more information contact Jana Harris.

All of you

With **all of us** in mind.

Improving Care
Incidents in July

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In July we reported:

- **1,138** incidents – **700** rated green (no/low harm)
- **363** were rated yellow and **67** rated amber
- **8** rated as red, it was 4 in June
- **97%** of incidents resulted in no or low **actual** harm, or were external to our care
- **30** patient safety incidents that resulted in moderate harm or severe harm. They were **19** category 3 and **4** category 4 pressure ulcers, **1** tissue viability incident, **5** self harm incidents, **1** related to assessment, treatment and intervention.

We had **171** restraint interventions in July, up from 152 in June. **80%** of prone restraints were 3 minutes or less. We continue to offer support and advice to teams around reducing restrictive interventions.

We had **70** falls in July, it was 37 last month. All falls are reviewed to identify measures required to prevent reoccurrence.

We need to ensure all incidents are reported so that we can maintain our good incident reporting culture.

There were **10 confidentiality breaches** in July. There were 19 in June.

All of us can reduce the number of patient data or sensitive information breaches at the Trust.

Think. Check. Share.

With **all of us** in mind.

Improving Care
Reporting incidents involving protected characteristics

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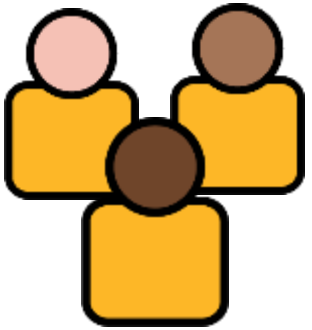
All protected characteristics incidents of any grading are discussed at the weekly Trust Clinical Risk meeting (attended by the Exec Trio, service directors, senior managers, estates and facilities, legal and specialist advisor colleagues). This review is to ensure that appropriate support is in place and any themes or pattern are identified. We equally focus on other protected characteristics when these are reported within a Datix.



In the month of July, there were **54** reported incidents of abuse against people's with protected characteristics.

- **31** race/ethnicity related
- **7** regarding gender
- **3** involving age
- **7** related to sexuality
- **1** involving disability
- **1** related related to gender identify/reassignment
- **1** involving marital or civil partnership status, and
- **3** related to religion or belief

All of these incidents are also reviewed by our Equity Guardians, to ensure a comprehensive review.

It's vital that people continue to report incidents word for word, as this paints the most accurate picture.

With **all of us** in mind.

Managing risk

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

Key areas of risk identified in the risk register are:

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

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

Winter planning is starting earlier this year, recognising the risks posed by COVID, flu and other respiratory infections. There is a focus on areas that have an impact on patients and the stability of the NHS, such as discharge from hospital.

COVID is still an identified risk for the Trust, impacting on staffing levels. We also have outbreaks in some of our areas which impact on the services we deliver. Please continue to do all you can to stay safe.

Advanced, a third-party software supplier to the NHS, has been subject to an external ransomware cyber incident. We are unaffected but it highlights the risks to all NHS providers. Make sure you stay alert against potential cyber attacks.

Improving resources
Our finances in July

NHS
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Performance Indicator	Year To Date	Forecast 2022 / 23
Surplus / (Deficit)	£3.3m	£3.2m
Agency Spend	£3.3m	
	4.6%	
Overhead Costs	15%	
Financial sustainability and efficiencies	£2.4m	£6.4m
Cash	£84.4m	£80.3m
Capital	£1.1m	£13.1m
Better Payment Practice Code	95%	

In month financial performance is a surplus of £0.6m with a year to date surplus of £3.3m. We are forecasting to meet our year-end target

The Trust allocation of the overall West Yorkshire Integrated Care Board (ICB) agency cap is £7.8m. Performance is measured against both this, and also as a percentage of total pay expenditure.

Cash in the bank remains positive although it is forecast to reduce in the year due to continued capital investment and payment of a number of outstanding invoices and costs.

The capital programme for 2022/23 has been agreed as £13.1m and is forecast to be delivered in full.

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

A great place to work
Our performance in July

- **5.5%** sickness rate (excluding Covid related absence)
- **1.3%** COVID sickness YTD
- In July we had **46** new starters to the Trust, and **57** leavers
- We currently have **4,134** substantive members of staff

To celebrate South Asian Heritage month our staff have been sharing their personal stories and experiences. These informative stories can be found on our website and are shared through our social media channels.

Make sure you book in your **appraisal** and start the process with your self assessment. It is important that all staff have an appraisal as it provide an opportunity to focus on your development and wellbeing, and in setting your objectives.

The new rates for staff on agenda for change can be **found here**. This will be processed nationally in September and staff will receive their arrears in their September pay. If the pay increase causes a staff member to be in a higher **pension banding tier**, their mandatory pension contribution will increase.

We now have gender neutral toilet choices in parts of our Trust. This is supported by our LGBT+ staff network. They will be rolled out further in coming months. Read more on the intranet.

From October the amount of pension contributions you pay is changing. Instead of the rate being linked to full-time equivalent salary, it will be based on actual salary for any part-timers. Some staff will see the rate they pay go down whilst others will see an increase. Further details will be sent to individuals affected later this year. You can see the new contribution rates here.

Become a Trust improvement facilitator by taking the Institute for Healthcare Improvement's Certificate of Quality and Safety. For more info contact Rachel Williams

Take home messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Remember to record COVID absence on ESR or HeathRoster, as well as on Sharepoint.

Safety comes first, always. Do whatever you can to keep yourself and others safe.

Help us to fight flu by volunteering as one of our peer to peer vaccinators.

Take part in our 'All of you' campaign by recording yours and our service user's equality data.

Become a Trust improvement facilitator by signing up for the IHI Quality and Safety certificate.

Take a look at how EyUp funding could help you improve service user experience

If you haven't done so already book in your appraisal and start your self-assessment.

Your wellbeing is important to us. Look after yourself and support colleagues.

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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 September 2022
Agenda item 9.1

Private/Public paper:	**Public**		
Title:	**Integrated Performance Report Review**		
Paper presented by:	**Director of Finance**		
Paper prepared by:	**Deputy Director of Corporate Governance**		
Purpose:	To provide the Trust Board with an update on the proposed review of the Integrated Performance Report (IPR)		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	The Integrated Performance Report, provides assurance to Trust Board on compliance with standards, identifying emerging issues and actions being taken for all strategic risks.		
Any background papers / previously considered by:	IPR is reviewed at Trust Board, with the exception of strategic meetings when Board members are sent the IPR for information. IPR is reviewed at the Executive Management Team (EMT) and Operational Management Group (OMG) meeting on a monthly basis		

Executive summary:	A programme of work is taking place to review the IPR. This is being led by the Director of Finance, Estates and Resources and supported by the Deputy Director of Corporate Governance.
	
	The review will focus on:
	• Timeline of preparation
	• Content
	• Platform upon which the IPR is built
	
	In order to ensure that the IPR continues to meet the needs of the Board, and the Trust as a whole, the following tasks are to be undertaken:
	• Director/Senior Manager stakeholder sessions have been set up to take place over October and to include Non-Executive colleagues in November to review and discuss format and content, including:
	  ○ Inclusion of benchmarking data where available.
	  ○ Where a KPI is red and has been for a period of time, we will set a trajectory for improvement		

With all of us in mind.

	○ Inclusion of care group dashboards, this is already included in the version that goes to OMG and EMT but is currently removed before submission to Trust Board. ○ Explore use of reading room functionality in diligent to facilitate the removal of publication summary. ○ Review whether communications, engagement and equality and volunteering section are removed from the main IPR and moved into an independent report to Board. ○ Review whether the Priority programmes report should remain part of the IPR. ○ Review the covid and emergency preparedness sections with a view to integrating into existing sections (i.e workforce) ○ Review whether any metrics or updates are required from Provider Collaboratives ○ Remove duplication of information that is presented by Board Committees. ○ Re-order dashboards/KPI's to report by strategic objective ○ Review thresholds and forecasts ○ Review the format of the IPR to investigate if the production process can be made more efficient, to allow greater time for analysis and validation by Care Groups. • Following the initial Director/senior manager review, an action plan will be shared with the Finance, Investment & Performance Committee before a broader board discussion on the proposed future format and content.
Recommendation:	**Trust Board is asked to NOTE the proposed approach to the development of the Integrated Performance Report and COMMENT accordingly.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27th September 2022
Agenda item 9.2

Private/Public paper:	**Public**		
Title:	**Integrated Performance Report**		
Paper presented by:	**Director of Strategy and Deputy Chief Executive**		
Paper prepared by:	**Director of Finance & Resources and Director of Quality & Nursing**		
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for August 2022.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	The Integrated Performance Report, provides assurance to Trust Board on compliance with standards, identifying emerging issues and actions being taken for all strategic risks.		
Any background papers / previously considered by:	IPR is reviewed at Trust Board each month IPR is reviewed at Executive Management Team (EMT) meeting on a monthly basis		
Executive summary:	**Priority programmes** • The Trust had 9 people placed in out of area beds at the end of August, a reduction from our peak of 20 in recent months. The Trust's Inpatient Improvement Programme continues to work internally and externally to improve this position. • NHS England launched the new Patient Safety Incident Response Framework in August. A structured 12-month implementation work programme has commenced, with planned go live in September 2023. • The Trust's Quality Strategy is under development with amended deadline of December 2022 agreed to enable staff engagement sessions to take place and alignment with other strategic priorities and financial planning. • Implementation of a Trust-wide approach to digital dictation by March 2023 is facing some challenges in moving forward at pace including the delay in recruitment of a Project Manager to assist capacity for the project, hence current rating. This is being kept under review.		

Addressing Inequalities

- A key priority for the Trust is to improve the recording and collection of protected characteristics across all services - this will be monitored by the Trust's Equality, Inclusion and Involvement Committee.
- In August, 70% of service users had had their equality data (ethnicity, disability, sexual orientation and postcode) recorded. Developments are ongoing to ensure data capture will be extended to all services.
- Specific actions the Trust is taking to address inequalities include co-designing services with communities ensuring representation is reflective of the population and covers all protected groups and carers, using approaches such as community reporters and researchers to capture patient stories, offering enhanced equality and diversity training and ensuring health assessments for people with a learning disability.

Covid-19

- Protocols are in place to maintain staff and patient safety.
- The Covid-19 Moving Forward Group continues to monitor Covid prevalence, measures and national guidance.
- The Trust OPEL level remains at an average of 2.4, with five service areas now operating at OPEL 2. Four service areas remain at OPEL 3.
- The roll out of the annual staff influenza vaccination programme will commence in October 2022, with a target of 90% for frontline staff uptake.

Quality

- The Trust continues to perform well against the majority of quality indicators.
- The percentage of patients on the Care Programme Approach (CPA) offered a copy of their care plan remains below target at 38% in August. This is a combination of the way that the information is drawn from the system and the way that care is offered, and significant work has been undertaken to address this. The work continues in front line services to adopt collaborative approaches to care planning. A new person-centred metric has been identified and work is being undertaken to implement this in the coming months.
- The percentage of patients with an up to date risk assessment is below target for both community (78%) and inpatient teams (82%), but represents an improved position. A deep dive into the risk assessment data has been completed and improvement measures put in place across all services in order to further improve performance.
- Waiting times for neurodevelopmental waits within CAMHS are below target., As previously reported, waiting list initiatives are in place to work towards stabilising this position from March 2023. Children do not need to have a diagnosis in order to receive a CAMHS service and services will be provided to meet their presenting needs.

- The number of restraint incidents was 161 in August, a decrease from 171 in July.
- There were 9 information governance breaches reported in August, a decrease from 10 in July.
- The number of inpatient falls was 63 in August, a decrease from 70 in July.
- The percentage of CAMHS patients waiting less than 18 weeks from referral to treatment was 60% in August, a slightly improved position from 57% in July. CAMHS continue to prioritise children with high levels of need and if a child's needs escalate whilst they are waiting for a service, the service will provide additional support.
- 97% of incidents reported in August 2022 resulted in no harm or low harm or were not under the care of the Trust.
- 91% of prone restraints had duration of 3 minutes or less, above target of 90%. This is an improved position.

People

- Our substantive staff in post position remains stable through the first 5 months of this financial year, despite the pressures on recruitment, retention, and increased service acuity.
- International nurse recruitment continues, and we now have 19 colleagues working across our inpatient services with 5 more due to join the Trust by the end of September.
- Overall vacancy rate in August was 16.7% in August against a target of 10%.
- Total numbers of new starters into the Trust since April is higher than the number of leavers for the same period.
- Sickness absence in August was 4.7%, a reduction from 5.5% in July.
- Staff appraisals is below target at 61.3%. All staff have been reminded the importance of appraisals and encouraged to book these and all Care Groups have seen improved performance since last month. Compliance is reviewed monthly by the Operational Management Group and Executive Management Team.

NHSI Indicators

- The Trust continues to perform well against the majority of national metrics.
- Inappropriate out of area bed days continue to be above the numbers experienced in recent years with 247 days in August, a decrease from 339 in July. This is due to a number of challenges faced by the Trust (increased acuity, Covid-19 outbreaks and challenges to timely discharge).
- There was one young person under the age of 18 admitted to an adult ward in August. Robust governance processes are in place to safeguard young people.
- The percentage of service users seen for a diagnostic appointment (paediatric audiology) within 6 weeks was 100% in August, an improvement from 91.5% in July.

	• The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within one week is below target at 83.3% against a 95% target. Small numbers impact on this measure. **Locality** • Barnsley Children's Speech and Language Therapy (SALT) Service has been shortlisted for the Chief Allied Health Professions Office Award for Digital Practice. • Mental health acute wards continue to see high levels of acuity and demand. • Work to maintain patient flow continues, with the use of out of area beds closely managed. • Demand into the Single Point of Access (SPA) and capacity issues are leading to ongoing pressures in the service. SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment has been at risk of being delayed. • Mental health community teams are experiencing significant workforce challenges. This is being supported by Trust-wide work on recruitment and retention. • Newton Lodge and Bretton Centre bed occupancy is below the 90% target at 84% and 87% respectively, yet acuity remains high. • South Yorkshire Liaison and Diversion Service have been chosen to take part in the Awards for Lived Experience Charter Sites. The focus is equality, involvement, and inclusion. • The percentage of children treated within 18 weeks in core CAMHS remains challenging with the position in Wakefield being particularly under pressure. In general waiting lists/times from referral to treatment are improving. • Waiting numbers for children's Autistic Spectrum Conditions (ASC)/Attention Deficit Hyperactivity Disorder (ADHD) (neuro-developmental) diagnostic assessment in Kirklees remain problematic. Increased capacity is now in place. • Waiting list times pressures continue in community learning disability services. People with learning disabilities on waiting lists are receiving regular welfare phone calls to ensure they remain well, and have not escalated in need. • Adult Attention Deficit Hyperactivity Disorder (ADHD) and autism referrals continue to increase, and remain higher than pre-pandemic levels. • A business case to increase capacity in the adult ADHD service has been approved. **Communications, Engagement and Involvement** • Coronavirus updates continue to all staff and governors, focused on any changes to guidance.

	• The 'All of You' campaign on collecting equality data campaign continues to be promoted. • Wellbeing initiatives continue to be promoted. • Monthly themed lunch box talks are being delivered. The talks share community equality films created in partnership with local communities, with discussion. • The Trust have secured funding to deliver a deep dive Trust-wide survey to investigate the experiences and views of its workforce with regards to racial equity in the workplace. **Finance** • In month financial performance is a surplus of £0.6m, with a year to date surplus of £3.9m. This is £0.9m better than plan. Additional spend is profiled for the remainder of year, ensuring delivery of the revised £3.2m surplus. • Agency spend was 716k in August, with year to date spend of £4m. Actions are in place to address agency spend, which will be overseen by the Trust's agency group. • The capital programme for 2022/23 has been agreed as £13.1m, and this is forecast to be delivered in full. Capital spend to date is £1.2m. • Cash in the bank remains positive at £86.1m, although it is forecast to reduce in the year due to continued capital investment and forecast increasing spend. • Pay costs were £17.9m in August, a decrease from £18.5m in July. • Out of area bed costs were £235k in August, a decrease from £378k in July. • Performance against the Better Payment Practice Code is 95%.
Recommendation:	**Trust Board is asked to RECEIVE the Integrated Performance Report and COMMENT accordingly.**

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

August 2022

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Table of Contents

Click on each section heading to navigate to that section

	Page No
Introduction	4
Summary	5 - 7
Priority Programmes	8 - 20
Covid-19	21 - 22
Emergency Preparedness	23
Quality	24 - 41
People	42 - 44
National Metrics	45 - 48
Locality	49 - 57
Finance	58
System-wide Monitoring	59
Publication Summary	60
Appendix 1 - Finance Report	61 - 76
Appendix 2 - SPC Charts - Explained	77 - 78
Glossary	79

Introduction

Please find the Trust's Integrated Performance Report (IPR) for August 2022. The development of the IPR will continue to evolve to reflect any changes in the operational environment.

Many of the agreed metrics identified to monitor performance against our strategic objectives have been populated, whilst others are in development with indicative timescales provided.

With reference to key information relating to Covid-19, where possible the most up-to-date information is provided, as opposed to the August month-end data. This will ensure that Trust Board can have a discussion on the most current position available, as opposed to the position four weeks earlier. Given the fact different staff provide different sections of the report, there may be some references to data from slightly different dates.

It is worth reminding the reader of the report of the Trust's four strategic objectives against which our performance metrics are designed to measure progress. These are:

- Improving health
- Improving care
- Improving resources
- Making SWYPFT a great place to work

Performance is reported through a number of key performance indicators (KPIs). KPIs provide a high level view of actual performance against target. The report has been categorised into the following areas to enable performance to be discussed and assessed with respect to:

- Executive summary
- Priority programmes
- Covid-19 response
- Emergency preparedness, resilience and response (EPRR)
- Quality
- People
- National metrics
- Locality
- Finance & contracting
- Systemwide monitoring

The priority programmes section has been updated to reflect the Trust's priorities and associated metrics for 2022/23. The national metrics section has also been updated to reflect changes in the NHSEI oversight framework, long-term planning metrics and NHS standard contract metrics. We also need to consider how Trust Board monitors performance against the reset and recovery programme. The Trust is also keen to include performance data related to the West Yorkshire and South Yorkshire Integrated Care Systems (ICSs) – this is an iterative process as work is underway within the ICSs to determine how performance against their key objectives will be assessed and reported. Our Integrated Performance Strategic Overview Report is publicly available on the internet.

This section has been developed to demonstrate progress being made against the Trust objectives using a range of key metrics. More detail is included in the relevant sections of the Integrated Performance Report.

Priority programmes

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• Wellbeing initiatives continue to be promoted.
• Monthly themed lunch box talks are being delivered. The talks share community equality films created in partnership with local communities, with discussion.
• The Trust have secured funding to deliver a deep dive Trust-wide survey to investigate the experiences and views of its workforce with regards to racial equity in the workplace.

Finance

• In month financial performance is a surplus of £0.6m, with a year to date surplus of £3.9m. This is £0.9m better than plan. Additional spend is profiled for the remainder of year, ensuring delivery of the revised £3.2m surplus.
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• Performance against the Better Payment Practice Code is 95%.

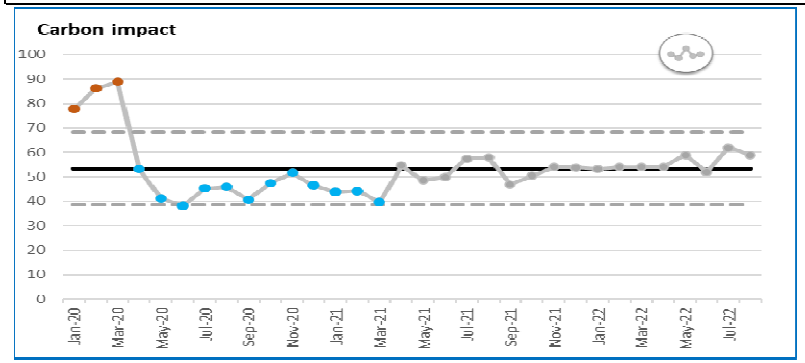
The following section highlights the performance against the Trust's strategic objectives and priority programmes for 2022/23. For some metrics, we have identified when we anticipate this data to be available. Some of the identified metrics will be reported quarterly. We will also incorporate statistical process charts in each section as relevant to identify improvement or areas that require further work or investigation. Key agreed milestones have also been identified and reporting against these milestones will be provided at the identified date or by exception.

We have added a column which will identify variation and assurance where we are monitoring against a threshold. See appendix 2 for key to the icons used.

Improving health

Priority programme	Metrics	Threshold	Jun-22	Jul-22	Aug-22	Variation/ Assurance	Year end forecast	Notes
Ensure that equality, involvement and inclusion is central to everything we do to reduce inequalities, tackle stigma & eliminate discrimination	Percentage of service users who have had their equality data recorded (ethnicity, disability, sexual orientation, deprivation, carers)	*90% (ethnicity only)*	59.6%	70.1%	70.3%			Figures shown are the combined percentage for completion of ethnicity (96.6%), disability (41.4%), sexual orientation (43.2%) and from July 2022 postcode (99.8%). The threshold is currently based on the national target for ethnicity recording only, which is already in place and achieving. This is subject to review by the Chief Operating Officer. We are looking at developing a phased target to monitor our progress against this metric.
	Referrals and admissions by ethnicity, disability, sexual orientation, deprivation, carers	N/A	See reducing inequalities section of the report for detail					
	Timely completion of equality impact assessments (EIAs) in services and for policies (Quarterly)	100%	60% service EIAs complete 64.8% policy EIAs complete	Due October 2022				
	Completion of equality mandatory training (Quarterly)	>=80%	93.8%	Due October 2022				
Support social responsibility & sustainability in the Trust & our communities	Carbon Impact (tonnes CO2e) - business miles	76	52	62	59			Data showing the carbon impact of staff travel / business miles. For August staff travel contributed 59 tonnes of carbon to the atmosphere.
Work in partnerships at System & Place to improve the health of our communities	Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks), by ethnicity, disability, sexual orientation and deprivation	55%	64.4%		Due November 2022			Reported 6 weeks in arears. A weighted average is used given there are different targets in different places.
	Forensic lead provider: % of patients in service with a physical health check and % with a care improvement and maintenance plan in place	100%	Medium Secure - 100% & 100% Low Secure - 92% & 100%					Figures shown are the average of last 4 financial quarters. England position for Medium Secure is 90% and 95% respectively and for Low Secure is 56% and 96% respectively.

What the data is telling us – this section is in development. Statistical process control charts will be inserted here to alert the reader to charts which identify improvement or that require further work or investigation



The SPC chart shows that as at August 2022 we are remaining in a period of common cause variation - no action is required. The drop in mileage figures are a direct consequence of Covid-19 and now that restrictions are being lifted and face to face activity is increasing we should anticipate that this will rise. Levels are not expected to return to those seen pre-Covid-19 as there should be a more blended approach to working going forward. The performance against this measure will continue to be monitored and if required, the upper and lower control limits re-calculated to include post-Covid-19 levels only.

	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

Implementation deliverables	
	On Target to deliver within agreed timescales
	On Trajectory but concerns on ability/confident to deliver within agreed timescales
	Off Trajectory and concerns on ability/capacity to deliver within agreed timescales
	Action will not be delivered within agreed timescales
	Action Complete

Below we have set out progress against the key agreed milestones. Reporting against these milestones is provided at the identified date or by exception.

Improve health

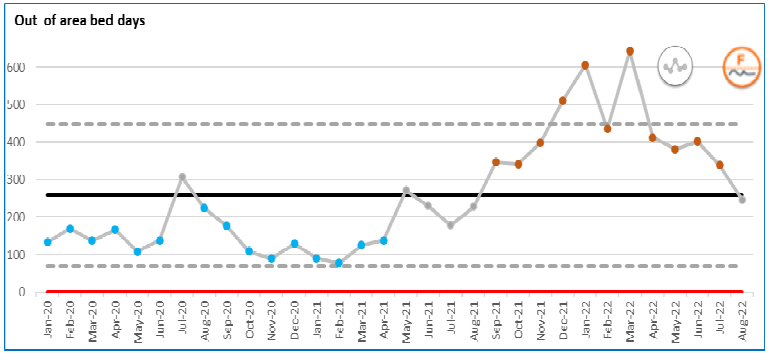
Key Milestones - (report by exception and any concerns on ability and/or capacity to deliver actions within agreed timescales)			
Support social responsibility & sustainability in the Trust & our communities	Following successful appointment of change manager and approval of social responsibility and sustainability strategy by Trust Board, work is now focused on developing action plan with metrics and measures to monitor progress.		
Work in partnerships at System & Place to improve the health of our communities	Barnsley provider alliance - • Commence target operating model development by July 2022		On track. Groups are working very well together. Plans on a page are completed for the three key workstreams: frailty and dementia, SMI (severe mental illness) health checks, and health checks for those with a learning disability.
	Barnsley provider alliance - • Alliance Agreement decision-making form development, variation, and future proofing by September 2022		On track
	Barnsley provider alliance - • Co-design and development of a marketing, communication, equality, inclusion, and involvement approach by December 2022		On track with branding, and recently agreed naming of Barnsley Community Health and Care Alliance.
	Forensic lead provider, West Yorkshire: • Progress the repatriation plan for West Yorkshire residents, achievement of annual targets against strategic repatriation ambition (quarterly update)		Ongoing progress is being made to reduce out of area placements. Review of those out of area and repatriations is now included in weekly meetings of the Single Point of Access.
	Forensic lead provider, West Yorkshire: • Achieve annual financial plan (quarterly update)		The provider collaborative is operating in line with financial plan. Oversight is via the Trust Collaborative Committee.
	Forensic lead provider, South Yorkshire: • Achieve successful 'go live' in 2022/23		The provider collaborative went live on 1st May 2022.
	Forensic lead provider, South Yorkshire: • Achieve annual financial plan (quarterly update)		The provider collaborative is operating in line with financial plan. Oversight is via the Trust Collaborative Committee.
	Community Mental Health transformation • West Yorkshire: Advanced Clinical Practitioners and Single Point of Access workers recruited by Jul 2022		ACP recruitment complete but there have been some challenges in recruiting to the SPA practitioner roles in Calderdale. SWYPFT General Manager is working closely with Programme Leads to progress.
	Community Mental Health transformation • West Yorkshire: Additional Roles Reimbursement Scheme (ARRS) roles recruited by October 2022		Recruitment is ongoing, and whilst each place has now recruited a proportion of ARRs roles, numbers so far are lower than in the agreed phasing schedule.
	Community Mental Health transformation • South Yorkshire: Successful completion of tender to provide community connectors into the 6 Barnsley neighbourhoods by October		On track

Improve Care

Priority programme	Metrics	Threshold	Jun-22	Jul-22	Aug-22	Variation/ Assurance	Year end forecast	Notes
Deliver safe care including our quality priorities to improve coproduction of care plans and risk management	Number of records with up to date risk assessment - Inpatient	*95%*	72.1%	78.0%	*82.0%*			August data is provisional and will be refreshed next month. All areas need to improve performance for FIRM risk assessments, which remains under target in all areas for those on CPA who have had a staying-well plan within 7 days and those who have had a formulation within 7 days. A series of deep dives has been taking place which has indicated a combination of service pressure factors, data quality issues, and pathway systems and technical issues regarding team-to-team allocations for example. The intelligence gleaned from this has led to some rapid improvement work which has demonstrated some improvement, and all areas will be focussing on this over the coming month. Operational services are working with performance and system colleagues to resolve any data capture issues and system anomalies. We have set up a trajectory of improvement to full performance by the end of Quarter 3.
	Number of records with up to date risk assessment - Community	*95%*	72.2%	54.2%	*78.3%*			
	% Service users on CPA offered a copy of their care plan	*80%*	33.5%	36.1%	38.2%			Work continues in front line services to adopt collaborative approaches to care planning. A new metric has been identified and work is being undertaken to implement this in the coming months which will demonstrate improved performance.
Continually improve the care we provide, ensuring it is responsive, inclusive & timely	Number of staff in post on adult acute mental health inpatient wards		235.9	233.9	232.0			Numbers of registered nurses on inpatient acute wards has been declining steadily for a number of years. Reducing by 38% in recent months. The number of healthcare assistant and trainee nurses has also declined, with a decline of 14% in the last 12 months.
	Average length of stay in adult acute mental health inpatient wards	*32 (national benchmark)*	44	45	40			Data is based on adult acute discharges only and so is likely to fluctuate. A higher number is indicative of patients being discharged who have longer lengths of stay. Individuals are being admitted at a higher level of acuity, taking longer to reach recovery. Length of stay is continuously monitored through the patient flow team. We are looking at ways to reduce this average and aim to develop a trajectory for reduction and phased target with a view to being more in line with the national benchmark by the end of Q1 23/24
	Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	22	15	23			In August there was an increase in the race related incident reported against staff in Mental Health Inpatients. The majority of incidents are linked to a small number of service users in the Forensics Care Group.
	Inappropriate out of area bed placements (days)	Q1 - 1456	402	339	247			
	Percentage of video consultations	Trend monitor	1.8%	2.0%	1.7%		N/A	SPC assurance ratings are indicative of the move away from national lockdown restrictions implemented due to Covid-19 and the subsequent associated reduction in video and telephone consultations and increase in face to face contacts.
	Percentage of telephone consultations	Trend monitor	28.9%	29.2%	27.9%		N/A	
	Percentage of face to face consultations	Trend monitor	69.2%	68.8%	70.4%		N/A	
	CAMHS - Average wait to neurodevelopmental assessment from referral - Calderdale	126	644	542	488			Average wait in days. Clients are seen in order of need and not by how long they have waited. Number on waiting list at end of August - 356. Waiting list initiatives in place, we will not reach a steady state until Q1 of 2023/24
	CAMHS - Average wait to neurodevelopmental assessment from referral - Kirklees	126	535	479	532			Average wait in days. Clients are seen in order of need and not by how long they have waited. Number on waiting list at end of August - 880. Waiting list initiatives in place, we will not reach a steady state until Q1 of 2023/24
	Learning Disability - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	74.1%	*81.6%*	*67.3%*			July and August data is provisional at the time of producing this report as data is reported quarterly and will be refreshed in November 2022. Work is in place to improve performance with the actions to minimise the impact of the waits reported to clinical governance clinical safety committee.
	Referral to assessment within 2 weeks (external referrals)	75%	67.8%	90.2%	79.4%			SPC charts shows that whilst there was a dip in performance in June, there is no cause for concern due to the increase to within acceptable range in July and August.
	Assessment to treatment within 6 weeks (external referrals)	70%	98.0%	93.7%	92.7%			

Glossary	
CAMHS	Child and adolescent mental health services
CPA	Care Programme Approach
WTE	Whole time equivalent

What the data is telling us – this section is in development. Statistical process control charts will be inserted here to alert the reader to metrics that require further work or investigation.
(SPC charts to be included here where relevant)

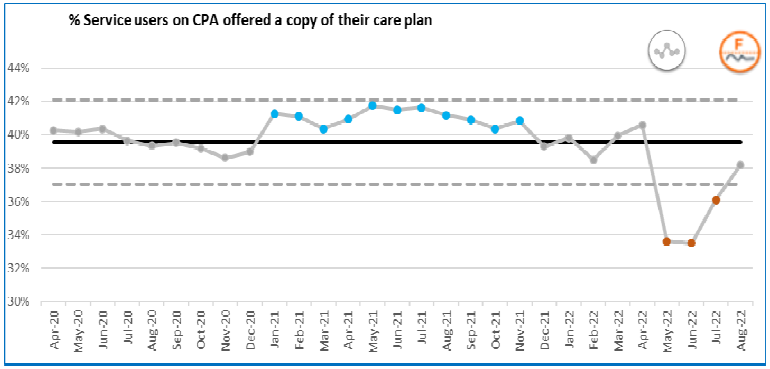


There has been a step change increase in out of area bed usage from summer 2021 onwards. There are several reasons for the increase including staffing pressures across the wards, increased acuity, Covid outbreaks and challenges discharging people in a timely way.

The inpatient improvement programme is aiming to address many of the workforce challenges. Systems are being put in place to manage and unblock barriers to discharge as well as effective coordination of out of area placements so that people can be repatriated as quickly as possible.

Many of these challenges are happening across other providers nationally. NHSE have recognised this and provider Trusts have submitted trajectories to zero out of area placements by the end of the 2023/24 financial year.

The Trust had 9 people placed in out of area beds at the end of August, a reduction from our peak of 20 in recent months and now back in line with our submitted trajectory.



Performance against the percentage of service users offered a copy of their care plan has dropped below the expected range and into special cause concerning variation. Work continues in front line services to adopt collaborative approaches to care planning. A new person-centred metric has been identified and work is being undertaken to implement this in the coming months which will improve performance

	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

Improve Care

Key Milestones - (report by exception and any concerns on ability and/or capacity to deliver actions within agreed timescales)			
Deliver safe care including our quality priorities to improve coproduction of care plans and risk management	Use the Patient Safety Incident Response Framework to analyse our data and intelligence to identify the Trust's patient safety priority areas. Develop comprehensive improvement plans by September 2023.		NHS England launched the new Patient Safety Incident Response Framework (PSIRF) on 16 August 2022. The framework is supported by numerous documents including a preparation guide and toolkit. Work towards implementation is over a structured 12 month period starting in September 2022, with the aim of going live in September 2023. The preparation guide is structured into 5 phases, commencing with 'orientation' where we will scope and plan our work up until November 2022. We continue to network with national, regional and place-based groups to learn and support our journey. An internal project board has been established to support this work, and an implementation team established. Regional support will be available through the Patient Safety Collaborative throughout the project. An animation summarising what PSIRF is about is available here https://www.youtube.com/watch?v=TyYekgo_IN0&t=4s
	Development of a structured approach and process for quality improvement		Structured QI process drafted and presented to Quality Improvement Group in September for approval. It will be used as part of care plan and risk assessment improvement programmes.
Continually improve the care we provide, ensuring it is responsive, inclusive & timely	Improving Access to Care (IATC): Completion of baseline analysis of waiting times & support for people while they wait by October 2022		This work is progressing well, and is on track. Data is being gathered from Care Groups to form a baseline stock take of current position as to what is being done to reduce waiting times and support people whilst they wait across the Trust's identified hotspot service areas e.g. neurodevelopmental CAMHS and Learning Disability Services, and by equality data. Work of the SystmOne waiting list project is being realigned to support this programme.
	Improving Access to Care (IATC): Creation of standardised Waiting Times management framework by December 2022		
	Out to public consultation on Older People inpatient services by January 2023		Additional workshop requested by the system in advance of stakeholder engagement event in Autumn. January start date for consultation process will still allow this to be completed in advance of purdah.
	Revised quality strategy to be approved at Trust Board in December 2022		The Quality Strategy is under development, with staff engagement sessions taking place and alignment with other strategic priorities and financial planning. EMT have agreed an extension to this deadline to December 2022.

Improve resources

Priority programme	Metrics	Threshold	Jun-22	Jul-22	Aug-22	Variation/ Assurance	Year end Forecast	Notes
Spend money wisely & increase value	Surplus/(deficit) against plan	£3,178k	£1,522k	£580k	£575k			Positive financial performance with vacancy levels a key reason.
	Capital spend against plan	£13.1m	£409k	£713k	£476k			Capital expenditure is forecast to increase later in the year once the Bretton Centre and Ward 19 major capital schemes commence.
	Agency spend managed within the overall workforce	<4%	4.0%	5.10%	4.0%			Decreased spend on agency staffing in August.
	Overhead costs	TBC	16%	15%	15%			Threshold to be confirmed
	Financial sustainability and efficiencies delivered over time	£6,350k	£589k	£589k	£589k			In line with plan although currently majority of savings are non-recurrent. Figure is cumulative.
Use our estates to enable effective ways of working to support staff & deliver best care	Metrics under development							
Use digital approaches to deliver best care and support to service users, carers, staff and the wider community	Communication preferences of service users captured/recorded on SystmOne		Questionnaire to collect this information is live on SystmOne					
	Percentage of wards live with EPMA over time	96.5% by March 2023	45%	48%	52%			15/29 wards live in August. One ward is undergoing renovations so go live will be delayed.

Glossary

EMPA	electronic prescribing and medicines administration

What the data is telling us – this section is in development. Statistical process control charts will be inserted here to alert the reader to metrics that require further work or investigation.
(SPC charts to be included here where relevant)

Improve resources

Key Milestones - (report by exception and any concerns on ability and/or capacity to deliver actions within agreed timescales)			
Spend money wisely and increase value	To develop a 3-year financial plan by September 2022		2022/23 revised plan agreed, and a programme of work that will deliver financial sustainability and promote a culture of improvement, productivity and control across the Trust is being scoped. The programme of work includes the re-establishment of the agency group and focus on workforce recruitment and retention.
	Loss making services in Service Line Reporting (SLR) understood and action plan developed by September 2022		This work is scheduled to be progressed during Q2 and no risks or issues are being flagged to date. Costing Manager is now in post and has developed a proposal and project plan for costing reporting.
Use our estates to enable effective ways of working to support staff & deliver best care	Estates strategy to be approved at Trust Board in February 2023		Following a presentation to Trust Board it has been agreed that the Estate strategy will be presented to Board by February 23
	Agree final costings for Bretton development Autumn 2022		
	Commence work on Bretton site November 2022		
Use digital approaches to deliver best care and support to service users, carers, staff and the wider community	To oversee and facilitate the introduction, configuration and development of digital access to personal health records for service users by March 2023		A project has been mobilised to oversee and facilitate the introduction, configuration and development of digital personal health record capabilities for our service users through the portal Patient Knows Best (PKB). The project approach is centred around inclusivity, engagement, involvement and active participation across all stakeholder groups. In scope initially will be demographics, appointments, and shared correspondence. The Involvement and Engagement Team are supporting the inclusion of service users and carers in the development of the functionality. Technical discussions are ongoing between the Trust, PKB and the Trust's integration partner.
	Implementation of a Trust wide approach to digital dictation by March 2023.		The recruitment of a Project Manager post to assist capacity for the project to move forward at pace has been delayed and discussions with finance are on-going.

Make SWYPFT a great place to work								
Priority programme	**Metrics**	**Threshold**	**Jun-22**	**Jul-22**	**Aug-22**	**Variation/ Assurance**	**Year end forecast**	**Notes**
Make SWYPFT a great place to work, supporting staff & addressing workforce challenges	Vacancy rate (Overall)	<10%	16.5%	16.6%	16.7%			
	Turnover external (YTD projection)	>10-12<	15.1%	15.0%	14.7%			
	Sickness absence - Month	<=4.4%	4.8%	5.5%	4.7%			Covid-19 absence included in overall sickness absence figure from July 2022
	Workpal appraisals - rolling 12 months	>=90%	Reporting Under Development	56.7%	61.3%			
	Quarterly summary from staff survey. This will include response rate from underrepresented staff groups and narrative report on progress made against workforce strategy	N/A	Report to be made available once results analysed					The quarterly pulse staff survey was undertaken in July, this is being analysed currently. Report will be shared when available.

What the data is telling us – this section is in development. Statistical process control charts will be inserted here to alert the reader to metrics that require further work or investigation. (SPC charts to be included here where relevant)

Make this a great place to work

Key Milestones - (report by exception and any concerns on ability and/or capacity to deliver actions within agreed timescales)			
Make SWYPFT a great place to work, supporting staff & addressing workforce challenges	Milestones are aligned to the delivery of the workforce strategy and OD plan. Implementation plan is being refreshed.		Progress this month: • International nurse celebration event and further interviews taken place • New starters outpacing leavers for consecutive months • New People Directorate leadership structure agreed and going through change process -full directorate away day on 8/9/22 • People directorate and staff side away day • Partnership group established to manage any potential industrial action • 2022/23 appraisal window open • Regular meetings with staff governors in place • New lead role for diversity and inclusion shaped and recruitment underway • Agency Group re-established • Pay award and arrears processed

Reducing Inequalities

Covid-19 shone a light on existing health inequalities which is now a national priority.

We know there are differential impacts on groups in our population:
• People with mental health or a learning disability are known to have reduced life expectancy.
• Black, Asian, and Minority Ethnic (BAME) individuals are more likely to experience poor health.
• Gypsy, Roma and Traveller communities face large barriers to accessing services.
• People with a physical or sensory disability experience impacts relating to communication, information, and the built environment.
• Those living in our more deprived areas have a lower average life expectancy and experience poorer health.
• There is evidence that LGBTQ+ people have disproportionately worse health outcomes.
• Some people experience multiple impacts and disadvantages.
• Meeting the requirements of the Public Sector Equality Duty and our legal obligations under the Equality Act 2010 and NHS Constitution is a priority.

Key actions the Trust are taking to address inequalities are:
• Improving data collection gaps – addressed using the 'All of You' campaign, and staff development.
• Developing a dashboard – in line with NHSE/I and CORE20PLUS5 and using the Kings Fund approach to identify inequalities.
• Triangulating insight and feedback, and capturing stories to create a narrative to support the dashboard.
• Using service-level equality impact assessments, updated periodically to reflect changes in community profiles.
• Co-design of services with communities ensuring representation is reflective of the population and covers all protected groups and carers.
• Enhanced equality and diversity training for both Trust Board and staff to create the right conditions and culture.
• Literature bank for equality and diversity, and community films to support insight and understanding of diverse groups.
• Monitoring use of translation services at a service level against patient profile, and ensuring service information is in the right format and accessible.
• Identifying digital access as part of initial assessment via SystmOne.
• Capturing patient and staff feedback, and equality monitoring responses to highlight specific issues.
• Ensuring reflective and representative workforce and leadership.
• Using tools to capture patient stories, and approaches such as community reporters and researchers.
• Creative approaches developed through 'Recovery Colleges' and 'Creative Minds'.
• Faith based and spiritual support through 'Spirit in Mind'.

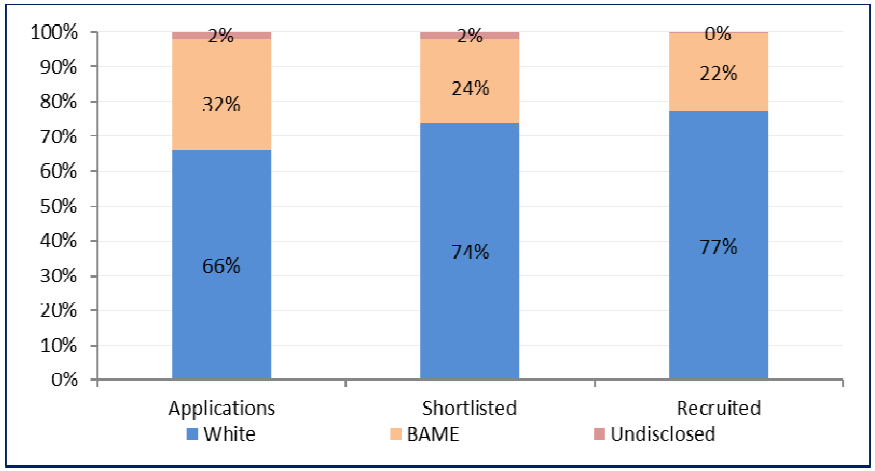
Specific examples include:
• Carers passport and identification of carers.
• Increasing the diversity of volunteers.
• Increasing peer support workers across the Trust.
• Health assessments for people with a learning disability.
• Embedding equality in our change approach.
• Creating opportunities for a reflective workforce, through learning and development programmes.
• Delivering Race Forward and appointing a clinical lead.
• Refresh of the 'Transgender policy' and 'Accessible Information Policy' using a co-produced approach.

This section of the report will be developed over the coming months as more data becomes available and further analysis is undertaken.
Some key metrics have been initially identified, with a focus on recruitment of staff into the Trust and referrals and admissions into Trust services.
A key priority for the Trust is to improve the recording and collection of protected characteristics across all services - this will be monitored by the Trust's Equality, Inclusion and Involvement Committee. A campaign is being launched related to the collection and recording of protected characteristics and we anticipate this will have a positive effect on the quality of this data. Also requirements linked to the Control of Patient Information (COPI) notice require gaining consent, and the Trust is working to link this to the collection of equality data too.

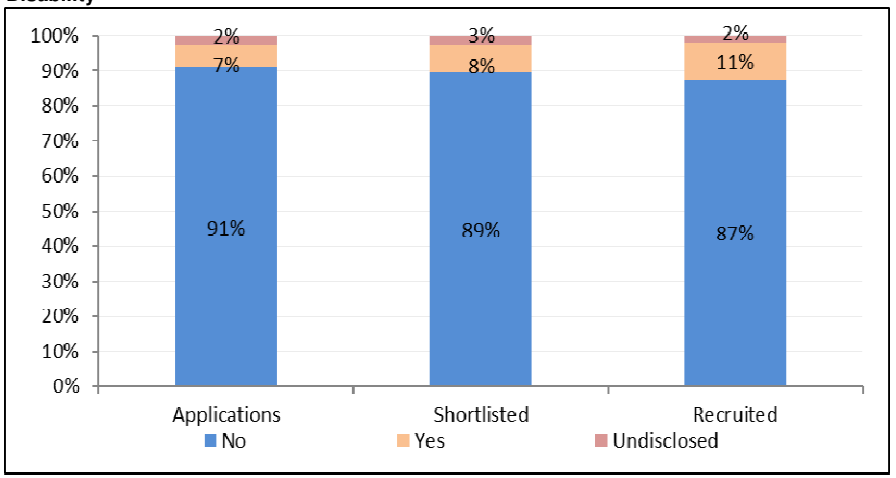
Reducing Inequalities

Recruitment - rolling 12 months to end of Quarter 1 2022-2023

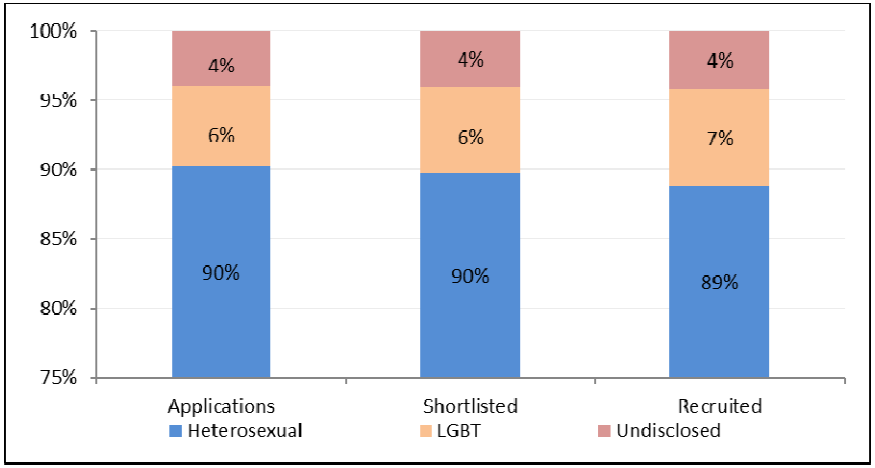
Ethnicity



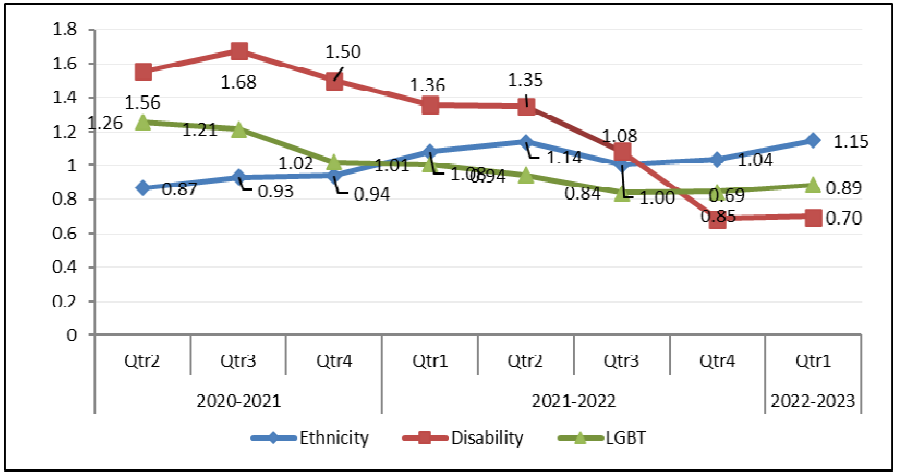
Disability



Sexual Orientation



Relatively likelihood of being appointed



Relative Likelihood YTD Quarter 1 2022-2023:	BAME:	Disability:	LGBTQ+:
	1.15	0.70	0.89

Reducing Inequalities

Recruitment - rolling 12 months to end of Quarter 1 2022-2023 Continued…

Notes:
We are now showing the trend for the relative likelihood. Including Trust population would not be helpful, as we are looking at new staff entering existing population. Including local population (census) data will not be helpful as people apply for posts from outside the Trust catchment area.

Undisclosed data is not used in the relative likelihood calculation for any of the three categories.

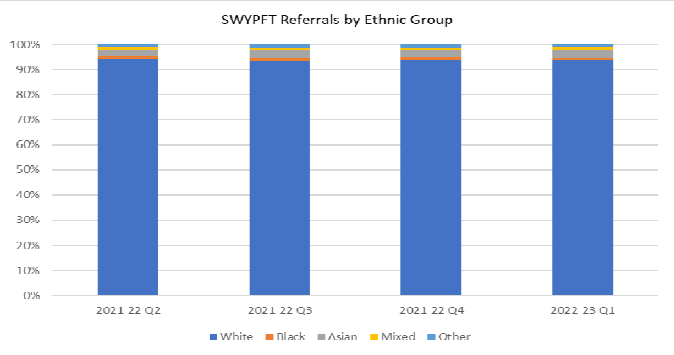
BAME - relative likelihood of being appointed compared to white applicants this quarter = 1.15
Disability - relative likelihood of being appointed compared to non - disabled applicants this quarter = 0.7
LGBTQ+ - relative likelihood of being appointed compared to heterosexual applicants this quarter = 0.89
NB relatively large proportions of undisclosed could unintentionally skew the data

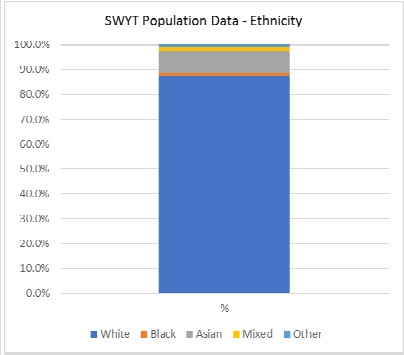
Relative likelihood key
1.00 = target figure, equally as likely to be appointed.
Greater than 1.00 = less likely to be appointed
Lower than 1.00 = more likely to be appointed

Action
Our recruitment approach is being reviewed as part of the People Directorate restructure, and work is ongoing regarding inpatient recruitment as part of the regular taskforce meeting
Review recruitment and selection training
Review recruitment and selection policy
Work with staff networks around action planning

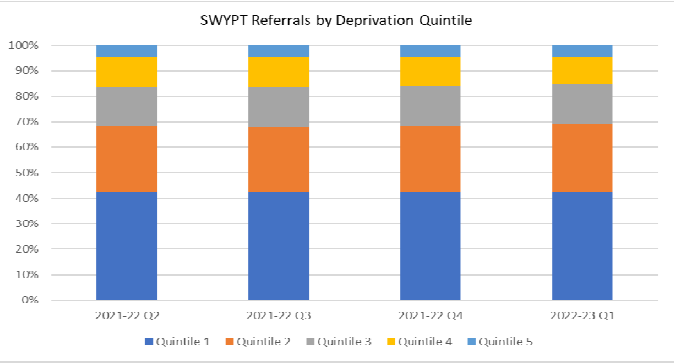
Reducing Inequalities

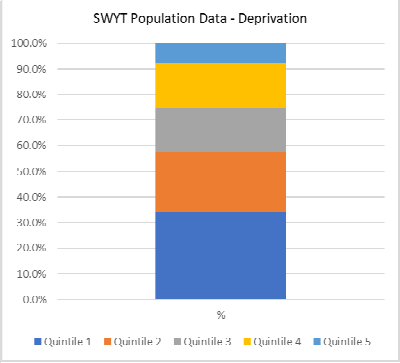
Referrals - (Includes physical health, mental heath, learning disability and forensics)





Ethnic Group	2021-22 Q2	2021-22 Q3	2021-22 Q4	2022-23 Q1	Local Population
White	94.3%	93.4%	93.9%	93.6%	87.1%
Black	1.1%	1.1%	1.0%	1.1%	1.4%
Asian	2.8%	3.3%	3.0%	3.3%	8.9%
Mixed	0.8%	1.0%	0.9%	1.2%	1.6%
Other	1.0%	1.2%	1.3%	0.8%	1.1%



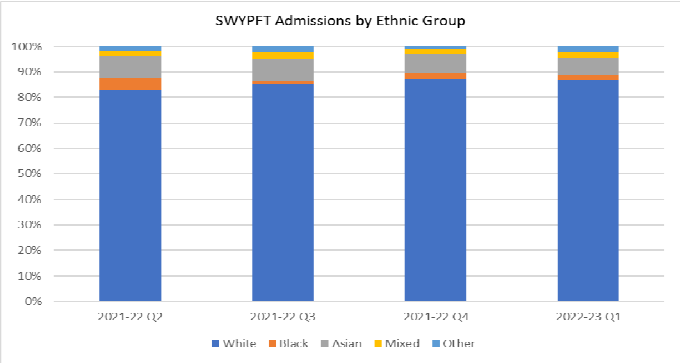


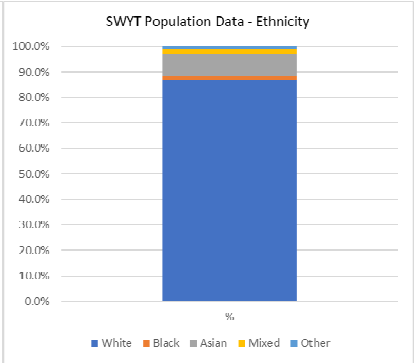
Quintile	2021-22 Q2	2021-22 Q3	2021-22 Q4	2022-23 Q1	Local Population
Quintile 1	42.5%	42.2%	42.3%	42.4%	34.1%
Quintile 2	26.1%	26.1%	26.2%	26.8%	23.4%
Quintile 3	15.1%	15.5%	15.3%	15.4%	17.0%
Quintile 4	11.7%	11.6%	11.4%	10.9%	17.8%
Quintile 5	4.6%	4.7%	4.7%	4.5%	7.8%

Notes:
- Percentage breakdowns for comparison exclude unknown/unrecorded
- Quintile 1 represents the top 20% most deprived households, based on the Indices of Multiple Deprivation
- Charts above relate to local population data

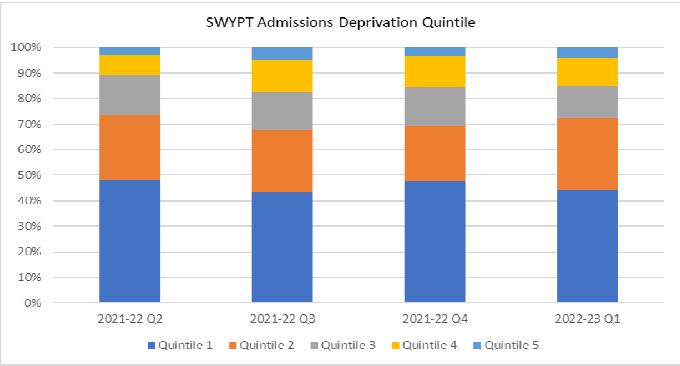
Reducing Inequalities

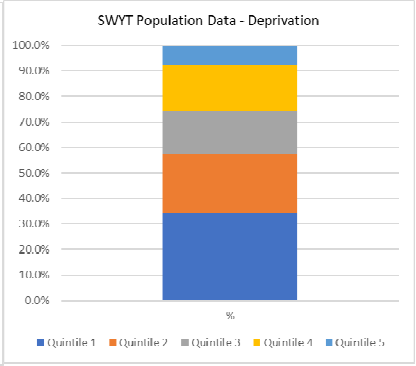
Admissions - (Includes physical health, mental heath, learning disability and forensics)





Ethnic Group	2021-22 Q2	2021-22 Q3	2021-22 Q4	2022-23 Q1	Local Population
White	82.9%	85.2%	87.2%	86.6%	87.1%
Black	4.6%	1.3%	2.2%	2.2%	1.4%
Asian	8.8%	8.8%	7.9%	6.7%	8.9%
Mixed	2.0%	2.6%	1.8%	2.2%	1.6%
Other	1.6%	2.1%	0.9%	2.2%	1.1%





Quintile	2021-22 Q2	2021-22 Q3	2021-22 Q4	2022-23 Q1	Local Population
Quintile 1	48.0%	43.6%	47.9%	44.6%	34.1%
Quintile 2	25.4%	24.3%	21.5%	27.7%	23.4%
Quintile 3	15.9%	14.6%	15.0%	12.8%	17.0%
Quintile 4	8.0%	13.0%	12.0%	11.1%	17.8%
Quintile 5	2.7%	4.5%	3.5%	3.9%	7.8%

Notes:
- Percentage breakdowns for comparison exclude unknown/unrecorded
- Quintile 1 represents the top 20% most deprived households, based on the Indices of Multiple Deprivation
- Charts above relate to local population data

Covid-19 response

This section of the report focuses on a number of components of the Trust's response to Covid-19 including testing, support to the system and PPE.

Managing the clinical response

PPE position

Supplies of and access to PPE remain good, as they have been for the last two years. The IPR will now only report on PPE levels by exception

Testing

KPI	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
No of Service users Covid-19 positive and now recovered	6	37	41	5	40	30	2	7	21	0
No of Service users Covid-19 positive and still within 28 days, monitoring not completed	0	0	0	0	0	0	0	0	0	24
No of Service users Covid-19 positive and deceased within 28 days of positive test	0	0	0	1*	1*	1*	0	0	1	2
No of wards with outbreaks	2	10	8	1	8	5	0	1	1	2

There is a lag in reporting data particularly if service user is discharged from care and/or notification of death awaiting registration.

*relate to community acquired infections

Patient testing & pathway/Outbreak response & management

There has been an increase in inpatients testing positive for COVID-19. In August these cases are mainly due to outbreaks

Testing approach - Current position

- Amendments to the testing approach have been implemented, in line with national and regional guidance.
- Sadly, there have been two patient deaths on Crofton Ward. Both have been identified as Healthcare Associated Infection (HCAI) definite, and Covid19 is cited on the death certificate. For one patient this was on Part 1 and for the other Part 2 of the death certificate. Appropriate scrutiny, reporting, reviewing, and investigation procedures are being followed.
- Covid-19 testing for staff and patients changed from 31st August, in line with the Covid-19 Testing in Periods of Low Prevalence advice from NHS England.

Patients:

- Swabbing for symptomatic testing through PCR testing.
- Inpatient asymptomatic Covid-19 admission testing is undertaken utilising lateral flow test (LFTs) and testing timescales on admission, day 3 and day 5, in the following cases:
  - On wards that have been identified as high risk of serious illness from Covid-19. These wards are Older Peoples Services, Stroke Rehabilitation Unit, Neuro Rehabilitation Unit and Learning Disability Wards.
  - Individuals that are assessed at high risk of serious illness for Covid-19 and/or admitted from a household that has a positive case.
- Testing also continues in the following cases:
  - Covid-19 positive inpatients are tested using LFTs, in line with national step-down guidance, to reduce isolation periods.
  - Inpatient asymptomatic testing prior to discharge to care home/hospice, done through PCR testing.
  - For some patients who are on treatment pathways e.g.- planned operation/ treatment/ procedure.
- Outbreak and hotspot testing is provided utilising PCR testing, with adequate capacity from local labs as required.

Covid-19 response

Staff:
• Symptomatic testing – Using LFTs or through internal testing route.
• Staff working on wards that have been identified as high risk of serious illness from Covid-19 continue with twice weekly LFT testing. These wards are Older Peoples Services, Stroke Rehabilitation Unit, Neuro Rehabilitation Unit and Learning Disability Wards.
• Individuals that are assessed at high risk of serious illness for Covid-19 continue with twice weekly LFT testing.
• Outbreak and hotspot testing is managed and provided through internal testing route, with adequate capacity from local labs as required and on IPC advice.
• Staff who are Covid-19 contacts, including households contact of positive case, can continue to work if they are asymptomatic, and testing LFT negative.
• Covid-19 positive staff are also following national step-down guidance, to reduce isolation periods, using LFTs.

Supporting the system

Care home support offer
• Significant support to care homes continues to be provided from the general community team in Barnsley.
• Support also includes direct care from community staff including our specialist palliative care teams, district nurses and matrons and our out of hours nurses.
• Mental health and learning disability support has also been provided into care homes across the whole of the Trust footprint to support the residents.

Emergency Preparedness

This section of the report identifies the Trust's response to the Covid-19 pandemic.

Supporting the system

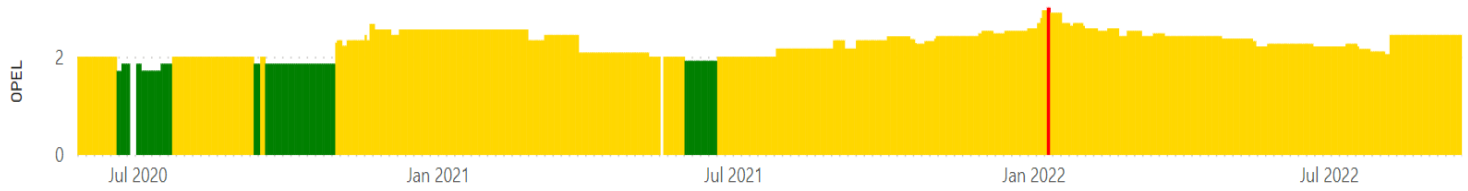
ICS stress test and outbreak support

- The Trust continue to work closely with partners in outbreak support responses in each of our four places. The Trust has fully engaged with system command structures and other relevant meetings.
- Strong leadership from the Infection Prevention & Control (IPC) team continues so the Trust can ensure appropriate IPC measures are in place.
- The Trust is supporting and engaged with partners across our places in the event a spike/wave of COVID re-emerges to allow suitable and effective response.

Standing up services

Emergency preparedness, resilience and response (EPRR) update including OPEL levels

- The Moving Forward Group continues to meet, and monitors COVID-19 prevalence, measures, and guidance in the Trust. Advising and making decisions regarding COVID-19 arrangements, risk assessments and staffing. Any decision made by this group are escalated to the Operational Management Group (OMG) and from there to the executive management team (EMT)
- The Trust OPEL level remains at an average of 2.4 with five service areas now operating at OPEL 2. Four service areas remain at OPEL 3.
- The roll out of the annual staff influenza programme commences on 24 October 2022, due to a delay in the vaccine deliveries. This year all staff groups will be targeted at once as opposed to previous years where we had a staggered approach. The target for frontline uptake is 90% which is an increase of 5% from last year. Whilst this will be challenging, steps are being put in place to push the achievement of this target.



Current average OPEL level

2.44

Key
OPEL Level 1
OPEL Level 2
OPEL Level 3
OPEL Level 4

Quality Headlines

Section	KPI	Objective	CQC Domain	Owner	Target	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 5	Improving Health	Responsive	CH	TBC	68.4%	67.0%	66.0%	61.3%	57.2%	60.0%	N/A
Complaints	% of feedback with staff attitude as an issue 12	Improving Health	Caring	LJ	< 20%	10% 2/21	6% 1/16	4% 1/25	19% 4/21	18% 4/22	20% 4/20	1
Service User Experience	Friends and Family Test - Mental Health	Improving Health	Caring	DT	85%	84%	81%	85%	85%	88%	85%	1
	Friends and Family Test - Community	Improving Health	Caring	DT	95%	94%	94%	92%	93%	93%	92%	1
Quality	Number of compliments received	Improving Health	Caring	DT	N/A	43	18	25	25	31	10	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) 4	Improving Health	Caring	DT	trend monitor	17	25	38	26	30	16	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions 4	Improving Health	Caring	DT	trend monitor	1	3	0	3	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches 4	Improving Health	Caring	DT	0	1	0	0	0	0	0	1
	% Service users on CPA offered a copy of their care plan	Improving Care	Caring	CH	80%	40.0%	40.6%	33.6%	33.5%	36.1%	38.2%	2
	Number of Information Governance breaches 3	Improving Health	Effective	MB	<12	18	12	9	19	10	9	2
	Delayed Transfers of Care 10	Improving Care	Effective	CH	3.5%	1.5%	2.0%	2.4%	2.1%	2.6%	3.0%	1
	Number of records with up to date risk assessment - Inpatient 11	Improving Care	Effective	CH	95%	80.3%	80.8%	77.2%	72.1%	78.0%	*82.0%*	3
	Number of records with up to date risk assessment - Community 11	Improving Care	Effective	CH	95%	68.6%	74.7%	62.4%	72.2%	54.2%	*78.3%*	3
	Total number of reported incidents	Improving Care	Safety Domain	DT	trend monitor	1071	1021	1190	1126	1175	1210	
	Total number of patient safety incidents resulting in Moderate harm. (Degree of harm subject to change as more information becomes available) 9	Improving Care	Safety Domain	DT	trend monitor	15	18	31	25	26	12	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) 9	Improving Care	Safety Domain	DT	trend monitor	3	5	3	1	4	3	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) 9	Improving Care	Safety Domain	DT	trend monitor	2	3	4	1	0	2	
	Safer staff fill rates	Improving Care	Safety Domain	DT	90%	109.4%	111.5%	115.1%	116.6%	115.8%	115.6%	1
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	DT	80%	86.2%	84.5%	87.0%	85.0%	84.7%	83.1%	1
	Number of pressure ulcers (attributable) 1	Improving Care	Safety Domain	DT	trend monitor	15	30	60	45	49	24	
	Number of pressure ulcers (Lapse in Care) 2	Improving Care	Safety Domain	DT	0	0	1	0	0	0	0	1
	Eliminating Mixed Sex Accommodation Breaches	Improving Care	Safety Domain	DT	0	0	0	0	0	0	0	1
	% of prone restraint with duration of 3 minutes or less 8	Improving Care	Safety Domain	CH	90%	87.5%	90.0%	100.0%	87.5%	80.0%	91.0%	1
	Number of Falls (inpatients)	Improving Care	Safety Domain	DT	trend monitor	54	38	37	37	70	63	
	Number of restraint incidents	Improving Care	Safety Domain	DT	trend monitor	187	146	148	152	171	161	
	% people dying in a place of their choosing 14	Improving Care	Caring	CH	80%	89.3%	89.3%	74.1%	85.7%	100.0%	85.3%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safety Domain	DT	6	0	0	0	0	0	0	1
	C Diff avoidable cases	Improving Care	Safety Domain	DT	0	0	0	0	0	0	0	1
Improving Resource	System Oversight Framework metric 13	Improving Resource			2	2	2	2	2	2	2	2
	CQC Quality Regulations (compliance breach)	Improving Resource			Green	Green	Green	Green	Green	Green	Green	Green

** See key included in glossary*
Figures in italics are not finalised
*** - figures not finalised, outstanding work related to 'catch up' activities in relation to the SystmOne implementation impacting on reported performance.*

1 - Attributable - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. There is evidence in care records of all interventions put in place to prevent patients developing pressure ulcers, including risk assessment, skin inspection, an equipment assessment and ordering if required, advice given and consequences of not following advice, repositioning if the patient cannot do this independently off-loading if necessary
2 – Lapses in care - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. Evidence is not available as above, one component may be missing, e.g.: failure to perform a risk assessment or not ordering appropriate equipment to prevent pressure damage
3 - The IG breach target is based on a year on year reduction of the number of confidentiality breaches across the Trust. The Trust is striving to achieve zero breaches in any one month. This metric specifically relates to confidentiality breaches
4 - Notifiable Safety Incidents are where Duty of Candour is applicable.
5 - CAMHS referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date. Work to establish a target for 22/23 is underway which takes into account non-compliance based on individual child and families needs but also ongoing data quality work which is expected to improve performance. Excludes autistic spectrum disorder waits and neurodevelopmental teams.
8 - The threshold has been locally identified and it is recognised that this is a challenge. The monthly data reported is a rolling 3 month position.
9 - Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed. Trend reviewed in risk panel and clinical governance and clinical safety group. Initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report.
9 - Patient safety incidents resulting in death (subject to change as more information comes available). All incident data is reviewed using SPC charts to identify any special cause variation, if this occurs this will be reported by exception. Otherwise reporting rates remain within normal variation.
10 - Trust monitors performance against 3.5% target as set in the mandate to NHS England from the Department of Health in 2017.
11 - Number of records with up to date risk assessment. Up to and including September 2020 the criteria used is - Older people and working age adult Inpatients, we are counting how many Sainsbury's level 1 assessments were completed within 48 hours prior or post admission and for community services for service users on care programme approach we are counting from first contact then 7 working days from this point. Given the recent implementation of the FIRM risk assessment tool, from October 2020 onwards - 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 and is monitored under the NHS oversight framework.
13 - The NHSEI Single oversight framework was replaced in June 21 with the System oversight framework. Data prior to November 21 relates to the old framework. Further detail regarding the framework and the metrics monitored can be seen in the national metrics section of the report.
14 - This metric relates to the Macmillan service end of life pathway

Quality Headlines

• Number of restraint incidents - the number of restraint incidents during August decreased to 161 from 171 the previous month. Further detail is provided in the relevant section of this report.
• Number of falls (inpatients) – the total number of falls was 63 in August, which is a decrease from the previous month. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation. Further detail is provided in the relevant section of this report.
• Duty of candour - 0 breaches in August.
• Number of pressure ulcers (lapse in care) - 0 in August.
• Performance for CAMHS Referral to Treatment - services have highlighted that sustained increases in referrals will negatively impact on the length of wait.
• Risk and Care Plan Task and Finish Group is reviewing a range of factors to improve both the quality and reporting of clinical risk assessment.
• Patient safety incidents that resulted in a degree of harm of moderate harm, severe harm or patient safety related death tend to fluctuate over time, and data is constantly refreshed as further information comes to light. This results in some changes to the level of harm, severity and categories of incidents. We encourage staff to report with an upwards bias initially especially when the outcome is unknown. These are adjusted subsequently. Incident data is regularly analysed using statistical process control (SPC) to explore any potential higher or lower rates than would be usually expected. Where there are outlying areas, these will be reported on by exception.

NHS Patient Safety Strategy
Our patient safety specialists join national and regional patient safety discussions/information sessions and share information into the Trust. The Health Improvement Studies Institute will be undertaking an evaluation of the patient safety specialist role nationally over the coming 12 months. NHS England/Improvement continue to develop their programmes to support the NHS Patient Safety Strategy.

Patient Safety Incident Response Framework (PSIRF)
NHS England launched the new Patient Safety Incident Response Framework on 16 August 2022. The transition work commences in September 2022. There are several documents, including a preparation guide and a toolkit, to support us through a 12-month transition period culminating in going live by September 2023. We continue to network with national, regional and place-based groups to support our journey. An internal project board has been established to support this work. The first phase is 'orientation' where we will scope and plan our work between September to November 2022. Regional support will be available through the Patient Safety Collaborative throughout the project.

Patient Safety Education and training
Health Education England has published the first phase of patient safety training (levels 1 and 2). All are available on ESR. These comprise:
• Level 1 – essentials for all staff
• Level 1 – additional module for Board members and senior managers (Extended EMT)
• Level 2 – Access to practice (Band 6 and above, and medical staff).
A proposal has been made to make level 1 mandatory and level 2 essential to job role as above, and presented in a paper at a number of groups. This recommendation has been made to the Executive Management Team. Training providers for Level 3 (investigation) is available and, now PSIRF is released, we will consider our options. Levels 4 - 5 remain in development.

Learn from Patient Safety Events (LFPSE)
As reported in the previous IPR, Learn from Patient Safety Events will be a new national system that is being introduced to replace:
• National Reporting and Learning System (where we send our patient safety incidents)
• Strategic Executive Information System [StEIS] (where we report Serious Incidents)
The deadline for transition to be completed by is 31st March 2023.
Progress will be reported in future reports.

Safety First

Summary of Incidents

Incidents may be subject to re-grading as more information becomes available

Incidents that occur within the Trust will have different levels of impact and severity of outcome. The Trust grades incidents in two ways.

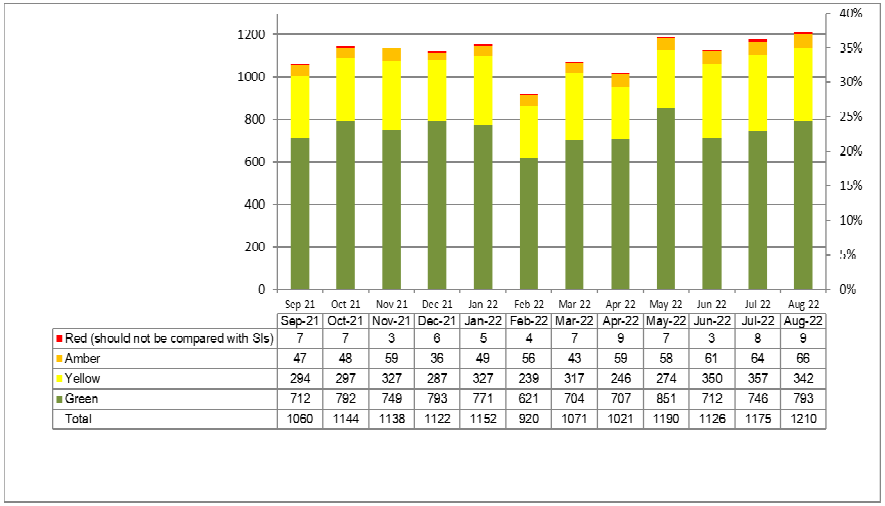
The Degree of Harm is used by all trusts to grade the actual level of harm to ensure consistency of recording nationally. When staff report incidents, they will complete the Degree of Harm to rate the actual harm caused by the incident. Where this is not yet known, they will rate this as what they expect the harm level to be. It will be reviewed and updated at a later point. This differs from the incident severity (green, yellow, amber, red), which is how we grade incidents locally in the Trust. Incident severity takes into account actual and potential harm caused and the likelihood of reoccurrence (based on the Trust's risk grading matrix).

A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (National Patient Safety Agency, 2004: Seven Steps to Patient Safety).
97% of incidents reported in August 2022 resulted in no harm or low harm or were not under the care of SWYPFT. This is based on the degree of actual harm.

Incident reporting levels have been checked using SPC and remain within the expected range. Any areas with higher or lower rates than normal are explored further.

Reporting of deaths in line with the Learning from Healthcare Deaths policy has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances.

All serious incidents are investigated using systems analysis techniques. Further analysis of trends and themes are available in the quarterly and annual incident reports, available on the patient safety support team intranet pages. See http://nww.swyt.nhs.uk/incident-reporting/Pages/Patient-safety-and-incident-reports.aspx



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Red (should not be compared with SIs)	7	7	3	6	5	4	7	9	7	3	8	9
Amber	47	48	59	36	49	56	43	59	58	61	64	66
Yellow	294	297	327	287	327	239	317	246	274	350	357	342
Green	712	792	749	793	771	621	704	707	851	712	746	793
Total	1060	1144	1138	1122	1152	920	1071	1021	1190	1126	1175	1210

Risk panel meets weekly and scans for themes that require further investigation. Operational Management Group continues to receive a monthly report, the format and content is regularly reviewed.

No never events reported in August 2022

Safety First cont…

Summary of Patient Safety Incidents resulting in moderate or severe harm or death

This section relates to the patient safety incidents that resulted in a degree of harm of moderate harm, severe harm or patient safety related death. Please note this is different to severity as described above.

Initial incident reporting is upwardly biased, and staff are encouraged to report incidents and near misses. Once incidents are reviewed by managers, and further information gathered and outcomes established, incident details such as severity, category and degree of harm can change. Therefore figures may differ in each report. This is a constantly changing position within the live Datix system. Incident reporting levels have been checked, and remain within the expected range. Any areas with higher or lower rates than normal are explored further.

Breakdown of incidents in August 2022:

12 Moderate harm incidents:
5 Pressure ulcer category- 3 incidents across Barnsley Neighbourhood Teams
3 Self Harm incidents- x2 Enhanced Team West - Wakefield, 1 Ward 18-Priestley Unit)
2 Slip, trip or fall – patient- 1 Crofton Ward (OPS), Wakefield, 1 Ward 19 (OPS))
1 Administration/supply of medication from a clinical area- Willow Ward - Barnsley
1 Unwell/Illness due to Covid19 referred to Acute Trust via 999 ambulance- Crofton Ward (OPS)

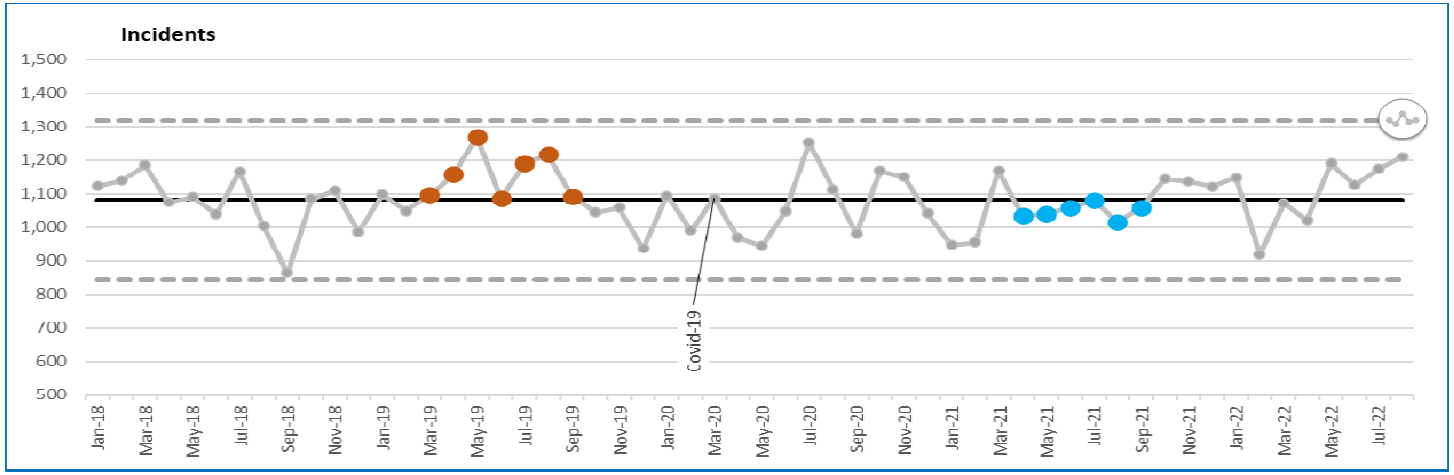
3 Severe harm incidents:
2 pressure ulcer category 4 incidents across Barnsley Neighbourhood Teams
1 Self Harm incident Assessment and Intensive Home Based Treatment Team / Crisis Team - Calderdale

2 Patient safety related deaths:
1 Suicide (incl apparent) - community team care - current episode (Core Team West - Wakefield)
1 Death - Covid-19 (review currently underway) (Crofton Ward (OPS), Wakefield)

Safety First cont…

Mortality

- Work on Structured Judgement Review (SJR) management has continued to progress well through additional resources.
- We continue to experience difficulties in identifying people who have capacity to undertake an SJR, due to existing capacity of our trained reviewers.
- A review of ongoing training and education to SJR reviewers will be re-considered, to include a focus on additional peer review support.
- Training continues to be delivered: 2 sessions have been delivered in March and September 2022.
- We will be taking part in an informal peer support group with colleagues in other mental health trusts across the north of England to share learning. The Patient Safety Support Team will review internal training and education approaches for SJR reviewers, to look at including more focus on peer support, with the introduction of the PSIRF framework.
- Learning from Healthcare Deaths policy is due for review January 2023. An extension has been requested to ensure we can incorporate changes through PSIRF (see earlier update).



The chart above indicates that there was a period of special cause concerning variation in mid 2019 (orange markers) however, since that point there has been common cause variation in the number of incidents reported.

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.

Learning Library

The learning library has been developed as a way to gather and share examples of learning from experience.
Click link for further details of the examples: https://swyt.sharepoint.com/sites/Intranet/learning-from-experiences/Pages/Learning-library.aspx

Learning from SI in low secure LD services.docx

Virginity Testing Hymenoplasty SBAR

Learning Library summary for JJB Norfolk

SBAR administering medicines to a patient on an Acute Trust ward

SBAR private ambulance

SBAR Parental consent to vaccination.docx

SBAR Learning from SI CAMHS 2021.9570

SBAR Learning from SI CAMHS 2021.3858

SBAR National review The Myth of Invisible Men

SBAR Ockenden report.docx

SBAR learning library learning from outbreaks

WEB134105 highlighting risks at home visits and staff safety

SBAR SI 2021.3314 Learning from Serious incident death in low secure services

SBAR SI 2021.9224 Learning from Serious incident death in Forensic services

Bluelight alerts

Bluelight alert 53 - 1 July 2022 - safe batteries

Bluelight alert 52 - 31 Dec 2021 - Potential safety concern from bracelet with tungsten carbide bead

Bluelight alert 51 - 7 Dec 2021 - Clozapine and constipation

Bluelight alert 50 - 9 Dec 2021 - Risk from worn, damaged and inadequately fitted furniture panels

Bluelight alert 49 - 7 July 2021 - Risk of choking

Bluelight alert 48 - 9 June 2021 - Use of en-suite toilet seat as ligature

Trustwide learning events

Content, including presentations, is available on the intranet.

The next event is on Monday 7 November, 10.00 - 12.00. If you would like to attend or share your learning from experience, please email learninglibrary@swyt.nhs.uk

Patient Safety Alerts

Patient safety alerts received - August 2022

Alerts are issued by the Central Alerting System (CAS) which is a national web-based cascading system for issuing patient safety alerts. Once received into the Trust, patient safety alerts are fully reviewed for understanding and action, sent to identified Trust clinical leads for reviewing safety alerts for a decision regarding whether it is applicable to the Trust or not, and if so, if it should be circulated. All alerts are entered on to Datix. Information is reported into the Medical Device and Safety Alert group on a monthly basis.

Patient Safety alerts not completed by deadline of August 2022 - None

Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
NatPSA/2022/006/DHSC	Shortage of alteplase and tenecteplase injections	03/08/2022	No - alert not applicable to trust	10/08/2022	05/08/2022
NatPSA/2022/007/MHRA	Recall of Mexiletine hydrochloride 50mg, 100mg and 200 mg Hard Capsules, Clinigen Healthcare Ltd due to a potential for underdosing and/or overdosing	04/08/2022	No - alert not applicable to trust	12/08/2022	05/08/2022

Safer Staffing Inpatients

August is, historically, a more challenging time for staffing and this has continued to be the case this year. A significant number of Band 5 new starters are expected in September whilst August remains the month where we are traditionally at a peak of our vacancies. The situation in August is compounded with an increase in annual leave being taken by substantive staff over the school holidays, which is also seen within the flexible workforce. This means we have an overall decrease in staffing resource available.

The acuity on the wards continues at increased levels, and requires similar staffing levels to the preceding months. Operational areas continue to be flexible and adaptable in their approach to staffing. However, we have had a slight decrease in unfilled requests, as well as a decrease in the number of requests. We continue to fall short of the registered nurse (RN) fill rate for day shifts, but maintain the overall fill rate. This describes the acuity on inpatient areas when looked at in conjunction with the unfilled shifts (see later in report). This continues the pressure on teams to deliver a high quality of care as well as being safe, and has impacted on Section 17 leave being taken at times, as well as other interventions being delayed. There will be a more accurate picture of these going forward as SafeCare continues to be rolled out.

Discussions to ensure that individual staff skills, such as being able to take charge, are being appropriately reflected in the health roster will give a more accurate narrative of what is happening within inpatient areas. We continue to look at other available resources, in addition to the flexible staffing pool and enhancing payment for certain shifts, to support operations.

International recruitment continues and we have 19 colleagues now, with five more due by the end of September, which will be spread throughout our inpatient areas including our first registered general nurse on the Neuro Rehabilitation ward. Recruitment continues at a pace, with a further 11 substantive Band 5 job offers made throughout August. We constantly monitor and adapt our adverts to ensure that our local connection is enhanced, as well as continuing the international drive. The above interventions will support our Band 5 recruitment, and we are anticipating a marked increase in our Band 5 workforce following the successful completion of their degree courses and starting new Band 5 roles from the end of August.

We look at various fill rates in the report, which gives a definitive picture of staffing compared to our establishment template – the number of staff that are budgeted for. However this must not be looked at in isolation, as it is not a true reflection of the requirement of the teams. This is what is meant by capacity (budgeted staffing numbers) v demand (acuity and requirement).

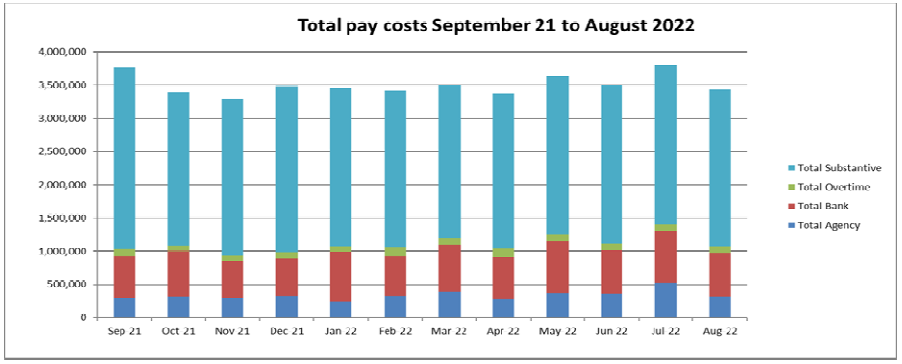
Three wards, an increase of one on the previous month, fell below the 90% overall fill rate threshold. The wards were Appleton and Priestley in the Forensic Care Group, as well as Lyndhurst within Calderdale. Inpatient areas continue to experience increased pressures through vacancies, sickness and staff being off clinical areas for various reasons. There are ongoing interventions, projects, and support when a ward has been identified as having ongoing and sustained staffing issues, to improve the situation. Consistent with the previous month, there were 22 (70.4%) of the 31 inpatient areas who achieved 100% or more overall fill rate. Of those 22 wards, 11 (a decrease of three on the previous month) achieved greater than 120% fill rate. The main reason for this being cited as acuity, observation, and external escorts.

Although safe and effective staffing remains a priority in all our teams, and there has been a system-wide increase of acuity on all inpatient areas, the focus for the flexible staffing resources has been Clark Ward, within Kendray Hospital in Barnsley, Poplars in Wakefield and The Dales in Halifax. There have been supportive measures put in place including increased block booking, placing bespoke recruitment adverts, and ensuring that additional resources are placed at their disposal. Despite all the pressures our fill rates continue to increase.

Safer Staffing Inpatients cont…

Registered Nurses days
Overall registered Day fill rates have decreased by 2.2% to 76.3% in August compared with the previous month.
Registered Nurses Nights
Overall registered Night fill rates have decreased by 1.0% in August to 89.9% compared with the previous month.
Overall Registered Rate: 83.1% (decreased by 1.6% on the previous month)
Overall Fill Rate: 115.6% (decreased by 0.2% on the previous month)
Health Care Assistants showed an increase in the day fill rate of 2.2% to 135.4% and the night fill rate remained at 149.4%.

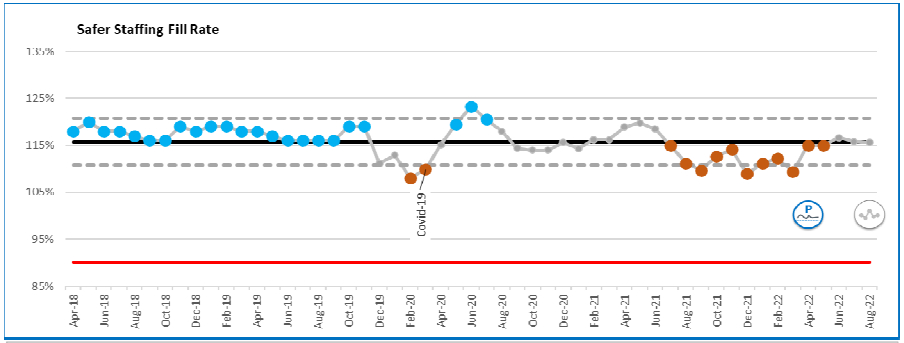
Unfilled shifts
An unfilled shift is a shift that has been requested of the bank office, flexible staffing, and could not be covered by bank staff, agency or Over Time. Although not exclusive, there are two main reasons for the creation of these shifts, and they are:
1- Shifts that are vacant through short- or long-term sickness, annual leave, vacancies, or other reasons that impact on the duty rosters.
2- Acuity and demand of the Service Users within our services including levels of observation and safety concerns.



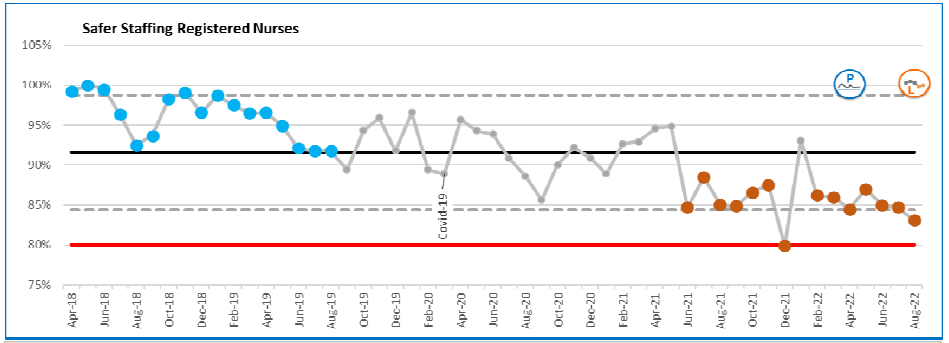
Unfilled Shifts				Filled Shifts
Categories	No. of Shifts	Total Hours	Unfill Percentage	
Registered	626 (-19)	6,602.00	43.49% (-3.30%)	808 (+63)
Unregistered	647 (-95)	7,280.33	13.82% (-1.83%)	3,992 (+8)
Grand Total	1,273 (-114)	13,882.33	20.46%	

We are continuing to target areas where vacancies are within our recruitment campaigns. Block booking and prioritisation within bank booking varies on a daily/weekly basis dependent on acuity and clinical need.
These figures allow us to monitor an increase on the flexible staffing resource and look at what appropriate resources are required from the trust bank flexible staffing resource.

Safer Staffing Inpatients cont…



The chart above shows that the staffing fill rate has had a number of periods of special cause concerning variation (orange markers) particularly since the outbreak of Covid-19, though performance has remained consistently above the target. As at August 2022 we remain in a period of common cause variation.



The chart above shows that the staffing rate for registered nurses has also has had a number of periods of special cause concerning variation (orange markers), particularly since the outbreak of Covid-19. In August 2022 we remain in a period of special cause concerning variation. Further information about staffing levels can be found on the previous page.

International Nurse Recruitment (INR) Programme

- 19 nurses in the Trust. 12 on wards passed their NMC (nursing and midwifery council) and practicing as nurses.
- We have nurses on wards in Fieldhead, Dewsbury, Barnsley and Halifax.
- 1 of our new starters this month will start as an RGN (registered general nurse) on Neuro rehab in Barnsley.
- End to end recruitment process now taking between 9-12 months in some cases.
- 7 remaining nurses currently undertaking OSCE (objective sturctured clinical examination) training at Fieldhead
- Cohort of 5 nurses starting in the Trust on the 217th September
- Cohort of 7 nurses starting in the Trust on the 27th October
- 42 conditional offers of employment from agency fed nurse pipeline
- 21 conditional offers of employment from direct application INR which has now started
- Forecasted to have over 60 nurses in the Trust by March 2023
- More interviews planned for further recruitment over the following months
- Planned recruitment event in Caribbean via NEU Professional agency for late October currently being organised – 2 SWYPFT interview panels – planned 125-150 interviews of both RMN (registered mental nurse) and RGN nurses.
- Successfully recruited to both Pastoral Officer role (started 19th September – internal appointment) and Clinical Skills Facilitator role (starting later October external appointment)
- NHSE have just published invitations for year 3 funding of INR which will give Trusts up to £7k support per successful appointment. SWYPFT will be bidding for year 3 funding.
- We have just received funding support to begin AHP (allied health professional) international recruitment. This will be a small pilot IR plan for 4 OT's between now and March 2023 utilising existing INR infrastructure as well as AHP leadership support.

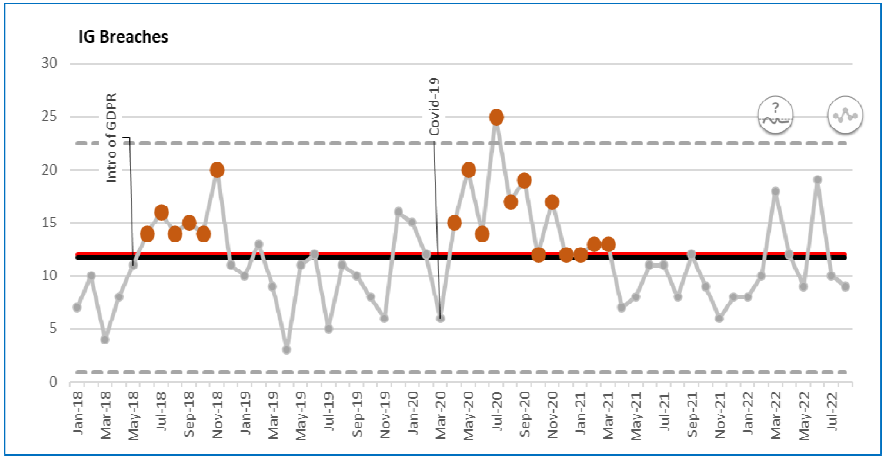
Information Governance (IG)

9 personal data breaches were reported during August. Notwithstanding the spike during June 2022 when 19 were reported, this continues the overall trend of lower numbers of incidents reported since 2020/21.

5 breaches involved information being disclosed in error, which is the lowest number in this category so far during the current financial year. They were largely due to letters being sent to former addresses, which hadn't been updated on the health record, the wrong patient's details being included in a letter, disclosures being made to the wrong patient due to failure to select the correct patient on the system, and emails being sent to the wrong recipient.

3 incidents of healthcare record issues were reported that had an impact on one or more individuals. These include uploading documents about multiple patients to one record and a record being shared for a study when consent had not been recorded.

No complaints were made to the Information Commissioner's Office (ICO) during August but the ICO informed the Trust that they are investigating a former employee for inappropriately accessing health records.



This SPC chart shows that both the introduction of GDPR in May 2018 and the outbreak of Covid-19 in March 2020 have had a negative impact on the number of information governance breaches with both seeing subsequent periods of special cause concerning variation (orange markers). As at August 2022 we remain in a period of common cause variation.

Commissioning for Quality and Innovation (CQUIN)

CQUIN schemes are in place for 2022/23 contracts. These mainly relate to the Trust's contracts with our place-based commissioners in each integrated care system (ICS). The overall financial value of CQUIN is 1.25% of total contract value. The indicators that the Trust will be monitored against include:

- Flu vaccinations for frontline healthcare workers
- Cirrhosis and fibrosis tests for alcohol dependent patients
- Routine outcome monitoring in children and young people and perinatal mental health services
- Routine outcome monitoring in community mental health services
- Use of anxiety disorder specific measures in IAPT
- Biopsychosocial assessments by mental health liaison services
- Malnutrition screening in the community
- Assessment, diagnosis and treatment of lower leg wounds

Q1 submissions have been undertaken for indicators that are not derived from existing national datasets. The metrics and quarter 1 performance can be seen below:

- Biopsychosocial assessments by mental health liaison services – full achievement.
- Malnutrition screening in the community (Barnsley contract only) – full achievement.
- Assessment diagnosis of lower leg wounds (Barnsley contract only) – partial achievement.
- Cirrhosis and fibrosis tests for alcohol dependent patients (Calderdale, Kirklees and Wakefield contract only) – full achievement.

For indicators that are derived from existing national datasets;
the following metric will be reported 12 weeks after quarter end (expected end of September 22):

- Use of anxiety disorder specific measures in IAPT (Kirklees only) – forecast full achievement.

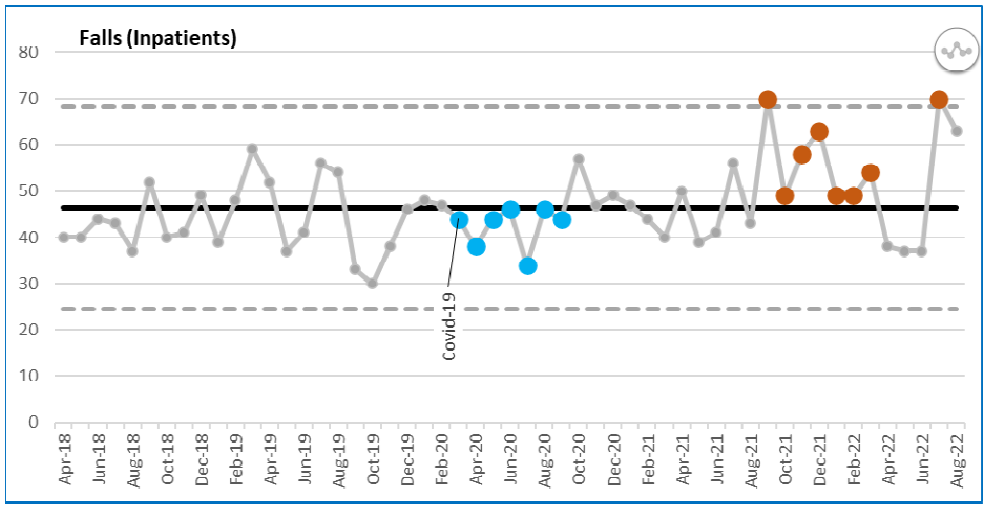
And;
the following indicators will be finalised at year end:

- Routine outcome monitoring in children and young people and perinatal mental health services – forecast partial achievement.
- Routine outcome monitoring in community mental health services – forecast full achievement

Work is taking place to further develop action plans to ensure maximum achievement for the year, and identify any risk associated with any of the indicators.

Falls (Inpatient)

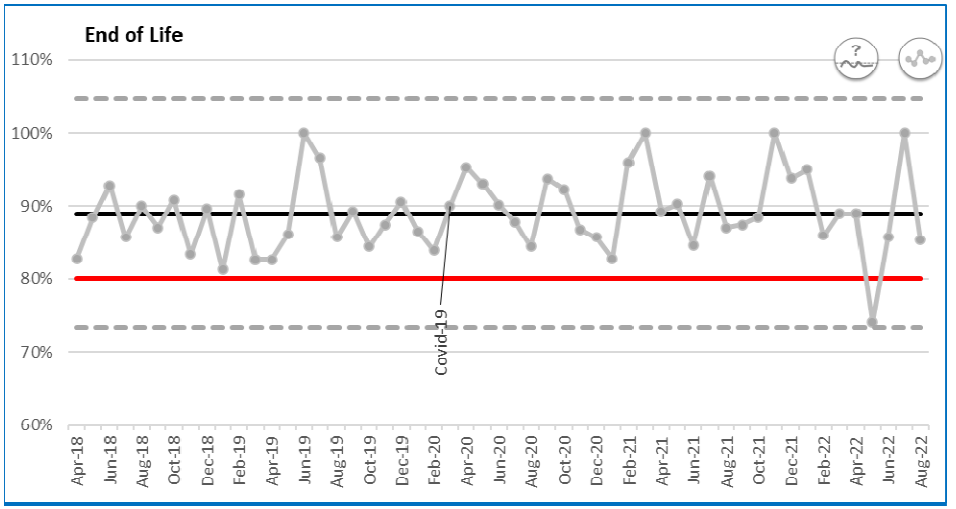
The total number of falls was 63 in August, which is a decrease from the previous month.



The SPC chart above shows that in August 2022, following a slight decrease in the number of falls, we have re-entered a period of common cause concerning variation.

End of Life

The total percentage of people dying in a place of their choosing was 85.3% in August.



The chart above shows that in August 2022 the performance against the metric has remains within the acceptable range.

Patient Experience

Friends and family test shows

- 92% would recommend community services.
- 85% would recommend mental health services

Mental Health Friends and Family Test Results	Target	May-22	Jun-22	Jul-22
Community Services	85%	86%	90%	85%
Acute	85%	90%	95%	92%
Secure & Forensics	60%	100%	75%	100%
Other*	85%	92%	85%	82%
Total	**85%**	**85%**	**88%**	**85%**

Specialist Services Friends and Family Test Results	Target	May-22	Jun-22	Jul-22
ADHD	85%	67%	69%	38%
CAMHS	75%	92%	71%	87%
Learning Disability	85%	93%	80%	82%

Community Services Friends and Family Test Results	Target	May-22	Jun-22	Jul-22
Children & Families	95%	100%	100%	100%
Inpatient	95%		100%	100%
Nursing	95%	100%	100%	100%
Other	95%	100%	100%	96%
Rehabilitation & Therapy	95%	92%	92%	90%
Specialist**	95%	89%	94%	96%
Total	**95%**	**93%**	**93%**	**92%**

*Includes insight team, perinatal, friends and family team

**Includes equipment and adaptation service, neuro physiotherapy, podiatry

We have seen a slight decline in the number of respondents that rated the services as ‘very good’ or ‘good’ across the Trust, mental health services and general operations.

Ratings continue to remain below target for Barnsley General Operations.

Patient Experience cont…

	Top three positive themes	Top three negative themes
Barnsley community service	1. Staff	1. Staff
	2. Access and waiting times	2. Clinical treatment
	3. Admissions and discharge	3. Communication
Mental Health Service	1. Staff	1. Staff
	2. Patient Care	2. Admission and discharge
	3. Access and waiting times	3. Access and waiting times
Trust wide	1. Staff	1. Staff
	2. Access and waiting times	2. Clinical treatment
	3. Admission and discharge	3. Access and waiting times

Staff, access and waiting times and admission and discharge are consistent positive themes and staff, clinical treatment and access and waiting times are the consistent themes for negative themes across the Trust.

Work is underway with the ADHD service to review their FFT and Patient Experience feedback to identify areas for improvement. We understand that people who are not given a diagnosis but have expected to have received one are disappointed in their contact with the service, further work will be undertaken to understand if this accounts for the dip in this month.

Safeguarding

Mandatory training remains above 80% for all safeguarding adults and safeguarding children training including PREVENT. The Safeguarding Team analyse the mandatory training statistics and inform relevant matrons where there were concerns with local compliance levels.

Safeguarding adults:
In August 2022 there were 32 reported safeguarding adult incidents. The three highest categories reported were: financial abuse, physical abuse, and emotional abuse. There were no red incidents.

Of these 32 reported incidents, five were amber incidents: domestic abuse, financial abuse (including potential cuckooing), forced marriage and two potential persons in position of trust (PiPoT) concerns. In all cases, appropriate multi-agency responses were actioned involving police, social care, and human resources. In the two PiPoT cases, HR processes have been actioned and the learning from one case is being considered as part of the Trust Sexual Safety Task and Finish Group.

Safeguarding children:
In August, there were 18 reported Safeguarding incidents across the Trust. Of the 18 reported incidents, the highest category of abuse identified was neglect which reflects national figures in relation to child safeguarding. The second most common was emotional harm, some of which were in relation to the impact of domestic abuse on children.

All except one incident were categorised as green or yellow. One incident was categorised as amber, which involved the impact of alcohol misuse on children, exposing them to emotional harm and neglect. All actions have been taken and a reduction of the category is anticipated. All cases resulted in referrals to the local authority, apart from one case that involved internal processes of receiving CAMHS referrals appropriately. All referrals made involved either adult service user's children or ones they cared for, or children in receipt of SWYPFT services for children.

Infection Prevention Control (IPC)

Surveillance: There have been zero cases of ecoli bacteraemia, C difficile, MRSA Bacteraemia and MSSA bacteraemia.

Mandatory training figures are healthy:
Hand Hygiene-Trust- wide total –91%
Infection Prevention and Control- Trust-wide total – 87%

Policies and procedures are up to date.

Complaints

There were 20 new formal complaints in August 2022, 0 were closed due to no contact/consent, 20 are awaiting consent/questions and 0 have a timescales start date.
20% of new formal complaints (n=4) have staff attitude as a primary subject.
10 compliments were received.
Customer services closed 5 formal complaints in August 2022.

Acknowledgement of receipt of the complaint within three working days – 90%.
Number of Responses provided within six months of the date a complaint received – 1 out of 5 closed in August 2022, this met the 6-month target.
Number of complaints waiting to be allocated to a customer service officer – 50.
Number of cases who breach the six months target who have not had a conversation to agree a new timeframe for completion – No cases breached the 6 months target without contact from the customer services team. All complainants either received a delay update letter or have received contact with their allocated case handler who provides regular update
Longest waiting complainant to be allocated to a customer service officer – 19th April 2022

Reducing Restrictive Physical Intervention (RRPI)

There were 161 reported incidents of using Reducing Restrictive Physical Interventions in August 2022, with a total of 507 restraint positions used. This is a reduction of 10 (6.2%) incidents from July 2022 which stood at 171 incidents.

The Horizon centre continue to have a small number of service users, who, due to their presentation are continuing to cause a high number of incidents.

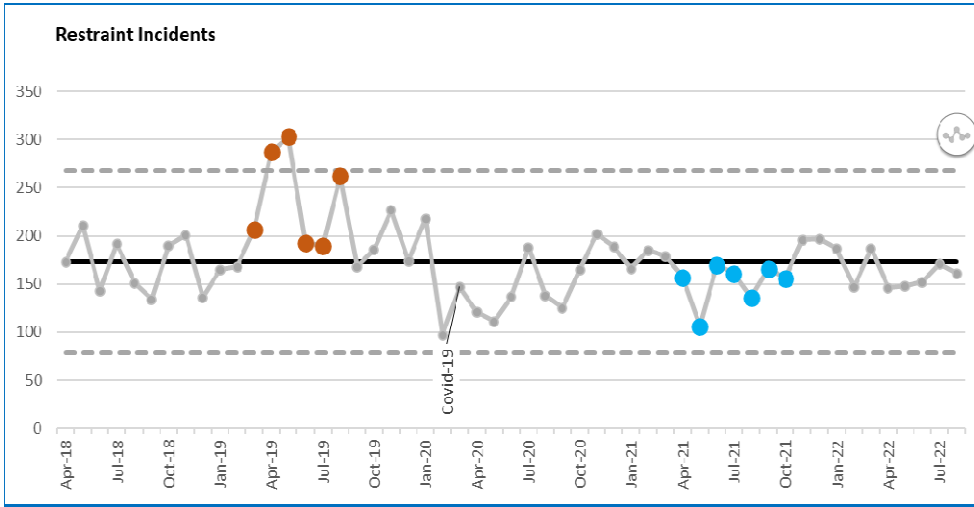
Restraint position	Number of restraint positions used	Percentage of type of physical intervention used
Standing	164 of 507	32.3%
Safety Pod	93 of 507	18.3%
Seated	75 of 507	14.7%
Supine - held on their back	70 of 507	13.8%
Restricted escort	39 of 507	7.6%
Prone then rolled	24 of 507	4.7%
Side	15 of 507	2.9%
Kneeling	14 of 507	2.7%
Prone - chest down position	13 of 507	2.5%

Prone restraint (those remaining in Prone position and not rolled immediately) was reported 13 times (2.5%) of the total of 507 total restraint positions. This is a reduction of 7 (35%) from last month which stood at 20 out of 404 restraint positions.

Only 12 (of the 13) of these restraints were reported correctly. One prone restraint recorded NO to the question “was this a prone restraint”. This has been corrected on the incident report, but confirmation awaited at time of writing.

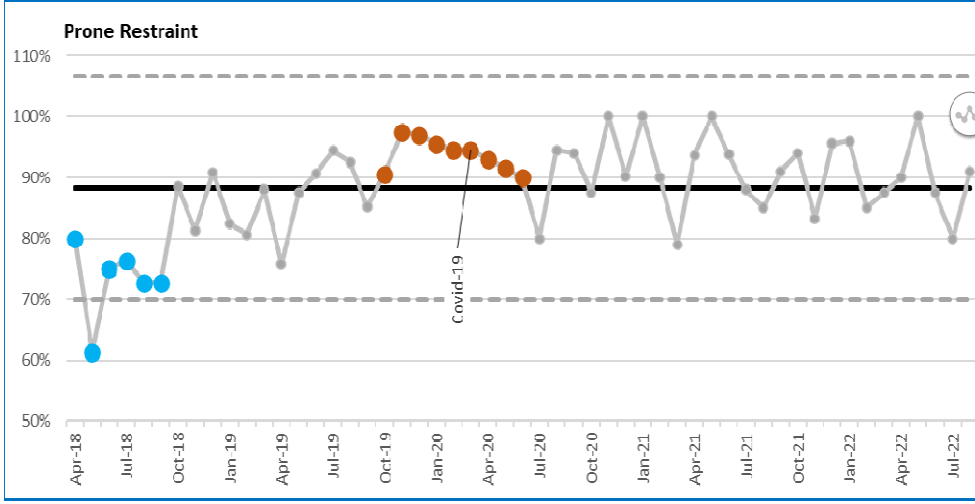
Number of prone restraints by team	
Stanley Ward	4
Newhaven	3
Horizon Centre	2
Walton PICU	2
Elmdale Ward	1
Nostell Ward	1

Reducing Restrictive Physical Intervention (RRPI)



This SPC chart shows that there was a period of special cause concerning variation in mid 2019 (orange markers) however since that point there has been mainly common cause variation in the number of incidents reported with a period of special cause improving variation (blue markers) more recently. In August 2022 we remain in a period of common cause variation.

The chart is based on the assumption that an increase in restraint incidents indicates a deterioration in performance however, as described above this is not always the case.



This SPC chart shows that there was a period of special cause concerning variation in late 2019 and early 2020, as well as two subsequent months of special cause concerning variation in October and December 2020 (orange markers).

Since that point to August 2022 there has been common cause variation (no concern) in the number of instances of prone restraint lasting less than 3 minutes.

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Owner	Threshold	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Establishment (ledger)	Improving Resources	Well Led	GM	-	4,910.0	4,910.0	4,956.0	4,956.0	4,956.6
Staff in post (Substantive)	Improving Resources	Well Led	GM	-	4,088.1	4,107.0	4,136.1	4,134.5	4,129.9
Workforce stability rate	Improving Resources	Well Led	GM	>=90%	85.0%	84.7%	85.0%	85.0%	85.3%
Vacancies	Improving Resources	Well Led	GM	-	821.9	803.0	819.9	821.6	826.7
Vacancy rate (Overall)	Improving Resources	Well Led	GM	<10%	16.7%	16.4%	16.5%	16.6%	16.7%
Vacancy rate (Minus Vacancy Factor applied)	Improving Resources	Well Led	GM	<5%	12.4%	12.0%	12.2%	12.2%	11.1%
Turnover external (YTD projection)	Improving Resources	Well Led	GM	>10-12<	16.0%	15.5%	15.1%	15.0%	14.7%
Turnover external	Improving Resources	Well Led	GM	>10-12<	1.5%	2.4%	3.3%	4.7%	6.1%
Turnover internal	Improving Resources	Well Led	GM	>10-12<	3.1%			Due Oct 2022	
Starters	Improving Resources	Well Led	GM	-	45.8	53.8	56.5	46.4	58.1
Leavers	Improving Resources	Well Led	GM	-	59.7	38.6	37.0	57.0	54.5
Sickness absence - YTD	Improving Resources	Well Led	GM	<=4.4%	4.6%	4.6%	4.6%	4.9%	4.8%
Sickness absence - Month	Improving Resources	Well Led	GM	<=4.4%	4.6%	4.5%	4.8%	5.5%	4.7%
Sickness absence (Covid-19) - YTD	Improving Resources	Well Led	GM	<=4.4%	3.2%	2.3%	1.9%	1.8%	1.6%
Sickness absence (Covid-19) - Month	Improving Resources	Well Led	GM	<=4.4%	3.2%	1.1%	1.5%	1.3%	1.2%
Sickness absence (stress anxiety)	Improving Resources	Well Led	GM	<=25%	35.6%	35.5%	37.9%	37.9%	38.1%
Leavers feedback returns	Improving Resources	Well Led	GM	-	48			Due Oct 2022	
Leavers feedback returns %	Improving Resources	Well Led	GM	>=25%	35%			Due Oct 2022	
Workpal appraisals - rolling 12 months	Improving Resources	Well Led	GM	>=90%	Reporting Under Development			56.7%	61.3%
Overall Training	Improving Care	Well Led	GM	>=80%	86.8%	86.2%	86.9%	87.2%	90.7%
Health & Safety									
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Improving Resources	Effective	GM	-	3			Due October 2022	

Additional Metrics to Highlight Response to and Impact of Covid-19

KPI	Target	As at 20th Jan 2022	As at 18th Feb 2022	As at 22nd Mar 2022	As at 20th Apr 2022	As at 18th May 2022	As at 22nd June 2022	As at 19th July 2022	As at 23rd August 2022	As at 20th September 2022	Trend	Notes
No of staff off sick - Covid-19 not working	N/A	140	61	167	111	44	58	80	23	23		
No of staff working from home - Covid-19 related		177	86	36	67	12	23	32	10	9		

Workforce Stability

• Our substantive staff in post position remains stable through the first 5 months of this financial year despite the pressures on recruitment, retention, and increased service acuity. Staff in post has risen by 1.0% (41.9 wte) since April, but has seen a small reduction in the last 2 consecutive months. Our establishment since April has also increased by a similar rate (46 wte).
• The vacancy rate for August is at 11.2% after our vacancy factor is applied. The vacancy factor will be amended monthly based on triangulation of recruitment activity, establishment growth and/or contraction. It is now set at 6.2% which is the cause of the 1.1% reduction from last month (standard 5% in July)
• Staffing pressures remain high across our inpatient and forensics wards due to vacancy gaps and competition to obtain bank and agency. Bank hours worked continues to increase and this is seen as a positive as staff are taking up more requests to fill availability. Filling staff shortages is becoming more difficult on weekdays than weekends due to pay incentives (weekend working).
• We saw more starters in August than leavers. This is the 3rd time in 4th months we have achieved this.
• Totals starters into the Trust since April (260.5) is outperforming the number of leavers for the same period (246.8 wte).
• The reason why our overall staff in post has not risen to reflect our greater starters v leavers WTE is due to substantive staff changes in contracted hours (staff reducing hours from FT to PT as an example)
• Our external turnover rate (cumulative) to August is 6.1%. In the same period last year it was identical at 6.1%. External turnover is projected to be 14.7% by March 2023. Internal turnover (churn) is projected to be 12.5% (See staff movements report for Trust detail in this area)
• Current workforce plans for recruitment toward nurse vacancy gives us gross maximum potential for 71 nurses between now and financial year end (current rolling band 5 advert, newly qualified accepted in September to December and International nurse recruitment conditional offers. Our substantive nurse in post position for the last 5 months has continued to grow every month (1223.1 to 1248.2 wte to end of August)
• Our inpatient workforce recruitment plan to March 2023 regarding nurse vacancies (currently 89.5wte) is forecasted to reduce to 46.5 wte subject to successful appointment of planned newly qualified nurses and our strong position for current and future international nurse recruitment. (See Inpatient Recruitment Plan_August 22)

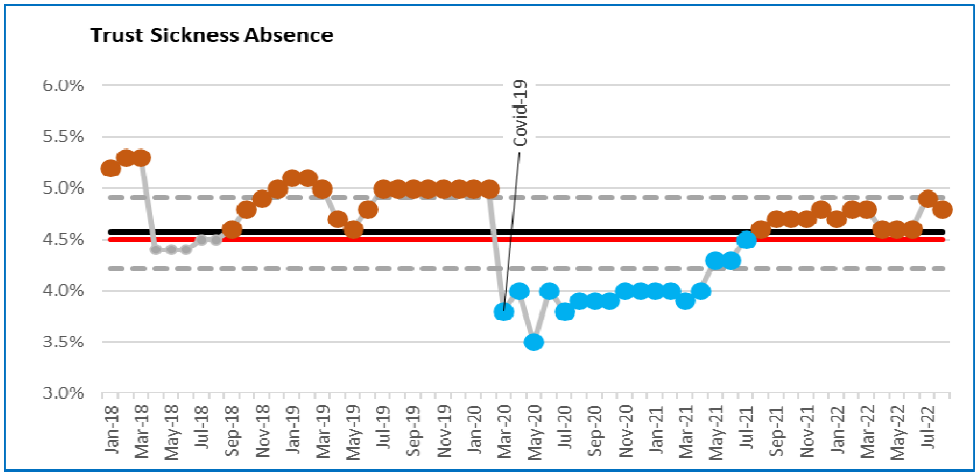
Absence

• As at 20th September, 23 staff were off work Covid-19 related, not working which compares to 23 towards the end of August. A further 10 were working from home.
• In August 81 staff were confirmed positive for Covid-19
• Overall regular absence has reduced in August to 4.8% cumulative from 4.9% in August. This time last year it was 4.3%. Higher absence is currently being seen in Forensics (7.0%), Inpatients (5.8%), Nursing (5.1%), Additional Clinical Staff (6.0%) and Estates & Facilities staff (8.1%) - Both Forensics and Inpatients have increased since last month despite our overall rate receding slightly since last month.
• Overall regular absence rate projection for March 2023 now stands at 4.8% - This would give us a 0.05% increase from last year.
• Prevalence for short term absence has increased significantly between June and July from 1.2% to 1.6%. This is partially due to re-classification of short term absence from Covid related to normal absence.
• Stress absence remains high at 38% Trustwide - Targeted work to begin in highest areas for stress prevalence.

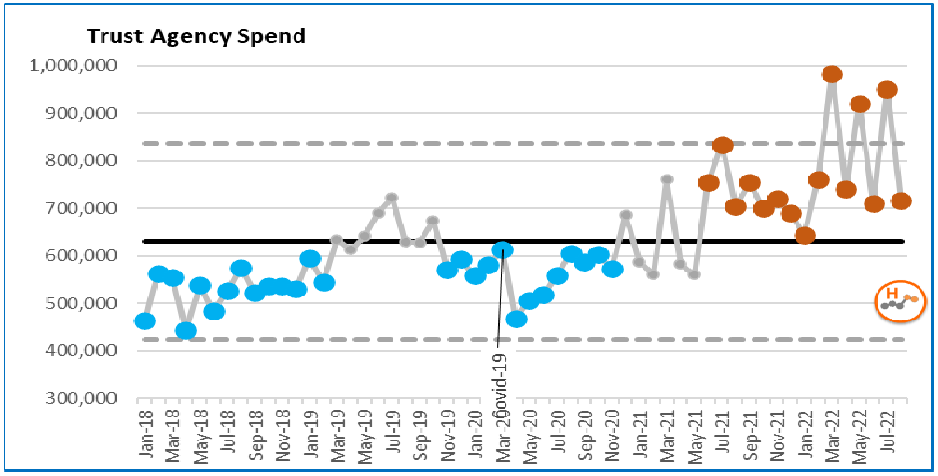
People Experience

• Appraisal uptake overall has improved from 56.7% in July to 61.3% in August. All Care group areas have increased their rate since last month. Projections for these rates and plans to improve are been undertaken.
• Inpatient services continues to remain significantly lower than other areas of the Trust.
• Mandatory training uptake (all areas) has also increased since July from 87.2% to 90.7%.
• Staff welcome event uptake continues to improve (88%). Local induction remains below target (71.8%) but has improved in month (0.7%).
• The People Directorate is currently undergoing a service delivery review and restructure (to be completed by end of September).
• Several initiatives are either implemented or being scoped/implemented regarding recruitment and retention including:
  o Staff RRP schemes including refer-a-friend, retention premia and incentive payments for extra hours.
  o Inpatient taskforce in place working on a number of workstreams regarding recruitment, comms and marketing of vacancies and opportunity.
  o Re-advertising and review of internal transfer scheme (above the bar).
  o A review of staff incentives payments which has been in place since December is ongoing. Currently extended to the end of September.

Analysis



The chart above shows that as at August 2022 we remain in a period of special cause concerning variation (orange markers). From July 2022 this also includes absence due to Covid-19. Further information regarding this



The chart above shows that in August 2022 we remain in a period of special cause concerning variation (orange markers). This is being monitored in workforce/finance.

This section of the report outlines the Trust's performance against a number of national metrics relating to operational performance.

• The NHS Oversight Framework - From 1 July 2022 integrated care boards (ICBs) have been established with the general statutory function of arranging health services for their population and will be responsible for performance and oversight of NHS services within their ICS. NHS England will work with ICBs as they take on their new responsibilities, the ambition being to empower local health and care leaders to build strong and effective systems for their communities. 2022/23 will be a year of transition as ICBs are formally established and new collaborative arrangements are developed at system level. Over the course of 2022/23 NHS England will consult on a long-term model of proportionate and effective oversight of system-led care.
The oversight framework has been updated for 22/23. It aligns to the priorities set out in the 2022/23 priorities and operational planning guidance and the legislative changes made by the Health and Care Act 2022, including the formal establishment of ICBs and the merging of NHS Improvement (comprising Monitor and the NHS Trust Development Authority) into NHS England. Ongoing oversight will focus on the delivery of the priorities set out in NHS planning guidance, the overall aims of the NHS Long Term Plan and the NHS People Plan, as well as the shared local ambitions and priorities of individual ICSs. ICBs will lead the oversight of NHS providers, assessing delivery against these domains, working through provider collaboratives where appropriate.
This table only includes operational metrics, there are a number of other workforce and quality metrics that are reported against in the relevant section of the IPR.
• NHS Long term plan - the trust fed a number of operational/data lines into the ICS planning programme with associate trajectories. Performance against those metrics will be reported at Trust level in the below dashboard and will be monitored by place in appropriate business delivery performance monitoring.
• NHS Standard Contract against which the Trust is monitored by its commissioners. The below table has been updated to reflect metrics included in the contracts for 22/23. In addition to the national metrics, there are a number of local metrics within each contract that is monitored within the appropriate care group/service. Metrics from these categories may already exist in other sections of the report.

National Metrics - NHSEI systems oversight framework, NHS long term plan, NHS standard contract

KPI	Objective	CQC Domain	Owner	Source	Target	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Data quality rating [8]	Variation/ Assurance
The number of incomplete Referral to Treatment (RTT) pathways of 52 weeks or more at the end of the reporting period.	Improving Care	Responsive	CH	SC	0	0	0	0	0	0	0	0	0	0	0		
Inappropriate out of area bed days 5	Improving Care	Responsive	CH	SOF/LTP		754	1253	1686	1196	643	413	381	402	339	247		
Community health services two-hour urgent response standard	Improving Health	Responsive	CH	SOF/LTP	80% from 1st Jan 23	Reporting to commence January 2023											
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	LTP	60%	88.5%	94.8%	82.5%	85.5%	85.7%	88.4%	83.7%	83.3%	92.9%	91.7%		
IAPT - proportion of people completing treatment who move to recovery 1	Improving Health	Responsive	CH	LTP/SC	50%	47.5%	53.7%	52.6%	53.4%	53.4%	55.0%	52.1%	53.1%	56.7%	*51.8%*		
IAPT - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period. - Barnsley	Improving Health	Responsive	CH	LTP	Q1 - 1563	1296	1298	1408	1379	489	455	445	479	407	426		
IAPT - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period. - Kirklees	Improving Health	Responsive	CH	LTP	Q1 - 3016	2335	2363	2604	2437	932	786	886	765	788	751		
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	LTP	92%	99.7%	92.2%	98.8%	98.5%	98.8%	99.0%	98.5%	98.5%	97.2%	96.1%		
Number of people accessing IPS services as a rolling total each quarter	Improving Care	Responsive	CH	LTP	19 per Qu - Calderdale 15 per qu - Kirklees 5 per qu - Wakefield	Reporting commenced Q1 2022					15 Calderdale			Due October 2022			
Number of individuals accessing specialist community PMH and MMHS services in the reporting period	Improving Care	Responsive	CH	LTP	Apr-Sep 318 per Qu Oct-Mar 336 per Qu	268	256	256	480	68	269	117	94	82	85		
Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)	Improving Care	Responsive	CH	SC	99%	100.0%	100.0%	68.9%	91.7%	68.9%	78.1%	95.9%	91.7%	91.5%	100.0%		
The percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient				SC	80%	82.7%	83.6%	84.0%	84.6%	84.9%	82.8%	88.7%	86.9%	92.2%	86.2%		
IAPT - Treatment within 6 Weeks of referral 1	Improving Health	Responsive	CH	SC	75%	97.9%	96.0%	94.2%	94.7%	94.0%	92.7%	96.0%	95.2%	97.5%	*97.2%*		
IAPT - Treatment within 18 weeks of referral 1	Improving Health	Responsive	CH	SC	95%	99.9%	99.9%	99.9%	100.0%	99.8%	100.0%	100.0%	100.0%	100.0%	*100.0%*		
The percentage of Children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within one week	Improving Health	Responsive	CH	SC	95%	87.5%	75.0%	90.0%	95.5%	83.3%	100.0%	100.0%	83.3%	85.7%	100.0%		
The percentage of Children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks	Improving Health	Responsive	CH	SC	95%	71.4%	93.1%	96.9%	94.9%	93.3%	91.3%	94.1%	100.0%	91.2%	83.3%		
Data Quality Maturity Index 4	Improving Health	Responsive	CH	SC	95%	99.0%	98.8%	99.4%	*99.4%*	99.4%	99.4%	99.5%	*99.5%*	*99.5%*	*99.5%*		

KPI	Objective	CQC Domain	Owner	Source	Target	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Data quality rating [8]	Variation/ Assurance
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	O	*TBC*	82	0	5	16	5	0	0	16	0	24		
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	O	*TBC*	5	0	1	1	1	0	0	1	0	1		
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	O	*Trend Monitor*	192	171	175	183	171	183			Due October 2022			
Proportion of people detained under the MHA who are BAME 2	Improving Care	Safe	CH	O	*Trend Monitor*	23.4%	18.7%	16.6%	18.0%	18.7%	18.0%						
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	O	95%	99.4%	98.3%	97.9%	96.2%	97.1%	100.0%	96.8%	100.0%	100.0%	99.0%		
% SU on CPA Having Formal Review Within 12 Months	Health & Wellbeing	Safe	SR/KT	O	95%	95.7%	94.2%	97.4%	96.1%	97.4%	97.2%	96.4%	96.1%	95.4%	93.9%		
% clients in settled accommodation	Improving Health	Responsive	CH	O	*60%*	87.7%	88.7%	88.4%	88.3%	88.2%	88.3%	88.3%	88.2%	87.7%	*86.9%*	⚠	
% clients in employment 6	Improving Health	Responsive	CH	O	*10%*	10.5%	10.2%	*9.9%*	11.1%	10.4%	10.6%	11.2%	11.6%	11.7%	*11.9%*	⚠	
Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance 1	Improving Health	Responsive	CH	O	90%	98.2%	98.2%	98.4%	98.2%	99.7%	98.0%	98.4%	98.4%	98.3%	*98.2%*		
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	O	99%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	*100.0%*		
Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	O	90%	98.2%	98.7%	99.1%	99.1%	99.0%	99.1%	99.1%	99.2%	99.3%	*99.3%*		

Glossary			
SOF	NHSEI System Oversight Framework	O	Other national metric
SC	NHS Standard Contract	SU	Service user
LTP	NHS Long Term Plan	CPA	Care programme approach

Variation Icons — The icon which represents the last data point on an SPC chart is displayed.

ICON						
SIMPLE ICON	• • •	• ? H L •	• H •	• L •	• H •	• L •
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

Assurance Icons — If there is a target or expectation set, the icon displays on the chart based on the whole visible data range.

SIMPLE ICON	?	F	P
DEFINITION	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass

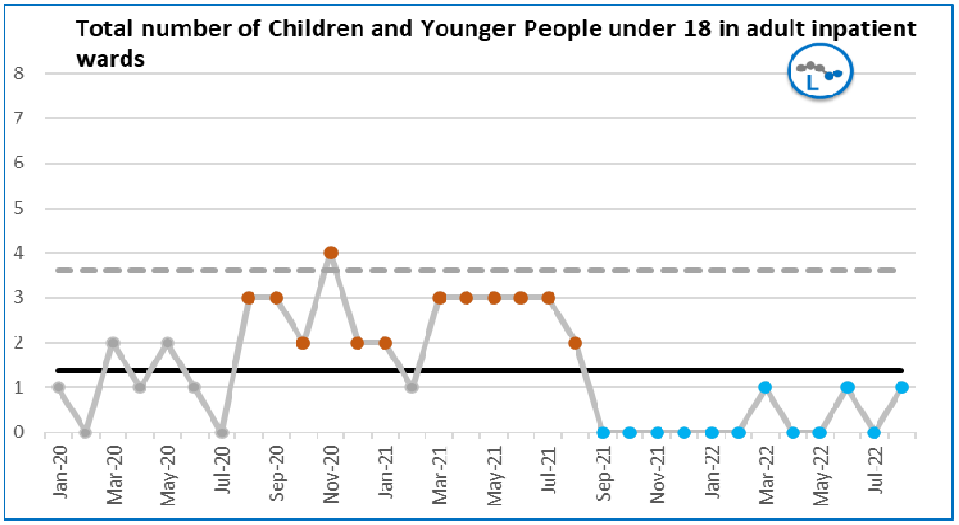
Headlines:

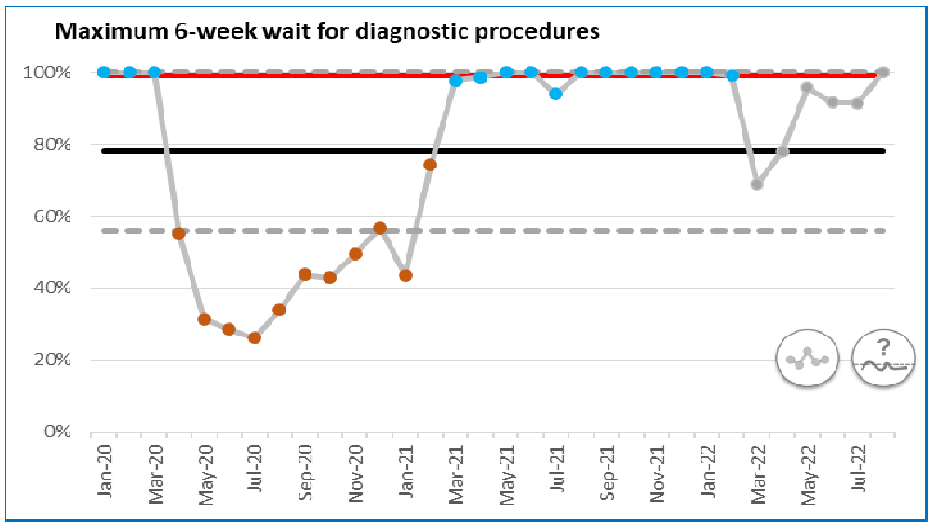
- The Trust continues to perform well against national metrics with performance against the majority within acceptable variance.
- The percentage of service users waiting less than 18 weeks remains above the target threshold at 96.1%
- 72 hour Follow up remains above the threshold at 86.2%
- The percentage of service users seen for a diagnostic appointment within 6 weeks in the paediatric audiology service is now above threshold at 100%
- The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within one week - small numbers impact on the achievement of the 95% threshold. In August 2 out of 2 urgent cases were seen within 1 week.
- The percentage of Children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks - As identified for the urgent metric, small numbers impact achievement. In August, 5 cases out of 30 were not seen within four weeks.
- During August 2022, there was 1 service user aged under 18 years placed in an adult inpatient ward for 24 days. The Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care and treatment reviews. Admissions are due to the national unavailability of a bed for young people to meet their specific needs. We routinely notify the Care Quality Commission (CQC) of these admissions and discuss the detail in our liaison meetings, actioning any points that the CQC request. This issue does have an impact on total Trust bed availability and therefore the use of out of area bed placements. In addition, the Trust's operational management group have recently signed off a new standard operating procedure for admitting young people to adult wards which has now been put into operation.
- % clients in employment and % clients in settled accommodation - There are some data completeness issues that may be impacting on the reported position of this indicator.
- Data quality maturity index - the Trust has been consistently achieving this target.
- IAPT proportion of people completing treatment who move to recovery remains above the 50% target at 51.8% for August.
- % SU on CPA Having Formal Review Within 12 Months has dropped under threshold during the month of August. Underperformance relates to Barnsley and Forensic Care Groups. Work taking place with Care Groups to improve performance.

Data quality:
An additional column has been added to the tables on the previous pages 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 issues have been identified in the reporting:

• The reporting for employment and accommodation for August shows 15.8% of records have an unknown or missing employment and/or accommodation status. This is a decrease compared to July which showed 15.5% of records have an unknown or missing employment and/or accommodation status. This has therefore been flagged as a data quality issue and work is taking place within business delivery units to review this data and improve completeness.

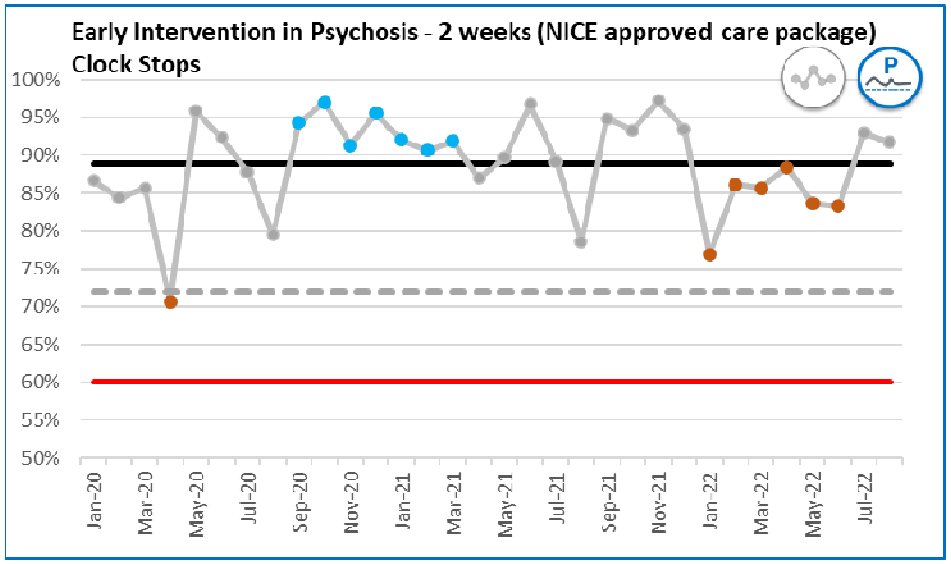
Analysis

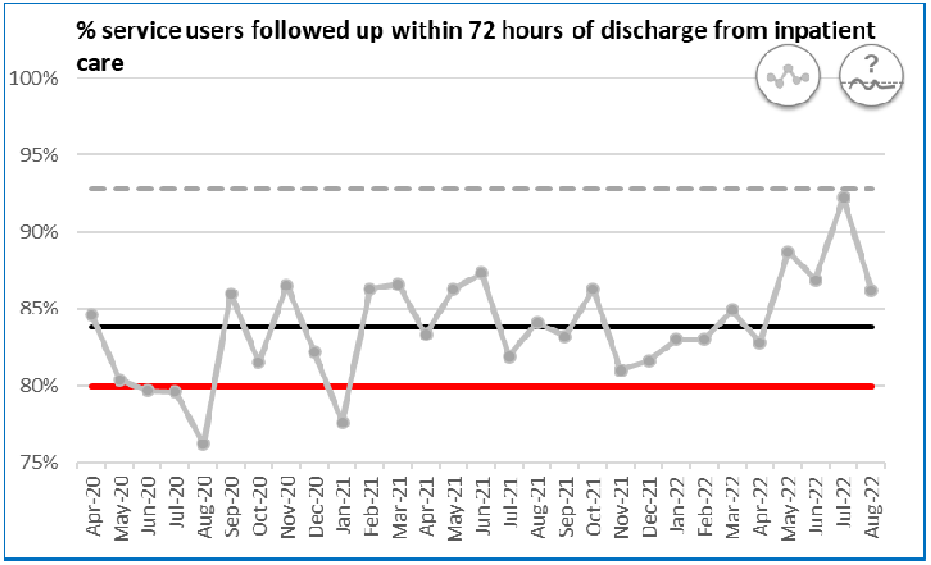




The SPC charts above show that we remain in a period of special cause improving variation regarding the number of beds days for children and young people in adult wards with one under 18 admission in August 2022. Due to the fluctuating nature of the diagnostic procedure waits we are in a period of common cause variation however whether we will meet or fail the target cannot be accurately estimated.

Analysis





The SPC charts above show that for clients being seen by EIP services we have now re-entered a period of common cause variation, we are still expected to meet the target. There are no concerns for clients discharged from inpatient care being followed up within appropriate timescales but due to the fluctuating nature of this metric, whether we will meet or fail the target cannot be estimated.

This section of the report is populated with key performance issues or highlights as reported by each care group.

Barnsley mental health services:

Alert/Action

• Record keeping improvement work continues to be prioritised. Outstanding FIRM risk assessments have reduced further to 34.6%.
• There are ongoing issues around access to inpatient beds leading to the Intensive Home Based Treatment Team (IHBTT) managing high risk patients in the community and impacting on discharges from Barnsley Hospital NHS Foundation Trust.
• Work is being progressed to address communication issues with inpatients. Previously this had resulted in inaccurate discharge dates being recorded and requests to complete 72 hour follow-ups. However, indicator remains 'green' at 95.8%
• There are ongoing issues around access to inpatient beds for those with challenging behaviours associated with dementia.
• CPA Reviews below target at 88.5%. There has been specific communication from Director of Services to address this, backed by management supervision to encourage improvements.

Advise

• Core team continues to have capacity and demand pressures, with current focus on reducing backlog of waits to enter treatment
• Waiting lists in IAPT remain high for Cognitive Behavioural Therapy (CBT) and Counselling.
• Work is being undertaken around the development of an all- age eating disorder service and further meetings being held with South Yorkshire ICS.
• Dialogue has commenced with Family Lives to develop their neighbourhood-based peer support service mobilisation plan. Expected to commence before end of October 2022.
• Appraisals are being prioritised across services/teams.
• Friends and Family Test remains positive at 85%

Assure

• Eating disorder training, provided by SYEDA, has been secured for 50 staff with sessions taking place in August and November. Feedback from the first cohort has been very positive, with staff requesting further training around eating disorders.
• We are working with Mental Health Matters to mobilise the Barnsley Safe Space and develop appropriate pathways
• On target for CQUIN 10b.
• Barnsley will be going live in September with the Clozapine Template on SystmOne on the clinical tree. This enables GP and other services on SystmOne to see relevant information.
• Question and answer sessions to discuss trans gender and non-binary issues have been arranged.
• South Yorkshire Liaison and Diversion Service have been chosen to take part in the Awards for the Lived Experience Charter Sites. The focus is equality, involvement, and inclusion.

Child and adolescent mental health services:

Alert/Action

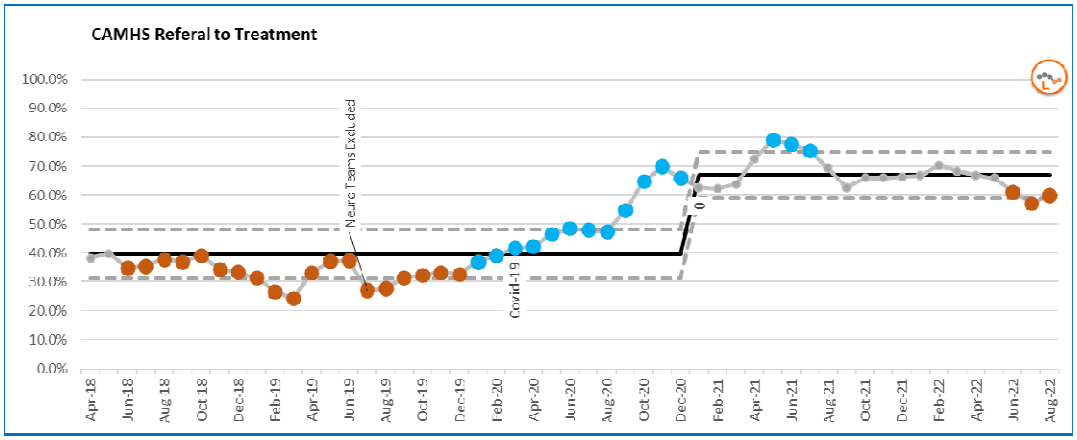
• There has been a general improvement with respect to mandatory training compliance and work continues to maintain/improve. Three areas remain 'amber' – reducing restrictive practice (71.4%), cardio pulmonary resuscitation (74.5%) and information governance (93.4%).
• Waiting numbers for Autistic Spectrum Conditions (ASC)/Attention Deficit Hyperactivity Disorder (ADHD) (neuro-developmental) diagnostic assessment in Kirklees remain problematic. Increased capacity is now in place.
• Wakefield CAMHS is an outlier with respect to numbers waiting from referral to treatment. An action plan has been developed and improvement is anticipated.
• There is an ongoing issue with shortage of specialist residential and Tier 4 places leading to inappropriate stays for young people on acute hospital wards and in Trust in-patient beds. This is noted on the Trust risk register.

Advise

• An Any Qualified Provider model is to be implemented by commissioners in Calderdale with regard to ASC/ADHD diagnostic assessment. Work is progressing to ensure a robust CAMHS response.
• In general waiting lists/times from referral to treatment are improving.
• The focus on maintaining staffing levels in Wetherby Young Offenders Institution and Adel Beck secure children's home continues, as these areas are particularly challenging to maintain full staffing establishments.
• Friends and family test is 'green' at 87%
• Waiting times for neurodevelopmental waits within CAMHS are below target., As previously reported, waiting list initiatives are in place to work towards stabilising this position from March 2023. Children do not need to have a diagnosis in order to receive a CAMHS service and services will be provided to meet their presenting needs.
• The percentage of CAMHS patients waiting less than 18 weeks from referral to treatment was 60% in August, a slightly improved position from 57% in July. CAMHS continue to prioritise children with high levels of need and if a child's needs escalate whilst they are waiting for a service, the service will provide additional support.

Assure

• Staff wellbeing remains a focus. Hybrid models of working are still being proactively utilised.
• The Trust has proactively engaged with Provider Collaboratives in South and West Yorkshire to strengthen the interface with inpatient providers and improve access to specialist beds.



The upper and lower control levels for this measure have been re-calculated from January 2021 following a sustained period of significant improvement, in order to better determine if current performance is within expected variation. As you can see from June 2022 we have entered a period of special cause concerning variation. For further information see narrative above.

Barnsley general community services:

Alert/Action

• A paper outlining the proposed service model for smoking cessation services in Calderdale is due to go to Local Authority Cabinet in November. The Trust's current contract for Yorkshire Smoke Free Calderdale runs until 31st March 2023, and it is anticipated a contract extension will be requested.
• There is a planned commissioner review of current health provision for the six resettlement programmes in Wakefield, which will include Urban House.
• Due to Covid restrictions over the last two years there is a significant backlog on the testing of medical devices in the community setting, which has been added to the risk register. Work is taking place with the Infection Prevention and Control Team and Estates to put a plan in place for updating the register of devices.

Advise

• Clarification on timescales to recommission Child Health Information System (CHIS) / Vaccination and Immunisations on a regional basis is awaited.
• Wakefield Local Authority intends to continue to commission the Live Well Wakefield service beyond March 2023 under the Provider Selection Regime (PSR) if timescales allow. If the PSR does not come into force by March 2023 the Council will be obliged to procure the service again, and would wish to extend the contract for 6 months to allow for this to take place.
• Absence continues in some children's services due to several factors e.g. long term sickness, maternity leave and the inability to recruit on a temporary basis and remains challenging.
• There are ongoing system issues in relation to access to Barnsley Hospital NHS Foundation Trust (BHNFT) generated discharge letters by SWYPFT's Barnsley Integrated Services Care Group. This has been escalated and BHNFT are currently liaising with the ICE system supplier with a view to this issue being resolved. A back up arrangement is in place for the Trust to contact the discharging ward for discharge instructions until the situation is resolved.
• There are concerns that Urgent Community Response data sets published nationally are not accurate. This is due to an issue with data extraction. Currently the data shows the Trust are not achieving the two-hour standard when it is achieving above the 70% target at 82%. National meetings are taking place to stand down the publishing of the data set until issues are resolved.

Assure

• The Children's Speech and Language Therapy (SALT) Service has been shortlisted for the Chief Allied Health Professions Office Award for Digital Practice.
• The Barnsley Community Integrated Stroke Team Annual Report has been completed and circulated. This has been well received with achievements and improvements for the residents of Barnsley noted by our commissioners.
• Further ICB (Integrated Care Board) investment has been secured for the Urgent Community Response Service, recognising the delivery model in Barnsley delivers a 24/7 service offer which goes beyond the national requirement.
• A new Life After Stroke Group is commencing in October.
• The Trust has received excellent feedback from dietetics students as to how they have been supported, encouraged, and developed whilst on placement in Barnsley.
• A work stream is commencing looking to introduce the e-prescribing functionality for services already migrated to the Integrated Neighbourhood Teams SystmOne unit. Once operational, this will enable clinicians to draft prescriptions and for these to be sent directly to the patient's pharmacy for collection.

ADHD/ASD services:

Alert/Action

• Referrals - Attention Deficit Hyperactivity Disorder (ADHD) referrals continue to increase and remain much higher than pre-pandemic levels.
• Referrals - Autism referrals have also increased compared to pre-pandemic levels.
• Friends and Family Test – Friends and family test remains red as at 38%. Improvement work is in place to address this, and gain learning from other teams.
• Training in amber: Information governance ↓91.7%. Work is ongoing to ensure all staff complete the training.

Advise

• Our partnership with Bradford District Care NHS Foundation Trust on the principles of "shared leadership for shared objectives" is working well. Steps to support the Bradford and Airedale Neurodevelopmental Service (BANDS) are successful so far.
• The business case to increase capacity in ADHD to 560 per year has been approved.
• New initiatives regarding ADHD Triage / ASD triage have been implemented, and will be evaluated.

Assure

• Changes made to the ADHD pathway are working well.
• There is a focus on staff appraisal.
• No clinical vacancies and all other vacancies (administration) on track to be filled.

Learning disability services:

Alert/Action

Community Services
• Waiting Lists in Community Services: The service recognises that waiting lists are below expected targets, and are undertaking a specific project to address.
• Staffing Issues: Staffing continues to be a concern across all localities and disciplines. The service has committed to undertaking more work to ensure recruitment and retention is a priority. All vacant posts are advertised, with some posts needing to be advertised more than once.

Assessment and Treatment Unit (ATU)
• Delayed transfers of care (DTOC): Many service users on Horizon require bespoke packages of care to meet their complex needs in the community, and finding suitable placements remains challenging and, although numbers fluctuate, can lead to delays in discharges.
• Staffing: Continues to be a challenge and is exacerbated by vacancies, sickness absence and acuity. As with community, some posts have to be advertised more than once in order to attract suitable applicants.
• High use of Seclusion/Long Term Segregation (LTS): There continues to be high use of LTS to support people to manage their wellbeing. Seclusion rates have reduced in August.
• Mandatory Training (Amber) – Improvements are noted in relation to cardio pulmonary resuscitation, national early warning score assessments (NEWS) and information governance. Actions are underway to address performance in relation to reducing restrictive physical interventions and food safety training.

Advise

Community
• Service users continue to experience complex needs that leads to high acuity within community caseloads.
• The workforce review is now progressing with workstreams to improve the infrastructure to better meet challenges and demand.

Assessment and Treatment Unit (ATU)
• The unit continues to carry a high number of vacancies, with high usage of bank and agency which impacts on continuity of care.
• Recruitment and retention remains a priority.
• The recruitment to joint ATU posts with Bradford is progressing well.

Assure

Community
• Mitigating actions in place to address waiting lists and a project to improve.
• Annual health checks across all 4 localities are continuing to improve.
• Robust plans in place to address mandatory training, supervision and appraisal shortfall.

Assessment and Treatment Unit (ATU)
• Recruitment continues to progress.
• Exploration of new roles e.g., Physician Associates is underway and will possibly support improvements in the physical healthcare offer to service users.
• Robust plans are in place to address mandatory training, supervision, and appraisal shortfalls.

Forensic services:

Alert/Action

• Bed Occupancy – Newton Lodge and Bretton Centre occupancy is below the 90% target at 84.01% and 87.35%. Newhaven is at 99.2%.
• Mandatory training areas in amber- Improvements have been made in all mandatory training except CPR ↓69.0% and IG ↓69.0%. Action plans to target hotspots in place.
• Sickness absence/covid absence – remains above Trust target set for the Care Group.
• Vacancies & Turnover – Turnover remains high ↓14.9%. The service has welcomed 15 new registered nurses, and have new unregistered staff commencing imminently.
• CPA- under target at 87.1% which is a mixture of community and inpatient cases, remedial action in place.
• FCAMHS- preliminary discussions have begun between NHS England, West Yorkshire Commissioning Hub, the Trust and wider partners regarding the transfer of the FCAMHS contract to a Provider Collaborative in future.

Advise

• Work with partners in the Adult Secure West Yorkshire Provider Collaborative continues. Current priorities cover service user flow through inpatient services, service users who are outside natural clinical flow, repatriation, and some early discussion regarding capacity planning.
• SWYPFT continue to lead on key areas of work, in particular the development of community forensic services across West Yorkshire.
• The roll out of trauma-informed care is progressing going well and training sessions for staff have commenced. The service will pilot this on Johnson Ward which will complement other improvement work on the ward.
• The service has its primary care contract out to tender currently.

Assure

• No delayed transfers of care recorded across all three services.
• High levels of data quality across the Care Group (100%).
• 100% compliance for HCR20 being completed within 3 months of admission
• 25 Hours structured activity for service users has been 100% for all three services.
• The service has a bespoke recruitment and retention plan, and this will remain a key area of focus throughout 22/23.
• The well-being of staff also remains a priority within the service.
• Friends and Family test is 100%

Calderdale Kirklees Wakefield and Trustwide Inpatients:

Alert/Action

• Acute wards have continued to manage high levels of acuity. The Trust have had above 100% occupancy levels across wards on a sustained basis and capacity to meet demand for beds remains difficult. Workforce challenges have impacted, with staff absences and difficulties sourcing bank and agency staff on top of vacancies leading to staffing shortages across the wards. Home Based Treatment Teams have faced similar staffing pressures.
• Work to maintain effective patient flow continues, with the use of out of area beds being closely managed. There has been a reduction in the usage of out of area placements, with some patients discharged and a lower rate of placement since April. However, a number of patients remain in beds throughout the country predominantly in PICU wards. The key focus continues to be on bringing patients back to local beds in as timely a way as possible, and providing care closer to home, whilst managing the demand for new admissions as safely as possible in partnership with community teams. The demand for beds overall has risen leading to pressures in the system and ongoing challenges in arranging admissions in a timely way.
• There is need to improve performance in 72 hour follow up in Calderdale. Following evaluation, the current figure principally relates to low numbers and some data quality issues. However, our focus remains on patient safety and effective discharge planning for all patients. The Trust-wide improvement plan remains in place and the Quality and Governance Lead will be working closely with relevant teams on this.
• Demand into the Single Point of Access (SPA) and capacity issues are leading to ongoing pressures in the service, necessitating the use of additional staff and additional sessions for assessment slots. Workforce challenges are continuing to compound these problems. SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment has been at risk of being delayed. The situation is being kept under close review by General Managers and teams, and all possible mitigations are in place.
• Community teams are continuing to experience workforce challenges. We currently have higher than usual levels of vacancies in community teams for qualified practitioners and proactive attempts to fill these have had limited success. We have action plans in place for certain teams and continue to be proactive and innovative in our approaches to recruitment and workforce modelling.
• All areas need to improve performance for FIRM risk assessments, which remains under target in all areas for those on CPA who have had a staying-well plan within 7 days, and those who have had a formulation within 7 days. A series of deep dives has been taking place which has indicated a combination of service pressure factors, data quality issues, and pathway, systems and technical issues regarding team-to-team allocations for example. The intelligence from this has led to some rapid improvement work which has demonstrated some improvement, and all areas will be focussing on this over the coming month. Operational services are working with performance and system colleagues to resolve any data capture issues and system anomalies. We have set up a trajectory of improvement to full performance by the end of Quarter 3.

Advise

• Senior leadership from matrons and general managers remains in place across 7 days. We are currently reviewing weekend working for senior managers to ensure we can build a sustainable model going forward that offers the required support to front-line 24/7 services.
• The Care Group CPA review performance action plan is still in place to ensure clarity of communication and process and support with staffing levels which has had an impact on performance. Quality and Governance Leads have undertaken specific improvement work with certain teams around leadership, data quality and recording.
• Intensive work to consider how we maintain quality and safety on our wards, and improve the well-being of staff and service users and encourage recruitment and retention is underway. We have recommenced a specific programme of work around sexual safety on our wards. We are building identified challenges and priorities into the workforce strategy and the inpatient improvement priority programme.
• Community services are optimising our use of space across Trust sites so that group work and more face-to-face therapies can be delivered, and are reviewing space utilisation in each building to optimise clinical capacity. Work continues in front line services to adopt collaborative approaches to care planning, build community resilience, and to offer care at home. This includes providing robust gatekeeping, trauma-informed care and effective intensive home treatment.
• Alongside trust-wide work on recruitment and retention, we are engaged in specific improvement planning to address workforce challenges in inpatient services. For example, in partnership with Nursing Quality and Professions colleagues, the development of a confident and competent workforce in which we are identifying core competencies for our workforce, with a focus on diversification and the utilisation of new roles and a potential skill-mix and shift-composition around the actual tasks and functions needed to run the wards. We are also building in the benefits of staff networks, preceptorship/ preceptorship academy, culture change measures and effective supervision models.
• We have worked with Nursing Quality and Professions and Performance colleagues to agree a new person-centred measure to demonstrate performance around collaborative care planning and are working towards implementation.
• Where there are waiting lists for services, for example for core psychology, comprehensive plans are in place for each individual including person-centred reviews and named contacts. We are participating in the trust-wide work on how we measure and manage waits in terms of consistent data and performance measurement.
• We continue to work in collaboration with our places to implement the community mental health transformation. We remain concerned that the new roles within primary care networks will draw experienced staff from our resources.
• We recognise the key role of supervision and appraisal in staff wellbeing and are ensuring time is prioritised for these activities and that where we need to improve action plans are in place. Positive supervision performance across community teams reflects this, and we are currently focussing on inpatient areas. Workplace wellbeing groups continue to thrive with excellent examples of initiatives in each of the hubs and in individual teams.
• We continue to work towards required concordance levels for CPR training and aggression management - this has been impacted by some issues relating to access to training and levels of did not attends (DNAs). We are working closely with specialist advisors to optimise this, and are now receiving current information per service line and timely advice of DNAs and training availability. We also have plans in place across inpatient services to ensure appropriately trained staff are on duty across all shifts at all times.

Assure

• We are performing well in gatekeeping admissions to our inpatient beds.
• Friends and Family Test – remains positive at 93% inpatients and above threshold for community in all areas.
• CPA reviews performance remains positive across Calderdale, Kirklees and Wakefield.
• There has been a successful launch of simulation-based training in Barnsley, in partnership with the acute trust focussing on physical well-being. This enables staff to practise real life scenarios within the safety of a simulated environment. Staff train and learn alongside others, and by using specific debriefing techniques, evaluate and analyse their own practice. We are now looking to scope and model a roll-out service wide.
• We have had further success in recruitment both internally and externally in to nursing posts in the acute inpatient workforce.

Communications, Engagement and Involvement

• Coronavirus updates sent out when required e.g. re testing and mask wearing.
• Comms support continues to the Covid Moving Forward group.
• Support provided to the poverty network, and information shared re cost of living support.
• Outcomes based tool – warm up comms prepared.
• Branching Minds Barnsley launch and next step comms supported.
• SystmOne waiting list comms support provided.
• Staff wellbeing initiatives promoted.
• 'Our Offer' booklet produced and 'Get to know us' booklet developed.
• Design and print of materials continuing for services and corporate functions.
• Trust website and intranet development and updates supported/
• Awareness days and weeks supported on social media and via internal communication channels.
• All of You campaign on collecting equality data campaign supported.
• Support provided to EyUp Charity, Creative Minds, Spirit in Mind, Recovery and Wellbeing Colleges and the Mental Health Museum.
• Media enquiries co-ordinated and responses issued.
• Promotion of West Yorkshire and South Yorkshire ICS initiatives and campaigns.
• Intranet working group supported, with focus as the intranet being a working trust asset.
• Support to flu campaign.
• 'Disability matters' event and staff disability policy launch.
• Suicide prevention comms and World Suicide Prevention Day planning.
• Older people's inpatient mental health transformation- internal and external comms and planning supported.
• Patients Know Best comms planning and warm up messages.
• Bretton Centre comms support, including carer engagement events.
• Ongoing support for staff recruitment.
• Staff wellbeing survey and staff survey results promotion.

Engagement, Equality and Volunteering Update

• Equality and Involvement annual action plans are now being delivered. Plans were co-produced with input from Trust leads, staff side, and staff networks and using engagement feedback, insight, and intelligence.
• Work continues to progress the equality dashboard and metrics in line with Trust priorities, national guidance, and local insight, with support from business intelligence.
• Case studies to improve health inequalities are progressing. CAMHS leads are now appointed, and an initial working group has been set up. Forensic admission work is being supported though the broader involvement the Trust has been delivering to improve racial equity. Work has been funded for the Yorkshire and Humber Involvement Network to support.
• Monthly themed Lunch box talks – lets talk about…. are being delivered. The talks share one of 12 community equality films created in partnership with local communities. Community members attend, and other useful equality information is shared to support a dialogue.
• An animation has now been developed for people who are detained to ensure those use services, carers, friends, and family can understand what that means, what may happen and what to expect. The animation was developed as a result of feedback from the discovery interviews which highlighted a lack of awareness before accessing the service of what it means to be detained.
• Work to support staff networks continues with an updated terms of reference developed in draft for comment, and an outline work plan to aid the allocation of support and additional resources required. The Equality and involvement team have supported a 'Disability Matters' event on 31 August with a national guest speaker.
• Equality data collection campaign continues. The 'All of You' campaign aim is to increase the recording of equality data from people who use and work in services. A campaign approach and poster are available the hashtag is being used in all comms.
• The team continue to support the Older People's Services transformation programme offering consultation advice and guidance, equality, and communication support. A CEE (communication, engagement and equality) meeting for partners is now being held every 2 weeks to ensure all partners have access to the same information. Plans for a stakeholder event, draft consultation document and briefings have been developed and work is underway to prepare for the event
• A Race Forward infographic has been developed and work to review the actions required to progress this work will be supported by the team. Updates are prepared for EII (equality, inclusion and involvement) Committee in September.
• Support with an involvement approach and equality impact assessment (EIA) for the Sustainability and Social Responsibility Strategy continues
• The Trust have secured funding to deliver a deep dive Trust-wide survey to investigate the experiences and views of its workforce with regards to racial equity in the workplace. This investigation will help inform the organisation's strategy to combat any racial biases that may be existing within the organisation.
• An asset-based approach to involvement is now underway, and a draft approach has been developed and shared with a broader steering group. Work will now take place over the next few months to develop the training. The approach will aim to recruit a bank of involvement leads who will all receive training to support our involvement approach. The bank of people will be called on to support pieces of work as they arise and will ensure we have the capacity to respond to the involvement agenda.
• Work to communicate Trust-wide involvement as an infographic has started and the narrative and approach will be shared with the Executive Management Team initially.
• Survey monkey will now transfer over to the Equality and Involvement Team. This change is being managed through a small group and plans are to ensure everyone is using one system. The work is progressing, and a toolkit will soon be available on the intranet as transition concludes in September.
• The quarterly partnership briefings produced by the team continue to be used in meetings and at MP briefings.
• The quarterly insight report was developed this quarter and shared with EMT to identify a 'you told us we listened' response.
• An 'Electronic EIA' is in development with the support of IMT colleagues. The framework for storing EIAs on SharePoint will mean that we can track grading, pull down reports and identify Trust-wide actions to address equality.
• Presentation and process to Operational Management Group (OMG) on mapping against a study on Suicide Prevention in South Asian Communities is underway. The approach is asking Care Groups to map their current position against the recommendations to identify a baseline. This work concludes mid September so actions can be identified.
• The work to support COPI (control of patient information) includes the development of identifiers for digital inclusion and preferred methods of communication as part of the approach. These new fields will support an understanding of digital access and communication requirements. In addition, the COPI approach includes revisiting equality data so this can be updated and increase reporting.
• Trust-wide training for equality, diversity and inclusion continues to be delivered and work with Learning and Development to identify target audience for training, and implications is being developed. The training was co-designed and developed by the team and sessions are in place.
• The Trust had a key role in the delivery of a regional event on Peer Support Workers. Health Education England invited our Trust to speak at the event with examples shared of the work we are doing in services such as perinatal.
• More learning on a 'beyond pills approach' is being brought into the Trust with our lead Peer Support Worker working closely with the pharmacy team to identify an approach. The Trust could be one of the first organisations to respond to this recent government-led report.
• The volunteer service continues to transfer volunteers to ESR (electronic staff record), and the return of volunteer is increasing. A large-scale piece of work in Barnsley to support community teams with volunteers is underway and 17 new volunteer managers are due to receive training to support these roles.
• Volunteer to career is progressing and the team attended a national event with HR colleagues to identify an approach. This approach will be shared initially with the Operational Manager Group in the next few weeks to gather ideas for a model.

Overall Financial Performance 2022/23

Executive Summary / Key Performance Indicators

Performance Indicator		Year To Date	Forecast 2022 / 23	Narrative
1	Surplus / (Deficit)	£3.9m	£3.2m	In month financial performance is a surplus of £0.6m with a year to date surplus of £3.9m. This is £0.9m better than plan. Additional spend is profiled for the remainder of year ensuring delivery of the revised £3.2m surplus.
2	Agency Spend	£4m 4.5%	£9.1m	The Trust allocation of the overall West Yorkshire Integrated Care Board (ICB) 2022 / 23 agency cap is £7.8m. Performance is measured against both this and also as a percentage of total pay expenditure. Year to date expenditure is £4m which is £0.8m more than cap.
3	Overhead Costs	15%		This key performance indicator is a measurement of corporate / overhead costs as a percentage of income for the year to date.
4	Financial sustainability and efficiencies	£2.9m	£6.4m	As per the NHS Operating Framework the Trust revised annual plan submission included a sustainability and efficiency requirement of £6.4m. This is being managed within the overall financial position and for the year to date, and forecast, is in line with plan.
5	Cash	£86.1m	£80m	Cash in the bank remains positive although it is forecast to reduce in the year due to continued capital investment and forecast increasing spend.
6	Capital	£1.2m	£13.1m	The capital programme for 2022 / 23 has been agreed as £13.1m and this is forecast to be delivered in full. Revisions to the programme have been agreed by Trust Board to take account of revised timescales and increased costs. Mitigations have been agreed to manage overall spend. It is recognised that the capital programme is largely profiled in Q3 and Q4.
7	Better Payment Practice Code	95%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 95% of all invoices have been paid within 30 days of receipt.

Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

System-wide monitoring

Integrated care systems (ICSs) are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.
Since 2018, they have been deepening the relationship in many areas between the NHS, local councils and other important strategic partners such as the voluntary, community and social enterprise sector. They have developed better and more convenient services, invested in keeping people healthy and out of hospital and set shared priorities for the future. The Trust sits within two ICS footprints, West Yorkshire and Harrogate, and South Yorkshire and Bassetlaw. This section of the report outlines the metrics that are in place across both ICS footprints along with system performance.

West Yorkshire and Harrogate Partnership

The Partnership finalised and published its five year strategy in March 2020. This document included 10 'big ambitions' – 10 measures that reflect what is important to the Partnership, and by which progress will be measured. These 10 items are:
1 - Increase the years of life that people live in good health in West Yorkshire and Harrogate compared to the rest of England. We will reduce the gap in life expectancy by 5% (six months of life for men and 5 months of life for women) between the people living in the most deprived communities compared with the least deprived communities by 2024.
2 - We will achieve a 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population by 2024 (approx. 220,000 people). In doing this, we will focus on early support for children and young people.
3 - We will address the health inequality gap for children living in households with the lowest incomes. This will be central for our approach to improving outcomes for 2024. This will include halting the trend in childhood obesity, including those living in poverty.
4 - By 2024 we will have increased our early diagnosis rates for cancer, ensuring at least 1000 more people will have the chance of curative treatment.
5 - We will reduce suicide by 10% across West Yorkshire and Harrogate 2020/21 and achieve a 75% reduction in targeted areas by 2022.
6 - We will achieve at least 10% reduction in anti-microbial resistance infections by 2024, by for example reducing antibiotic use by 15%
7 - We will achieve a 50% reduction in still births, neonatal deaths, brain injuries and a reduction in maternity morbidity and mortality by 2025.
8 - We will have a more diverse leadership that better reflects the broad range of talent in West Yorkshire and Harrogate, helping to ensure that the poor experiences in the workplace that are particularly high for black, Asian and minority ethnic (BAME) staff will become a thing of the past.
9 - We will aspire to become a global leader in responding to the climate emergency through increased mitigation, investment and culture change throughout our system.
10 - We will strengthen local economic growth by reducing health inequalities and improving skills, increasing productivity and the earning power of people and our region as a whole.

The Partnership have developed an approach to measurement and quantification, this was presented to the West Yorkshire & Harrogate Health and Care Partnership Board in September 2021. The approach identified reporting would be done annually into the partnership board and would be a mixture of quantitative data which will allow us to track delivery of the ambition progress over time; quantitative data on measures which it is anticipated will make a positive impact on the ambitions – but which can be measured more frequently; and key activities and actions we are taking which we believe will make the biggest difference in delivering the objective.

South Yorkshire and Bassetlaw Partnership

The South Yorkshire and Bassetlaw integrated care system produce a range of performance information each month. This includes a delivery report which includes information pertaining to restoration of elective services, urgent and emergency care, hospital and out of hospital, and primary care activity. For mental health services performance data regarding CAMHS access, out of area bed placements and IAPT is shown. All IAPT standards are currently being met and the dementia diagnosis rate is above standard. However children and young people waiting time targets are not being achieved.

Publication Summary

This section of the report identifies publications that may be of interest to the board and its members.

Community services statistics: June 2022, NHS Digital, 6 September 2022

Learning disability services monthly statistics, assuring transformation: August 2022, mental health services data set: June 2022, final, NHS Digital, 15 September 2022

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Finance Report

Month 5
(2022 / 23)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0 Executive Summary / Key Performance Indicators

Key Performance Indicator		Year To Date	Forecast 2022 / 23	Narrative
1	Surplus / (Deficit)	£3.9m	£3.2m	In month financial performance is a surplus of £0.6m with a year to date surplus of £3.9m. This is £0.9m better than plan. Additional spend is profiled for the remainder of year ensuring delivery of the revised £3.2m surplus.
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5	Cash	£86.1m	£80m	Cash in the bank remains positive although it is forecast to reduce in the year due to continued capital investment and forecast increasing spend.
6	Capital	£1.2m	£13.1m	The capital programme for 2022 / 23 has been agreed as £13.1m and this is forecast to be delivered in full. Revisions to the programme have been agreed by Trust Board to take account of revised timescales and increased costs. Mitigations have been agreed to manage overall spend. It is recognised that the capital programme is largely profiled in Q3 and Q4.
7	Better Payment Practice Code	95%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 95% of all invoices have been paid within 30 days of receipt.

Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
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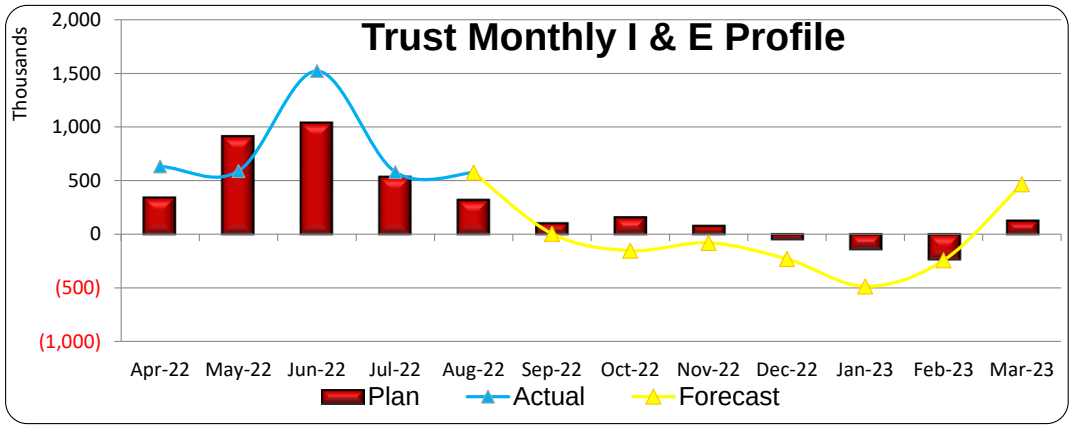
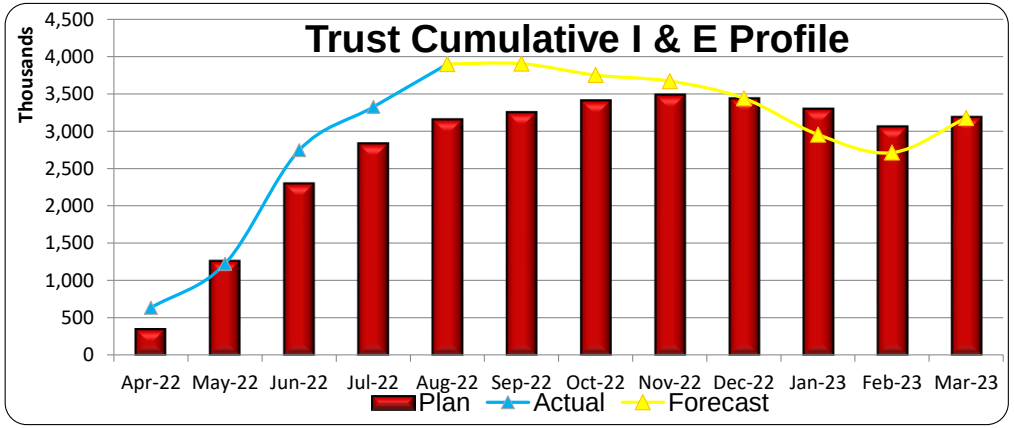
2.0 Income & Expenditure Position 2022 / 2023

Trust Financial Position

Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Description	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**
				20,283	20,254	(30)	Healthcare contracts	100,019	100,003	(16)	242,734	242,635	(100)
				9,223	8,818	(405)	Other Operating Revenue	43,598	43,719	121	107,662	108,534	872
				29,506	**29,072**	**(434)**	**Total Revenue**	**143,616**	**143,722**	**105**	**350,397**	**351,169**	**772**
4,647	4,559	(88)	1.9%	(18,395)	(17,937)	458	Pay Costs	(90,170)	(89,774)	396	(224,024)	(222,393)	1,631
				(10,167)	(9,979)	188	Non Pay Costs	(47,084)	(46,940)	144	(115,650)	(118,407)	(2,757)
4,647	**4,559**	**(88)**	**1.9%**	**(28,562)**	**(27,915)**	**646**	**Total Operating Expenses**	**(137,253)**	**(136,714)**	**540**	**(339,674)**	**(340,800)**	**(1,125)**
4,647	**4,559**	**(88)**	**1.9%**	**945**	**1,157**	**212**	**EBITDA**	**6,363**	**7,008**	**645**	**10,722**	**10,369**	**(353)**
				(483)	(489)	(5)	Depreciation	(2,512)	(2,522)	(10)	(5,847)	(5,843)	4
				(179)	(179)	0	PDC Paid	(895)	(895)	0	(2,148)	(2,148)	0
				37	86	48	Interest Received	187	309	121	450	799	349
4,647	**4,559**	**(88)**	**1.9%**	**320**	**575**	**255**	**Surplus / (Deficit)**	**3,144**	**3,900**	**756**	**3,178**	**3,177**	**(0)**
				0	0	0	Gain / (loss) on disposal	0	0	0	0	0	0
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,647	**4,559**	**(88)**	**1.9%**	**320**	**575**	**256**	**Surplus / (Deficit)**	**3,144**	**3,900**	**757**	**3,178**	**3,178**	**0**





Income & Expenditure Position 2022 / 23

The Trust financial position continues at a surplus run rate.
Workforce actions, through recruitment retention, are forecast to result in increasing expenditure.

The Trust revised financial plan, submitted June 2022, is a surplus of £3.2m. This is mainly profiled at the start of the year with workstreams such as recruitment and retention of workforce having an impact on the position.

NHS England - monthly submission

The actual financial performance as reported here is consistent with the monthly return made to NHS England and also to that reported into the West Yorkshire Integrated Care System (ICS). This declaration is also included within the self certification section of the return.

Income

Contracts, including agreed investments, initial tariff uplift and additional inflationary funding, has been agreed with the key commissioners. These will be updated to reflect the 2022 / 23 pay award funding in September 2022.

By their block contract nature there is minimal variation to agreed contract values. Risks relating to CQUIN delivery and any timing differences on agreed investments continue to be assessed.

Pay

Workforce, recruitment, retention and ensuring that all staff are fit, well and present at work are major driving factors of the Trust financial position. The plan, and forecast, position reflect current assumptions on increasing the overall Trust workforce and tries to appropriately reflect the difficulties of the current job market and that premium payments such as overtime are being utilised to support current levels.

The workforce plan did assume higher levels of vacancies at the start of the year and therefore the funded establishment will increase over future months.

As referenced in the income section above the 2022 / 23 Agenda for Change Pay Award has been confirmed. This is planned to be paid in September 2022; backdated to 1st April 2022. Initial estimates have indicated that costs will be higher than income and as such present a financial pressure to the Trust. This is the case across the West Yorkshire ICB and discussions are underway to validate potential risks and next steps.

Non Pay

Non pay expenditure is lower than planned although pressures do continue in the overall position. The main factors are described in the non pay breakdown. Inflationary pressures are being experienced in all areas of non pay expenditure but currently are most pronounced for utilities costs.

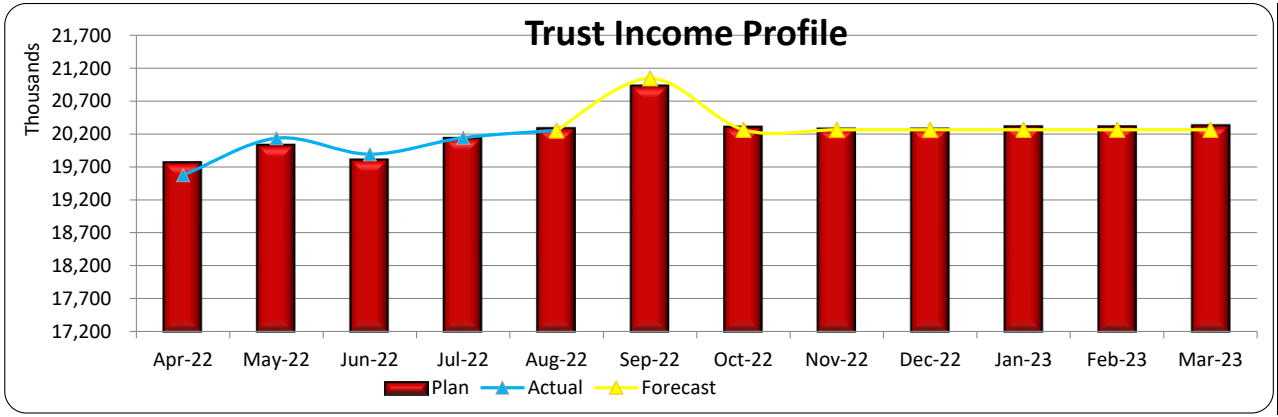
2.1 Income Information

Within the Trust Income and Expenditure position clinical revenue is separately identified. This is income received through contracts to provide clinical services. This does not include other income which the Trust receives such as contributions to training, staff recharges and catering income. This is included as other operating income.

The vast majority of income continues to be received from local commissioners (formerly CCGs, now Integrated Care Boards (ICBs)). For 2022 / 23 a hybrid of the previous year's financial regimes are in place. Formal contracts have resumed and are in place for all of the major commissioners. The financial element remains a block based upon national calculations and tariff changes. The same variation process as 2021 / 22 remains which means that investment in services will be added to contracts as and when agreed.

The block values have been calculated to include all income from NHS commissioners. This includes payment for clinical services, staff recharges and recharges for projects etc. from those organisations although this income is shown as other operating revenue within the Trust income and expenditure position.

Income source	Apr-22 £k	May-22 £k	Jun-22 £k	Jul-22 £k	Aug-22 £k	Sep-22 £k	Oct-22 £k	Nov-22 £k	Dec-22 £k	Jan-23 £k	Feb-23 £k	Mar-23 £k	Total £k	Total 21/22 £k
NHS Commissioners	17,501	18,083	17,285	17,878	18,049	18,024	18,016	18,016	18,016	18,016	18,016	18,016	**214,918**	**199,439**
ICS / System / Covid	854	854	854	854	854	854	854	854	854	854	854	854	**10,243**	**15,258**
Specialist Commissioner	242	324	320	325	319	317	317	317	317	317	317	317	**3,750**	**45,733**
Local Authority	433	454	484	427	429	450	450	450	450	450	450	450	**5,381**	**5,172**
Partnerships	422	422	395	413	345	399	399	399	399	399	399	399	**4,791**	**7,580**
Top Up / ERF	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**287**
Other Contract Income	124	(0)	555	246	258	1,000	228	228	228	228	228	228	**3,552**	**708**
Total	**19,576**	**20,136**	**19,893**	**20,143**	**20,254**	**21,045**	**20,265**	**20,265**	**20,265**	**20,265**	**20,265**	**20,265**	**242,635**	**274,176**
21/22	20,679	20,725	20,039	20,358	21,057	22,784	24,206	24,485	24,831	24,657	23,559	26,796	**274,176**	



In line with national guidance the income position shown reflects contracts agreed excluding the impact of the additional Agenda For Change and Consultant pay award which is to be actioned in September (with arrears to April 2022). This matches the treatment of pay expenditure.

Budgets and actuals will be updated next month to reflect this.

Initial estimates show a £2m pressure as a result of this although this will be validated through the process of making actual payments.

To date no variance to contract has been reported. Risks, such as CQUIN, are being assessed.

2.2 Pay Information

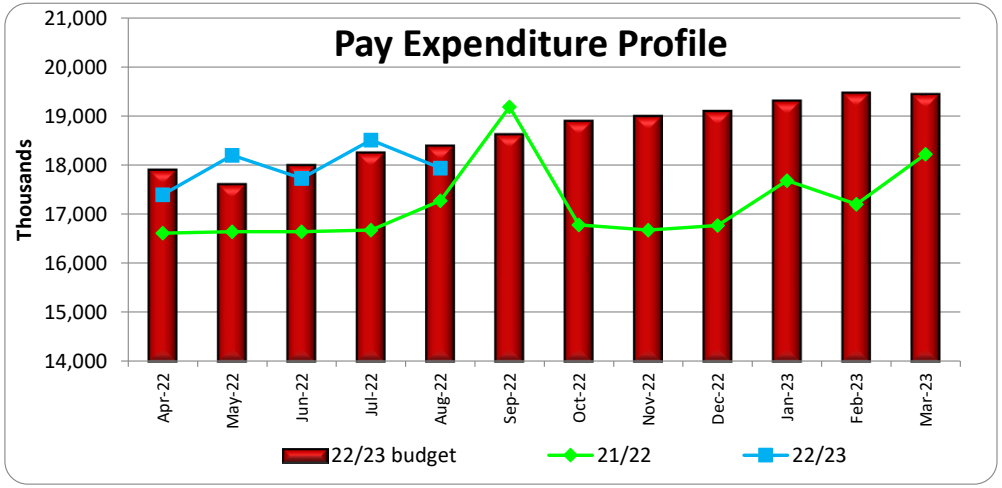
Our workforce is our greatest asset and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for in excess of 85% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). Trust priorities include a focus on the health and wellbeing of this workforce.

Current expenditure patterns highlight the usage of temporary staff (through either internal sources such as Trust bank or through external agencies). Actions are focussed on providing the most cost effective workforce solution to meet the service needs.

Staff type	Apr-22 £k	May-22 £k	Jun-22 £k	Jul-22 £k	Aug-22 £k	Sep-22 £k	Oct-22 £k	Nov-22 £k	Dec-22 £k	Jan-23 £k	Feb-23 £k	Mar-23 £k	Total £k
Substantive	15,672	16,136	16,033	16,399	16,217								**80,457**
Bank & Locum	986	1,145	985	1,161	1,004								**5,280**
Agency	740	920	711	950	716								**4,037**
Total	**17,397**	**18,201**	**17,728**	**18,510**	**17,937**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**89,774**
21/22	16,610	16,641	16,637	16,675	17,273	19,187	16,781	16,674	16,769	17,684	17,199	18,220	**206,351**

Bank as % (in month)	5.7%	6.3%	5.6%	6.3%	5.6%								5.9%
Agency as % (in month)	4.3%	5.1%	4.0%	5.1%	4.0%								4.5%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,130	4,109	4,129	4,148	4,162								**4,136**
Bank & Locum	251	294	252	307	259								**273**
Agency	148	141	149	142	137								**143**
Total	**4,530**	**4,545**	**4,530**	**4,597**	**4,559**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4,552**
20/21	4,461	4,455	4,396	4,447	4,494	4,494	4,489	4,450	4,482	4,559	4,532	4,591	**4,488**



For the first 5 months of the year pay expenditure has seen some variation each month with spend in August being lower than the previous month but in line with the average.

This position includes the original estimated 2% Agenda For Change pay award in line with national guidance and funding. This will be updated in September 2022 when actual payments are made in line with the revised pay scales. This will be backdated to 1st April 2022 so there will be a spike in next month.

WTE worked by substantive staff has increased in month. It is 32 WTE more than reported in April 2022 and 88 WTE more than August 2021. This information is triangulated with our workforce information. The WTE worked for bank, locum and agency staff has continued to fluctuate each month depending on service

2.2 Agency Expenditure Focus

Agency spend is £716k in August.
Year to date spend is £4,037k.

Agency costs have a continued focus for the NHS nationally and for the Trust. As such separate analysis of agency trends is presented below. The Trust has also included an additional key performance indicator for 2022 / 23 linked to agency as a proportion of the overall workforce.

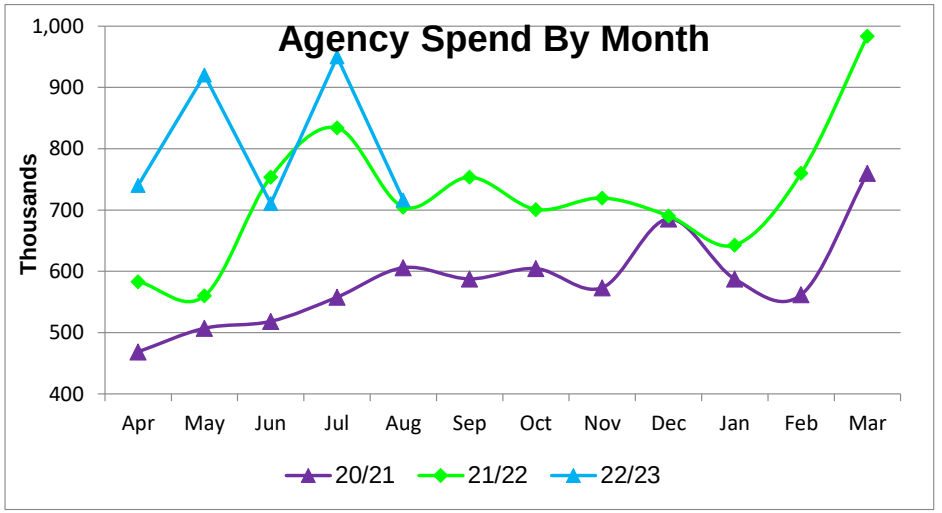
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible use of resources and providing a cost effective strategy.

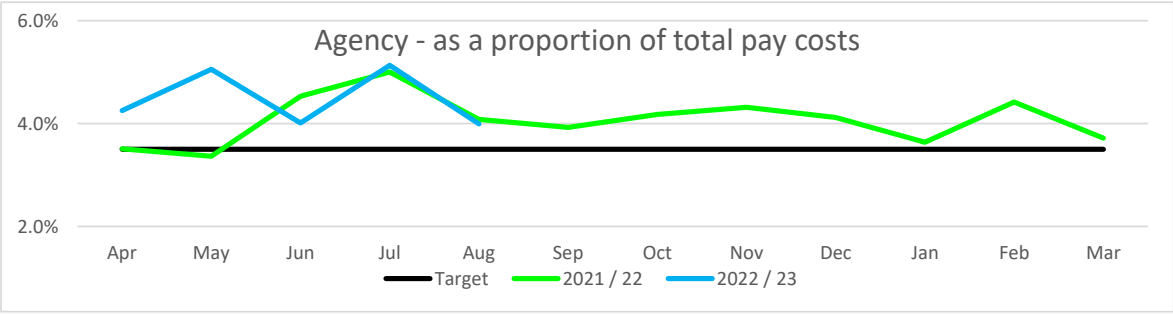
Under the NHS Single Oversight Framework, expected maximum agency levels have been set at an Integrated Care Board (ICB) level for 2022 / 23. Within this overall limit an allocation of £7.8m has been set for the Trust. Current forecasts are that this will be exceeded by c. £1.3m and therefore action plans to support delivery of this system target are required.

The Trust is already focussed on this as part of the wider workforce strategy as it's often seen as the last resort and the least cost effective but in some cases is the only viable option for ensuring continuity of safe services.

The main areas of expenditure remain supporting inpatient wards with both registered and unregistered nursing support utilised. To date these staffing groups accounts for £2m of spend whilst medical staffing represents a further £1.3m.

In addition to the £7.8m target focus has returned to non clinical agency usage. To date the Trust has spent £118k on admin and clerical staff in order to support service delivery.





From 1st April 2022 a new key performance indicator has been included within the Trust Integrated Performance Report that highlights the proportion of total Trust pay costs which are agency.

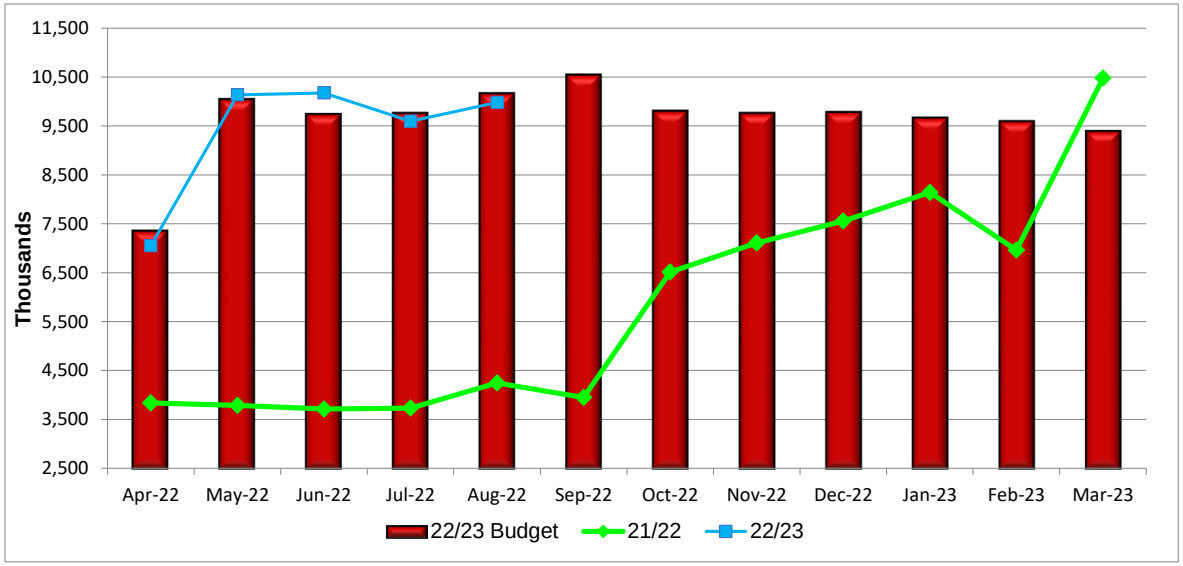
A revised cumulative target, based on the £7.8m target, of 3.5% has been set and monthly performance is shown on the left. Performance in August 2022 was 4.0% with cumulative year to date position of 4.5%.

2.3 Non Pay Expenditure

Whilst pay expenditure is the majority of all Trust expenditure, non pay expenditure also presents a number of key financial challenges. This analysis focuses on non pay expenditure within the BDUs and corporate services, and excludes capital charges (depreciation and PDC) which are shown separately in the Trust Income and Expenditure position.

Non pay spend	Apr-22 £k	May-22 £k	Jun-22 £k	Jul-22 £k	Aug-22 £k	Sep-22 £k	Oct-22 £k	Nov-22 £k	Dec-22 £k	Jan-23 £k	Feb-23 £k	Mar-23 £k	Total £k
2022/23	7,052	10,139	10,175	9,595	9,979								**46,940**
2021/22	3,834	3,783	3,712	3,729	4,246	3,949	6,512	7,107	7,556	8,140	6,961	10,478	**70,008**

Non Pay Category	Budget Year to date £k	Actual Year to date £k	Variance £k
Drugs	1,277	1,191	(86)
Establishment	3,887	4,568	680
Lease & Property Rental	3,074	3,050	(24)
Premises (inc. rates)	2,284	2,475	190
Utilities	930	848	(82)
Purchase of Healthcare	4,471	3,831	(640)
Lead Provider Collaborative	25,136	24,977	(159)
Travel & vehicles	1,806	1,816	10
Supplies & Services	2,549	2,631	82
Training & Education	1,126	700	(426)
Clinical Negligence & Insurance	429	424	(5)
Other non pay	114	430	316
Total	**47,084**	**46,940**	**(144)**
Total Excl OOA and Drugs	**41,336**	**41,918**	**583**



Key Messages

As per previous updates the major influence on Trust non-pay expenditure over the past year has been the implementation of the Adult Secure Collaboratives. For West Yorkshire this was in October 2021 and South Yorkshire has gone live from 1st May 2022. Budgets, and actual expenditure reflect this increase.

The impact of inflationary price increases continues to be the biggest variable pressure on non pay expenditure. In particular this is in utilities, food costs and travel (fuel) costs. The latter includes temporary mileage rate increases agreed by the Trust to support employees financially whilst they deliver Trust services. For utilities expenditure is £0.4m higher than the same period last year. This is a 73% increase with similar usage. Financial risks remain if unit prices continue to increase.

Operational pressures continue with high demand for services. Sustained high usage of out of area placements has been offset slightly in the purchase of healthcare category with savings in other areas such as radiology and pathology services. A separate breakdown is shown on page 10.

Drugs expenditure is less than planned. The impact of the Trust electronic prescribing system is being assessed with any cost savings to be recorded as against the Trust financial sustainability target. This target is currently coded to other non pay and explains the negative budget in this presentation.

Training and education costs are also behind plan for the year to date. This is forecast to increase in the next couple of months. The impact on services, with additional staff out of work whilst training, continues to be managed.

2.3 Out of Area Beds Expenditure Focus

The heading of purchase of healthcare within the non pay analysis includes a number of different services; both the purchase of services from other NHS trusts or organisations for services which we do not provide (mental health locked rehab, pathology tests) or to provide additional capacity for services which we do. From October 2021 this also includes the West Yorkshire Adult Secure Provider Collaborative and South Yorkshire Adult Secure Provider Collaborative from 1st May 2022.

Due to it's volatile, and potentially expensive nature, the non-pay focus has been on out of area bed expenditure. In this context this refers to spend incurred in order to provide clinical care to adult acute and PICU service users in non-Trust facilities. The reasons for taking this course of action can often be varied but some key reasons are highlighted below.

- Specialist health care requirements of the service user not available directly from the Trust or not specifically commissioned.
- No current bed capacity to provide appropriate care.

On such occasions a clinical decision is made that the best possible care option is to utilise non-Trust resources. Wherever possible service users are placed within the Trust geographical footprint.

This analysis is for the out of area placements relating to adult acute beds including PICU in all areas. This excludes activity relating to locked rehab in Barnsley or the purchase of other healthcare services.

Out of Area Expenditure Trend (£)

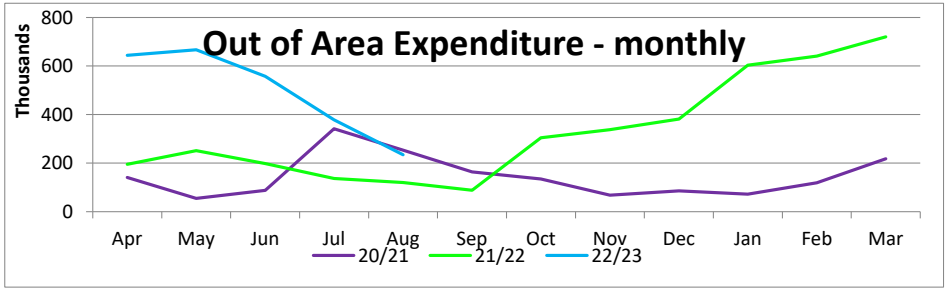
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
20/21	141	55	88	342	253	164	135	68	86	73	119	218	**1,741**
21/22	195	251	199	137	121	88	305	337	382	604	641	720	**3,981**
22/23	644	667	557	378	235								**2,482**

Bed Day Trend Information

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
20/21	110	54	120	305	147	76	111	105	148	124	100	126	**1,526**
21/22	221	313	316	223	261	409	422	460	555	653	498	690	**5,021**
22/23	484	512	587	479	355								**2,417**

Bed Day Information 2022 / 2023 (by category)

PICU	427	417	446	379	247								**1,916**
Acute	57	95	141	100	108								**501**
Total	484	512	587	479	355	0	0	0	0	0	0	0	**2,417**



The graph on the left highlights the reducing trend in out of area placement expenditure over the last 4 months. This is a positive reflection on appropriate actions taken by the operational teams and that ward capacity has not been as significantly impacted as January - April 2022. Covid-19, however, does continue to have an impact which is minimised as much as possible.

In August the usage of PICU beds has reduced again and Acute beds has remained broadly the same.

3.0 Statement of Financial Position (SOFP) 2022 / 23

Balance Sheet / Statement of Financial Position (SOFP)	2021 / 2022 £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	107,352	160,878	1
Current Assets			
Inventories & Work in Progress	189	189	
NHS Trade Receivables (Debtors)	973	392	4
Non NHS Trade Receivables (Debtors)	921	1,775	4
Prepayments	2,174	4,796	2
Accrued Income	816	3,969	3
Asset held of Sale	1,500	1,500	
Cash and Cash Equivalents	81,368	86,090	Pg 13
Total Current Assets	**87,941**	**98,712**	
Current Liabilities			
Trade Payables (Creditors)	(39,400)	(48,827)	5
Capital Payables (Creditors)	(1,790)	(782)	
Deferred Income	(6,480)	(3,907)	
Other Liabilities (IFRS 16 / leases)		(52,055)	1
Total Current Liabilities	**(47,670)**	**(105,571)**	
Net Current Assets/Liabilities	**40,271**	**(6,859)**	
Total Assets less Current Liabilities	**147,623**	**154,019**	
Provisions for Liabilities	(7,716)	(7,273)	
Total Net Assets/(Liabilities)	**139,907**	**146,746**	
Taxpayers' Equity			
Public Dividend Capital	45,624	45,624	
Revaluation Reserve	13,156	13,156	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	75,907	82,746	6
Total Taxpayers' Equity	**139,907**	**146,746**	

The Balance Sheet analysis compares the current month end position to that at 31st March 2022.

1. There has been a stepped change in the value of Trust assets from 1st April 2022 with the value of Trust leases (as per IFRS 16) now included. This is offset, in part, by the other liabilities line now added to this presentation.

2. Prepayment are higher than March 2022. This is usual and will reduce over the course of the year.

3. Accrued income is higher than planned. A number of purchase orders (Locala £1.1m, lead provider recharges £1.0m) have been chased to allow invoices to be issued.

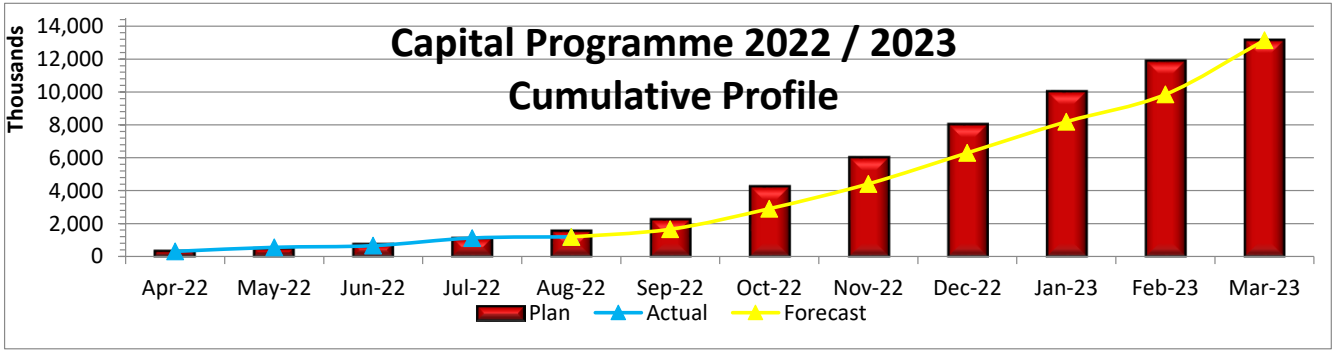
4. Overall debtors remain low and are proactively managed. This will increase as invoices are raised for the issues outlined above. To date only £84k is older than 30 days.

5. Creditors are also higher than expected although the Trust continue to pay 95% of valid invoices within 30 days.

6. This reserve represents year to date surplus plus reserves brought forward.

3.1 Capital Programme 2022 / 2023

Capital schemes	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k
Major Capital Schemes						
Bretton Centre	7,500	493	413	(80)	5,200	(2,300)
OPS transformation	500	200	0	(200)	667	167
Maintenance (Minor) Capital						
Clinical Improvement	745	136	2	(134)	735	(11)
Safety inc. ligature & IPC	1,065	210	12	(198)	944	(121)
Compliance	700	55	0	(55)	1,400	700
Backlog maintenance	350	0	0	0	350	0
Sustainability	350	0	0	0	350	0
Plant & Equipment	550	145	11	(134)	23	(527)
Other	0	0	440	440	1,032	1,032
IM & T						
Digital Infrastructure	450	0	0	0	1,509	1,059
Digital Care Records	40	16	4	(12)	67	27
Digitally Enabled Workforce	375	20	24	4	375	0
Digitally Enabling Service Users & Carers	65	0	0	0	65	0
IM&T Contingency	100	0	0	0	73	(27)
Lease Impact (IFRS 16) VAT Refunds	354	284	284	0	354	0
TOTALS	**13,144**	**1,559**	**1,190**	**(369)**	**13,144**	**(0)**



Capital Expenditure 2022 / 23

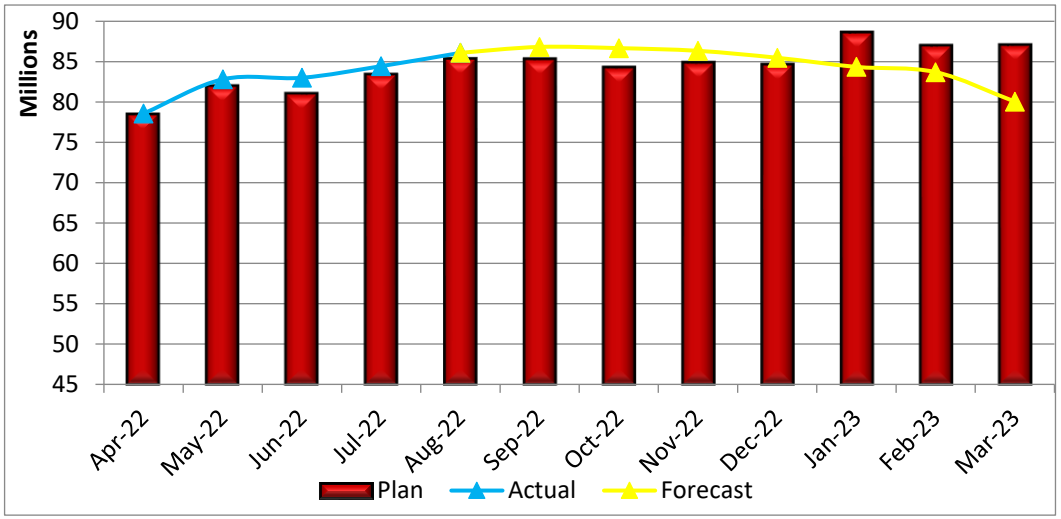
The Trust capital programme forms part of the overall West Yorkshire ICS capital plan. For 2022 / 23 the Trust component is £13.144m.

The profile of this programme increases over the next 6 month with the main drivers being the original plan for the major capital schemes.

Preparatory work on the Bretton Centre and Older Peoples schemes continue and this has resulted in variations to cost and timescales to both. These are reflected in the updated forecast. This models that the full £13.1m in year spend will be achieved.

Part of this mitigation has been bringing forward IM & T digital infrastructure works (from future years) which provides value for money and limits expected future supply chain issues in this area.

3.2 Cash Flow & Cash Flow Forecast 2022 / 2023

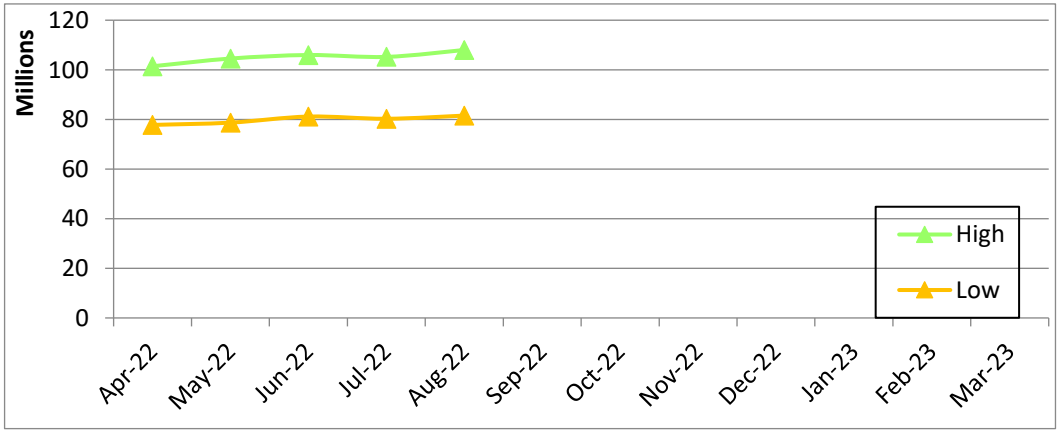


Cash remains positive.

The Trust cash position remains strong and is forecast to remain throughout the year. It is recognised that there is planned expenditure and payments that will reduce this value during 2022 / 23.

Risks will be identified as part of future reporting as and when they arise.

	Plan £k	Actual £k	Variance £k
Opening Balance	76,454	81,368	
Closing Balance	85,320	86,090	770



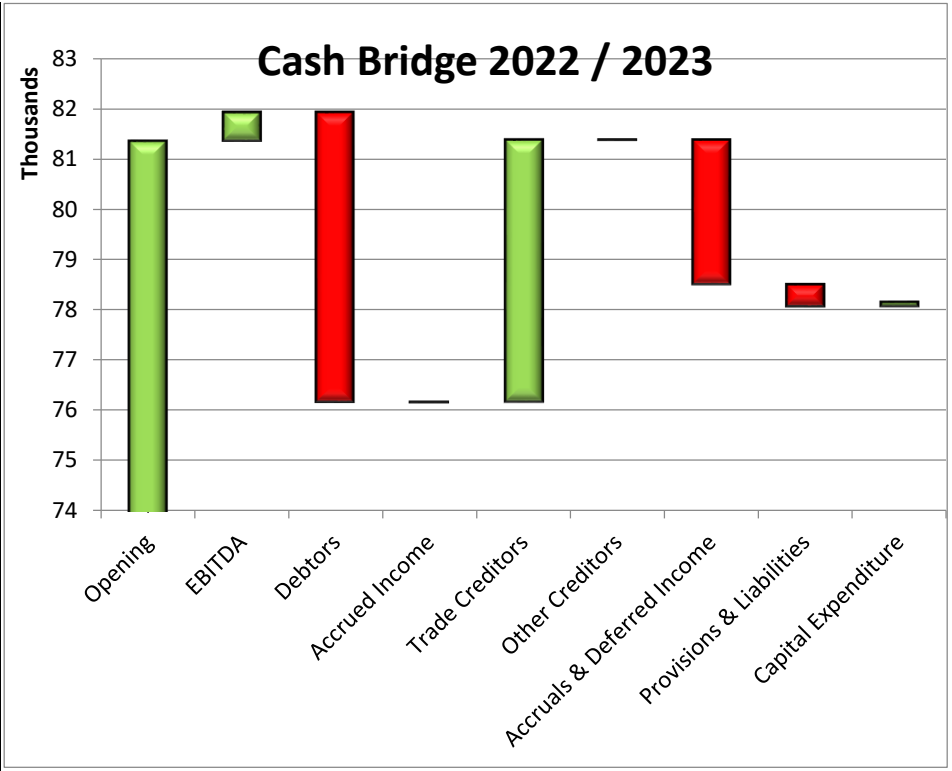
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £108m
The lowest balance is: £81.6m

This reflects cash balances built up from historical surpluses.

3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**76,454**	**81,368**	4,914	
Surplus / Deficit (Exc. non-cash items & revaluation)	9,645	10,217	571	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(1,776)	(7,548)	(5,772)	
Trade Payables (Creditors)	2,300	7,523	5,223	
Other Payables (Creditors)	0		0	
Accruals & Deferred income	0	(2,876)	(2,876)	
Provisions & Liabilities	0	(443)	(443)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(1,275)	(1,190)	85	
Cash receipts from asset sales			0	
Leases	(215)	(1,271)	(1,056)	
PDC Dividends paid	0		0	
PDC Dividends received			0	
Interest (paid)/ received	185	309	124	
Closing Balances	**85,320**	**86,090**	**771**	



The table above summarises the reasons for the movement in the Trust cash position during 2022 / 2023. This is also presented graphically within the cash bridge.

The surplus / deficit movement is the Trust I & E position adjusted for depreciation which is non cash and adding back in PDC as this only generates a cash impact on a 6 monthly basis and is shown separately.

Debtors, which includes the timing of prepayments, is higher than plan. This is the current focus to maximise the cash position and the interest this will generate with higher current interest rates.

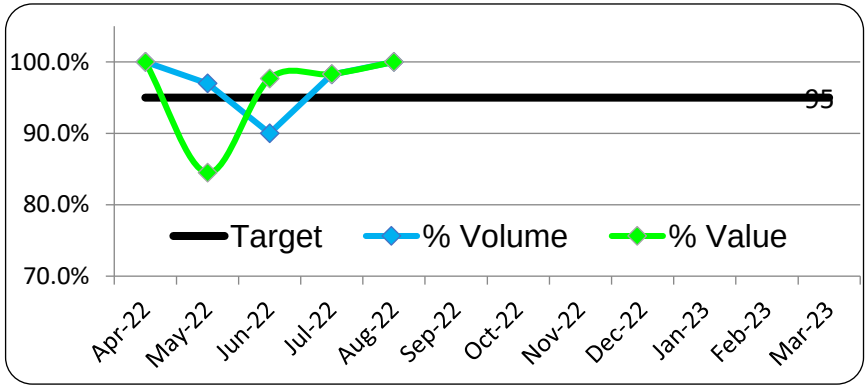
4.0 Better Payment Practice Code

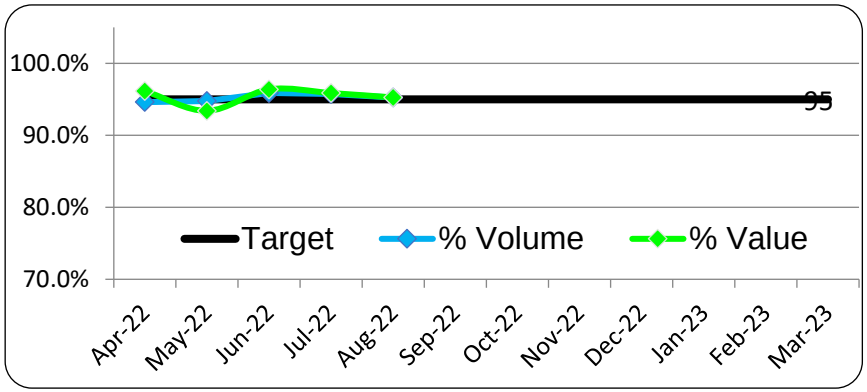
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

Performance continues to be positive although work continues to ensure that no issues remain outstanding and that systems work efficiently.

NHS	Number %	Value %
In Month	100%	100%
Cumulative Year to Date	98%	98%

Non NHS	Number %	Value %
In Month	95%	95%
Cumulative Year to Date	95%	95%





4.1 Transparency Disclosure

As part of the Government's commitment to greater transparency on how public funds are used the Trust makes a monthly Transparency Disclosure highlighting expenditure greater than £25,000 (including VAT where applicable).

This is for non-pay expenditure; however, organisations can exclude any information that would not be disclosed under a Freedom of Information request as being Commercial in Confidence or information which is personally sensitive.

At the current time NHS Improvement has not mandated that Foundation Trusts disclose this information but the Trust has decided to comply with the request.

The transparency information for the current month is shown in the table below.

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
25-Jul-22	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4462	658,037
19-Aug-22	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4493	622,947
01-Aug-22	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS24	544,330
31-Aug-22	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	202484	493,917
31-Jul-22	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 263	400,289
01-Aug-22	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510007141	340,354
31-Jul-22	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Tr	2100118427	293,365
22-Aug-22	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Tr	2100118458	293,365
02-Aug-22	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC001INV	269,313
02-Apr-22	Data Lines	Trustwide	Virgin Media Business Ltd	927686115	202,973
01-Aug-22	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSY001	185,000
19-Aug-22	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4482	178,986
25-Jul-22	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4450	170,627
27-Jul-22	Staff Recharge	Trustwide	Mid Yorkshire Hospitals NHS Trust	1600020704	168,655
27-Jul-22	Staff Recharge	Trustwide	Mid Yorkshire Hospitals NHS Trust	1600020706	168,655
27-Jul-22	Staff Recharge	Trustwide	Mid Yorkshire Hospitals NHS Trust	1600020708	168,655
27-Jul-22	Staff Recharge	Trustwide	Mid Yorkshire Hospitals NHS Trust	1600020720	168,655
17-Aug-22	Staff Recharge	Trustwide	Mid Yorkshire Hospitals NHS Trust	1600020915	168,655
01-Aug-22	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510007133	164,554
19-Aug-22	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4495	160,450
02-Aug-22	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber Mental He	0000092678	134,624
15-Jul-22	Purchase of Healthcare	AS Collaborative	Mersey Care NHS Foundation Trust	72483391	133,923
25-Jul-22	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4463	132,370
19-Aug-22	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4494	128,100
25-Jul-22	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4464	128,006
02-Aug-22	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber Mental He	0000092649	85,754
27-Jun-22	Computer Licences	Trustwide	Datix Ltd	SIN031242	84,213
27-Jul-22	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trus	321748	70,974
31-Jul-22	Drugs	Trustwide	Lloyds Pharmacy Ltd	109497	54,234
15-Jul-22	Drugs	Trustwide	NHS Business Services Authority	1000073927	41,188
30-Jun-22	Purchase of Healthcare	Forensics	Sheffield Childrens NHS Foundation Trust	2100221026	40,432
13-Jul-22	Mobile Phones	Trustwide	Vodafone Ltd	101719383	39,307
01-Aug-22	Utilities	Trustwide	Edf Energy Customers Ltd	000012844483	33,037
31-Jul-22	Purchase of Healthcare	Trustwide	Waterloo Manor Ltd	HO NHS LS 262 OBS	32,736
31-Jul-22	Purchase of Healthcare	Trustwide	Partnerships In Care Ltd	D510007142EPC	32,736
31-Jul-22	Purchase of Healthcare	Trustwide	Partnerships In Care Ltd	D510007144EPC	32,736
31-Jul-22	Purchase of Healthcare	Trustwide	Cygnet Health Care Ltd	WKE0245185	26,691
31-Jul-22	Purchase of Healthcare	Trustwide	Cygnet Health Care Ltd	BLA0244374	26,691
29-Apr-22	Purchase of Healthcare	Trustwide	Elysium Healthcare Ltd	NC001652	26,228
29-Apr-22	Purchase of Healthcare	Trustwide	Elysium Healthcare Ltd	NCO01652WY	26,228

4.2 Glossary

* Recurrent - an action or decision that has a continuing financial effect

* Non-Recurrent - an action or decision that has a one off or time limited effect

* Full Year Effect (FYE) - quantification of the effect of an action, decision, or event for a full financial year

* Part Year Effect (PYE) - quantification of the effect of an action, decision, or event for the financial year concerned. So if a CIP were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that

* 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), and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known.

* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. So are part of the Forecast Surplus, but not part of the Recurrent Underlying Surplus.

* Cost Improvement Programme (CIP) - is the identification of schemes to increase efficiency or reduce expenditure.

* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. These differ from In Year Cost Savings in that the action is identified in advance of the financial year, whereas In Year Cost Savings are a target which budget holders are expected to deliver, but where they may not have identified the actions yielding the savings in advance.

* CDEL - Capital Departmental Expenditure Limit. This refers to the amount of capital set by Her Majesty's Treasury each year which the whole of the NHS must remain within for capital expenditure.

* ICS - Integrated Care System.

* EBITDA - earnings before Interest, Tax, Depreciation and amortisation. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of it's services.

Appendix 2 - Statistical Process Control (SPC) Charts Explained

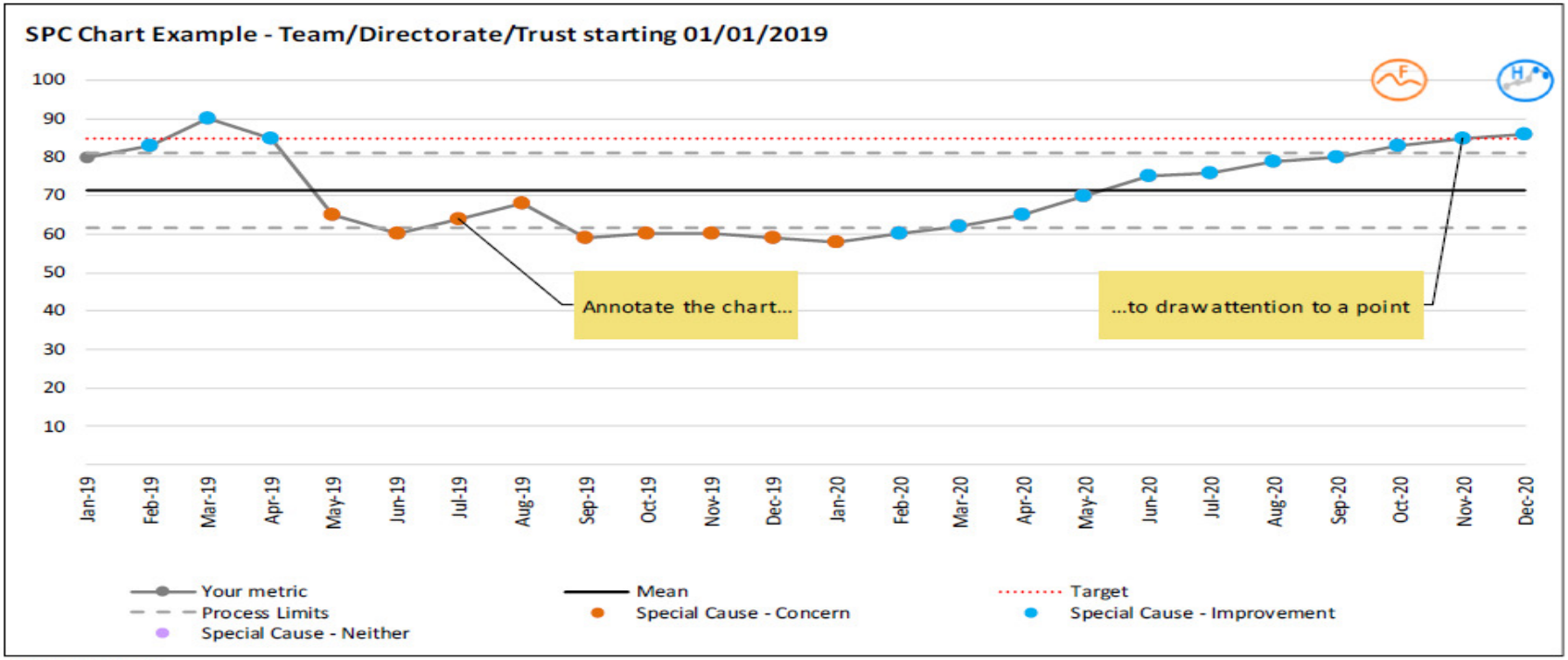
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data which are unlikely to have occurred due to chance and require investigation. They can also provide assurance on whether a target or plan will reliably be met or whether the process is incapable of meeting the target without a change.

Special Cause Variation is statistically significant patterns in data which may require investigation, including:

- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

	Variation Icons **The icon which represents the last data point on an SPC chart is displayed.**						**Assurance Icons** **If there is a target or expectation set, the icon displays on the chart based on the whole visible data range.**		
ICON									
SIMPLE ICON	● ● ●	● ? H L ●	● H ●	● L ●	● H ●	● L ●	?	F	P
DEFINITION	Common Cause Variation	Special Cause Variation where neither High nor Low is good	Special Cause Concern where Low is good	Special Cause Concern where High is good	Special Cause Improvement where High is good	Special Cause Improvement where Low is good	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass
PLAIN ENGLISH	Nothing to see here!	Something's going on!	Your aim is low numbers but you have some high numbers.	Your aim is high numbers but you have some low numbers	Your aim is high numbers and you have some.	Your aim is low numbers and you have some.	The system will randomly meet and not meet the target/expectation due to common cause variation.	The system will consistently fail to meet the target/expectation.	The system will consistently achieve the target/expectation.
ACTION REQUIRED	Consider if the level/range of variation is acceptable.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Consider whether this is acceptable and if not, you will need to change something in the system or process.	Change something in the system or process if you want to meet the target.	Understand whether this is by design (!) and consider whether the target is still appropriate, should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix 2 - Statistical Process Control (SPC) Charts Explained



Observations

Based on the data from latest calculation date (data point 1 - 01/01/19).

Single Point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control.There are 6 points above the UCL and 7 points below the LCL.
Trend	When there is a run of 6 increasing or decreasing sequential points this may indicate a sigificant change in the process. This process is not in control.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control.

Glossary

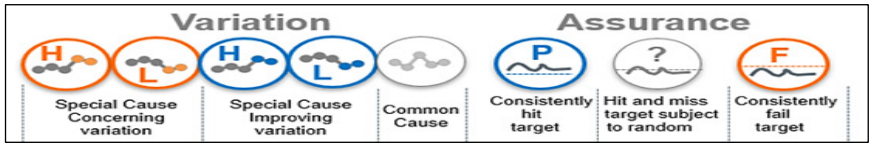
ACP	Advanced clinical practitioner
ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DoV	Deed of Variation
DoC	Duty of Candour
DQ	Data Quality
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FOT	Forecast Outturn
FT	Foundation Trust
FYFV	Five Year Forward View

HEE	Health Education England
HONOS	Health of the Nation Outcome Scales
HR	Human Resources
HSJ	Health Service Journal
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
IBCF	Improved Better Care Fund
ICD10	International Statistical Classification of Diseases and Related Health Problems
ICO	Information Commissioner's Office
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IPC	Infection Prevention Control
IWMS	Integrated Weight Management Service
JAPS	Joint academic psychiatric seminar
KPIs	Key Performance Indicators
LA	Local Authority
LD	Learning Disability
MARAC	Multi Agency Risk Assessment Conference
Mgt	Management
MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus Aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NHS TDA	National Health Service Trust Development Authority
NHSE	National Health Service England
NHSI	NHS Improvement

NICE	National Institute for Clinical Excellence
NK	North Kirklees
NMoC	New Models of Care
OOA	Out of Area
OPS	Older People's Services
ORCHA	Preparatory website (Organisation for the review of care and health applications) for health related applications
PbR	Payment by Results
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
SIs	Serious Incidents
S BDU	Specialist Services Business Delivery Unit
SJR	Structured Judgement Review
SK	South Kirklees
SMU	Substance Misuse Unit
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Plans
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TB	Tuberculosis
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YHAHSN	Yorkshire and Humber Academic Health Science
YTD	Year to Date

KEY for dashboard Year End Forecast Position / RAG Ratings	
1	On-target to deliver actions within agreed timeframes.
2	Off trajectory but ability/confident can deliver actions within agreed time frames.
3	Off trajectory and concerns on ability/capacity to deliver actions within agreed time frame
4	Actions/targets will not be delivered
	Action Complete

SPC Chart Icon Summary



NHSI Key - 1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures

NB: The year end forecast position for the dashboards was reviewed in October 2019 and revised to align with the NHSI rating system.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 September 2022
Agenda item 10.1

Private/Public paper:	**Public**		
Title:	**Serious Incident Quarter 1 2022/23 report**		
Paper presented by:	**Chief Nurse/Director of Quality and Professions**		
Paper prepared by:	Patient Safety Specialist/Associate Director of Nursing, Quality and Professions		
Purpose:	This report provides information in relation to incidents in Quarter 1 and more detailed information in relation to serious incidents. It also provides assurance that learning from healthcare deaths arrangements is in place. The report provides cumulative data for 2022/23 deaths. The learning from healthcare deaths section of this report will be published on the Trust website.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources		
	Make this a great place to work	✓	
BAF Risk(s):	2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents. 2.3 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care.		
Any background papers / previously considered by:	This report has been reviewed in Clinical Governance and Clinical Safety Committee (CGCSC). Previous version of this report, along with Annual Incident reports and Our Learning Journey reports, have also been reviewed in CGCSC and in Trust Board. CGCSC has also received papers in relation to Learning from Healthcare Deaths Policy requirements. Detailed Quarterly reports have been shared with the Care Groups. Data is also available at service line/team level via Datix. All managers have access to Datix dashboards to interrogate data further.		
Executive summary:	• The number of pressure ulcer incidents increased in Quarter 1. There was also a pressure ulcer incident reported as a serious incident in Q1. Reasons for the increase include warmer weather creating moisture associated skin damage and pressure damage and affecting intake of nutrition and hydration, plus promotion of reporting through training sessions on pressure ulcers by the Tissue Viability Team impacting on reporting due to greater awareness. • Serious Incidents reported included four apparent suicides of community patients under our care (across two localities), one pressure ulcer where a lapse in care had been identified and an information governance incident (theft of documentation from Trust vehicle). Investigations are underway or complete for all cases. • The actions from incidents are managed at Care Group level. The patient safety support team produces information on completion of action plans		

	from serious incidents and these are monitored through the Operational Management Group. Work is underway to build on our good practice in areas to develop a standardised approach across the care groups for monitoring SI action plans.
	• The Patient Safety Team now use Statistical Process Control (SPC)
	  ○ methodology within Datix to analyse incident data at a range of levels. Areas identified are pressure ulcers within Barnsley general community services, as commented above.
	• In Quarter 1, we saw 3,299 incidents reported which is within normal variation. We continue to see a high proportion of incidents (96%) with no or low harm or where they were external incidents, demonstrating a continued positive culture of risk management. Six incidents were reported as Serious incidents (0.18% of all incidents), which again is within normal range.
	• Our weekly clinical risk panel meeting continues to monitor all amber and red incidents, together with all incidents relating to staffing or protected characteristics, irrespective of grading.
	• All reviews, irrespective of level, will seek to identify learning.
	• In quarter 1, seven Serious Incident investigations were completed which identified 44 actions for improvement to address contributory factors. Of the actions, 29 arose from two SIs, both being complex cases with actions spanning a range of themes.
	• Record keeping remains one of the top themes we see arising from SI investigations. The learning will be incorporated into the Risk Assessment and Care planning improvement group.
	
	Learning from healthcare deaths
	• The Learning from healthcare deaths report provides figures on the number of deaths reported, reviewed and the review processes undertaken. Each case will undergo one of the National Quality Board scrutiny levels:
	  ○ Death Certification
	  ○ Case record review, including Structured Judgment Record Reviews. The managers 48-hour review on Datix is also classed as a first stage case record review.
	  ○ Investigation – that could be service level, serious incident reported on STEIS or other review.eg., Learning Disability Mortality Review (LeDeR), safeguarding.
	Risk appetite
	• Risk identified – the Trust continues to have a good governance system of reporting and investigating incidents including serious incidents and of reporting, analysing and investigating healthcare deaths.
	• This report covers assurance for compliance risk for health and safety legislation and compliance with CQC standards for incident reporting. This meets the risk appetite – low and the risk target 1-6.
	• The clinical risk – risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-6.
	• Financial or commercial risks - Reputational risks, negative impact on perceptions of service users, staff, commissioners. Risk appetite Cautious/Moderate 4-6.

Recommendation:	**The Trust Board is asked to RECEIVE and NOTE the report.**

South West Yorkshire Partnership NHS Foundation Trust

Trust wide Incident Management Report

Quarter 1 2022/23

Incorporating Learning from Healthcare Deaths reporting for the period 1 April 2022 to 30 June 2022

Report prepared by Patient Safety Support Team

July 2022

Contents

Executive Summary 3

1. Introduction 5

2. Incident Reporting Analysis 5

3. Trust wide Serious Incident (SI) Report 11

4. Learning from Healthcare Deaths Report 25

Appendix 1 Learning Disabilities Mortality Review (LeDeR) Update – August 2022 32

Appendix 2 - All incidents reported Trust wide between 01/07/2021 – 30/06/2022 by severity SPC charts 36

Appendix 3 – Learning Library summaries Quarter 1 2022/23 37

Executive Summary

This report provides information in relation to incidents reported in Quarter 1 2022/23 and more detailed information in relation to serious incidents. A brief analysis of actions arising from completed Serious Incident investigations submitted to commissioners for the period of 01/04/2022 to 30/06/2022 is included. The report also includes the Trust's report on Learning from Healthcare Deaths to provide assurance that arrangements are in place and to provide cumulative data for the period 01/04/2022 to 30/06/2022. The Learning from Healthcare Deaths report will be available separately on the Trust website.

This report does not cover the work of the BDUs in terms of implementing the learning; this will be available separately.

At the time of writing this report, the change from BDU to care group was not implemented, therefore care groups are referred to BDU's throughout the report. Datix has not yet been updated and reflects data by BDU not care group.

Quarter 1 2022/23 Headlines

- **3299** incidents reported
- Reporting remains similar level, within normal variation
- **96%** of incidents remain **low/no harm**
- 6 Serious incidents reported
- Serious incidents account for 0.18% of all incidents
- No homicides
- No Never Events
- High reporting rate with high proportion of low/no harm is indicative of a positive safety culture

- This report is produced by the patient safety support team and shows the data for incidents. Detailed Quarterly reports have been produced and shared with each Business Delivery Unit. Data is also available at service line level. All managers have access to Datix dashboards to interrogate data further.
- This report has overall figures for incident reporting. Q1 had 3299 incidents: higher than the previous quarter (3138) but within normal variation.
- 96% of incidents are graded as "low" or "no harm" showing a positive culture of risk management (the more low/no harm incidents reported means action is taken proactively at an early stage before harm occurs).
- "Violence and Aggression" continues to be the highest reported incident type (30%) (978 of all incidents reported in the quarter, similar percentage to the previous quarter).

- "Physical aggression/threat (no physical contact): by patient" 346 incidents (10%) remain as the most reported category, consistent with the previous quarter.
- There have been no 'Never Events' reported in the Trust during Q1 2022/23 with the last Never Event reported being in 2010/11.
- The total number of serious incidents reported through Strategic Executive Information System (StEIS) in Quarter 1 was 6; an increase on the previous quarter (Q4 21/22 – 1). The type of serious incidents reported this quarter has included:
    - Death (including suspected suicide) (4)
    - Pressure ulcer – category 3 (1)
    - Information governance incidents (1)
- Of the 4 deaths reported in Quarter 1 there were:
    - 4 apparent suicides (4 under current community team care)
- All incidents that are graded red or amber are extracted from Datix for inclusion in a report that is reviewed at the weekly clinical risk panel.
- All reported deaths are reviewed in line with the learning from healthcare deaths policy.
- 7 serious incident investigations have been submitted to the Commissioner during the quarter and 3 previously submitted serious incidents have been closed by Commissioners.
- The actions from incidents are managed at Business Delivery Unit level. The patient safety support team produces information on completion of action plans from serious incidents and these are monitored through the operational management group.
- During the Covid-19 pandemic period and to present, the 60 working days timescale has been suspended by NHS England and Improvement. However, we have continued to aim to work towards 60 working days where possible. We have met this timescale three times since 01/04/2022, but not in Q1 2022/23, due to new members of staff commencing in the team who have required additional support during the investigation and review stages, the desire from all the investigators to actively engage with family, which has led to new lines of enquiry and additional extensions in completion time.

Learning from healthcare deaths

- The Learning from healthcare deaths report provides figures on the number of deaths reported, reviewed and the review processes.
- The Learning from healthcare deaths policy guides staff with how to report deaths.
- The Trust has adopted the three levels of scrutiny suggested in the National Quality Board guidance:
    - Death Certification
    - Case record review, including Structured Judgment Record Reviews. The managers 48-hour review on Datix is also classed as a first stage case record review.
    - Investigation – that could be service level, serious incident reported on STEIS or other review e.g., Learning Disability Mortality Review (LeDeR), safeguarding.
- Total number of deaths reported on Datix by staff between 01/04/2022 – 30/06/2022 (by reported date, not date of death) = 96, all of which have been reviewed.
- Total in scope as described in report = 67

1. Introduction

This report has been prepared by the Patient Safety Support Team to bring together Trust wide information on incident activity during Quarter 1 2022/23 (01/04/2022 to 30/06/2022) including reported serious incidents and Learning from Healthcare Deaths.

Please note that figures within this report may vary from the individual Business Delivery Unit reports due to re-coding/grading changes of incidents whilst producing the reports from a live system. We have improved our methods of centralised data extraction for reports.

2. Incident Reporting Analysis

This report has overall figures for incident reporting. Quarter 1 (01/04/2022 to 30/06/2022) had 3299 incidents which is higher than the levels in the last quarter (01/01/2022 to 31/03/2022 - Quarter 4) 3138 although this is within normal variation.

96% of all incidents reported on Datix are classed as “low” or “no harm”. This shows a positive culture of risk management, low or no harm incidents reported mean action taken proactively at an early stage before harm occurs).

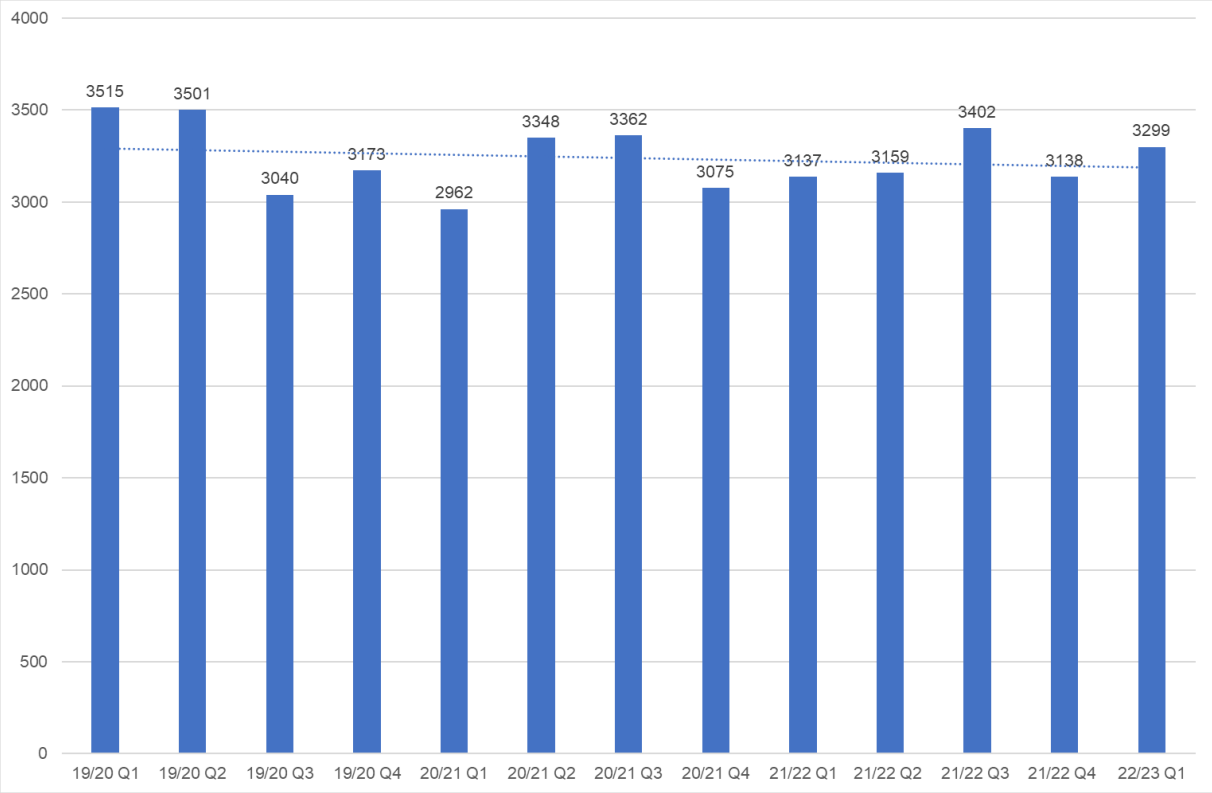
Headlines

Quarter 1 2022/23 Headlines

- **3299** incidents reported
- **Reporting remains similar level, within normal variation**
- **96%** of incidents remain **no/low harm**
- High reporting rate with high proportion of no/ low harm is indicative of a positive safety culture

Figure 1 below shows the pattern and number of incidents reported by quarter in the Trust from Q1 2019/20 to Q1 2022/23, revealing a slight downward trend, however the rate fluctuates as would be expected with the nature of incident reporting. With the Trust changing profile of services, direct comparisons should be viewed with caution as any change in service offer does not provide a like for like comparison.

Figure 1 Comparative number of incidents reported by financial quarter Q1 2019/20 to Q1 2022/23



Severity

Incidents that occur within the Trust will have different levels of impact and severity of outcome. The Trust grades incidents in two ways.

The degree of harm is used by all Trusts to grade the actual level of harm to ensure consistency of recording nationally. When staff report incidents, they will complete the degree of harm to rate the actual harm caused by the incident. Where this is not yet known, they will rate this as what they expect the harm level to be. It will be reviewed and updated at a later point. This differs from the incident severity (green, yellow, amber, red), which is how we grade incidents locally in the Trust. Incident severity considers actual and potential harm caused and the likelihood of reoccurrence (based on the Trust's risk grading matrix).

In Figure 2 there have been 21 red incidents reported in Quarter 1 2022/23 (as at 04/07/2022). This data is live data at the point of producing the report. The incident may be initially graded red for several reasons. An example would be a death (for healthcare deaths we encourage staff to report on Datix) which later is updated as natural causes or where the individual has not been involved with Trust services for over six months so this may be re-graded and not reported on STEIS, it can take some time to get this information. Not all red incidents meet the criteria for a serious incident (see section 6).

Figure 2 All incidents reported Trust wide between 01/07/2021 – 30/06/2022 by severity and financial quarter

	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23
Green	2087	2331	2093	2230
Yellow	931	911	881	866
Amber	120	143	148	181
Red	21	17	16	22
Total	3159	3402	3138	3299

Please see appendix 1 for the breakdown of all incidents reported Trust wide between 01/07/2021 – 30/6/2022 by severity SPC charts.

Figure 3 shows the severity breakdown for Q1 by BDU.

Figure 3 All incidents reported Trust wide between 1/04/2022 - 30/06/2022 by severity and BDU

BDU By Severity	Green	Yellow	Amber	Red	Total
Mental Health Inpatient Services	842	437	50	0	1329
Forensic Service	493	186	30	0	709
Barnsley General Community Services	455	78	77	2	612
Learning Disability services	145	54	4	0	203
Kirklees Community Mental Health Services	75	20	6	5	106
Barnsley Community Mental Health Services	46	24	5	6	81
Wakefield Community Mental Health Services	57	15	3	4	79
Calderdale Community Mental Health Services	36	24	4	5	69
CAMHS Specialist Services	38	17	1	0	56
Trust wide (Corporate support services)	39	10	1	0	50
ADHD and Autism services	4	1	0	0	5
Total	2230	866	181	22	3299

Type and Category of incidents

Figure 4 shows the overarching type of incidents reported in the Trust. All incidents are coded using a three-tier method to enable detailed analysis. Type is the broadest grouping, with type breaking into categories, and then onwards into subcategories. This report provides details of the number for type (Figure 4) and the top ten categories in the quarter (Figure 5).

Figure 4 Type of incident reported in Quarter 1 by BDU

	ADHD and Autism services	Barnsley Community Mental Health Services	Barnsley General Community Services	Calderdale Community Mental Health Services	CAMHS Specialist Services	Forensic Service	Kirklees Community Mental Health Services	Learning Disability services	Mental Health Inpatient Services	Trust wide (Corporate support services)	Wakefield Community Mental Health Services	Total
Violence and Aggression	1	5	15	4	10	367	15	123	423	6	9	**978**
Care Pathway, Clinical and Pressure Ulcer Incidents	0	12	432	7	3	3	3	2	51	0	3	**516**
Self-Harm	0	5	13	13	3	40	6	21	219	0	15	**335**
Medication	1	10	55	10	2	51	25	2	128	8	5	**297**
Health and Safety (including fire)	1	4	18	3	0	32	1	19	95	11	2	**186**
All Other Incidents	0	3	6	0	9	48	5	5	73	7	5	**161**
Slips, Trips and Falls	0	2	18	5	0	11	1	1	94	1	0	**133**
Safeguarding Adults	0	10	20	5	0	17	10	11	27	3	7	**110**
Security Breaches	1	0	4	0	4	69	1	2	15	7	2	**105**
Legislation and Policy	0	1	2	2	0	22	2	1	70	0	0	**100**
Death (including suspected suicide)	0	17	4	13	0	0	19	8	6	0	21	**88**
Missing/absent service users	0	0	0	0	0	9	0	0	67	0	0	**76**
Safeguarding Children	0	8	4	1	16	5	11	0	2	0	5	**52**
Sexual Safety incident	0	0	2	1	0	17	1	2	24	0	0	**47**
Information Governance Incidents	0	3	7	4	7	3	4	5	4	5	1	**43**
IT Related Issues	1	1	9	1	2	3	2	1	13	1	3	**37**
Infection Prevention/Control	0	0	3	0	0	12	0	0	18	1	1	**35**
Total	**5**	**81**	**612**	**69**	**56**	**709**	**106**	**203**	**1329**	**50**	**79**	**3299**

Figure 5 Trust-wide Top 10 most frequently reported incident categories (01/07/2021 – 30/06/2022)

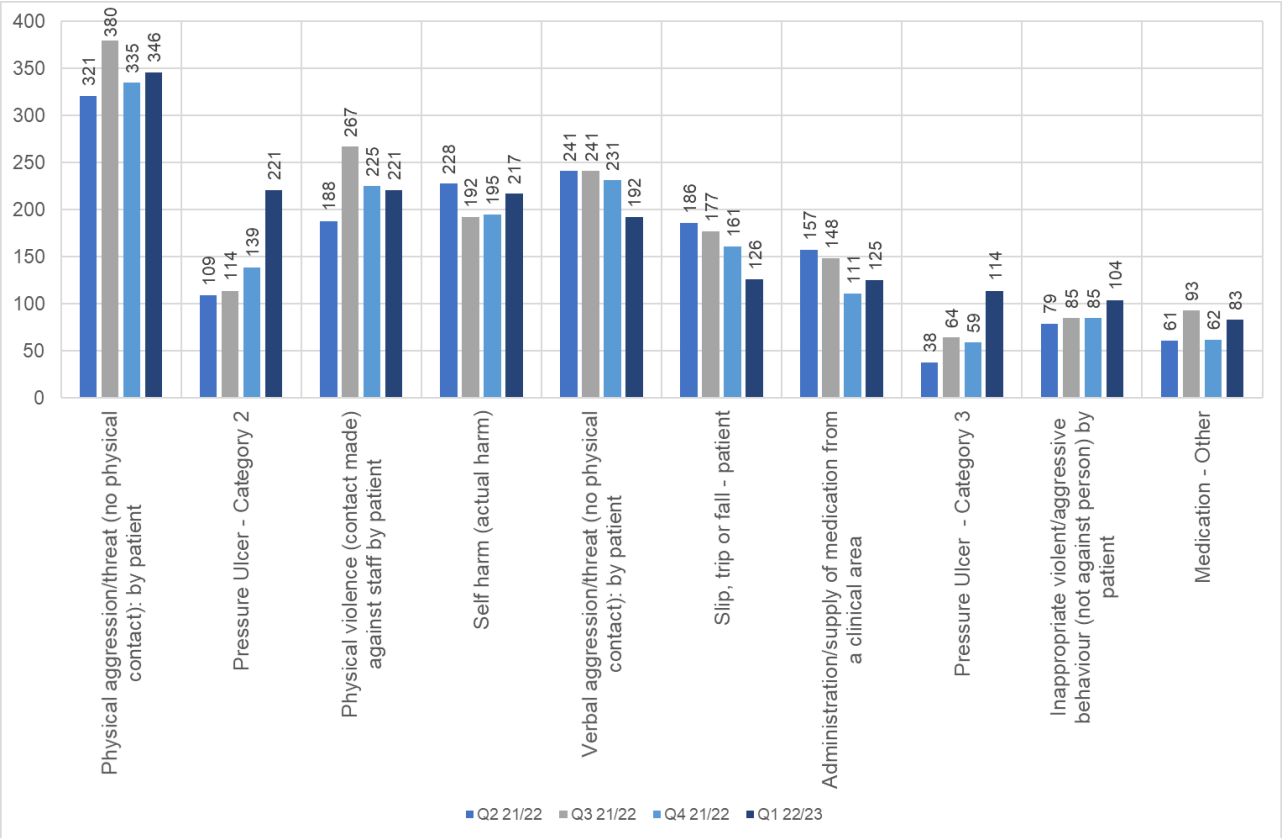


Figure 5 shows that in Quarter 1 2022/23 physical aggression/threat (no physical contact) by patient was the highest reported category of incident. Figures for previous quarters are included for comparison and this has been the top category for several quarters.

Although the Category 2 Pressure ulcer appears in the top 10, it should be noted that these are incidents that are generally identified by staff in the community, and many are attributable to other agencies. The Datix system is used to capture the identification and actions taken by our staff.

Reporting to National Reporting and Learning System

The Trust uploads patient safety incidents[1] (which are a subset of all incidents reported) from Datix to the National Reporting and Learning System (NRLS) on a weekly basis and has done so since 2004. All Patient Safety Incidents go through an internal management review and governance processes before being uploaded to NRLS. Data can also be refreshed if details change.

Local information on Datix is mapped to the national system in the background. The National Reporting and Learning System shares patient safety incidents with the Care Quality Commission (CQC). The CQC may then contact the Trust to enquire further about specific incidents.

Patient Safety Incidents do not include non-clinical incidents, or where staff were the affected party (e.g., violence against staff incidents). These are not reportable to NRLS as the

[1] A patient safety incident is defined as any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

harm/potential harm was not to a patient. The NRLS scores the **actual** degree of harm caused, as opposed to including potential harm as collected locally via Severity.

NHS England has developed a new system called Learn from Patient Safety Events (LFPSE) which will replace NRLS and the Strategic Executive Information System (StEIS) functions (for reporting serious incidents). It is expected that Trusts will go live with reporting by the end of March 2023. Transition work will include an update to Datix to enable this feature and will require work in the background and training for staff. We are awaiting further information in relation to LFPSE so that we can produce a plan with timescales for work to be completed such as the updates to Datix and training of staff.

In Quarter 1 2022/23, 1482 incidents were reported to the National Reporting and Learning System (as at 07/07/2022).

Learning from incidents

Learning Library

We have continued to use the #allofusimprove Learning library (our repository of information from a range of sources of learning from experience). Access further details here http://nww.swyt.nhs.uk/learning-from-experiences/Pages/Learning-library.aspx

The latest content has been added to the shared network folder -K:\#allofusimprove and the intranet page

Content added to the Learning Library in Quarter 1 is as below (please see Appendix 2 for further details of the SBAR's).

SBAR Parental consent to vaccination.docx

SBAR Learning from SI CAMHS 2021.9570

SBAR Learning from SI CAMHS 2021.3858

SBAR National review The Myth of Invisible Men

SBAR Ockenden report.docx

Greenlight alerts

Greenlight alerts have been created to provide a way to share important information and learning related to medication safety.

Greenlight alerts are available on the intranet

Bluelight Alerts

Bluelight alerts have been created to provide a way to share urgent learning quickly across the Trust.

There were no Bluelight alerts circulated in Quarter 1, however, previous alerts are available on the intranet and below:

If staff have urgent safety or learning information that needs to be shared across the Trust urgently, they should discuss the information with managers to firstly to agree if a Bluelight is the appropriate route for circulation, then follow the process on the intranet http://nww.swyt.nhs.uk/learning-from-experiences/Pages/Bluelight-alerts.aspx

We continued to use **human factors** techniques in analysing incidents and serious incidents. Information on online training is available here. http://nww.swyt.nhs.uk/incident-reporting/Pages/Human-factors-patient-safety-training.aspx

Learning from Serious Incidents

Section 7 is the Serious Incident report. Further information on this is available in the incident management annual report.

Learning from Healthcare Deaths

Section 8 of this report contains our report on learning from healthcare deaths.

Incident reports

Previous quarterly and annual reports on incidents and learning are available on the Patient Safety intranet pages.

3. Trust wide Serious Incident (SI) Report[2]

Background context

Serious incidents are defined by NHS England as:

> "…events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare." [3]

[2] Please note the SI figures given in different reports can vary slightly. This report is based on the date the SIs were reported to the CCG via the Department of Health Strategic Executive Information system (StEIS).

[3] NHS England. Serious Incident Framework. March 2015

There is no definitive list of events/incidents. However, there is a definition in the Serious Incident Framework which sets out the circumstances in which a serious incident must be declared considering the above:

Serious incidents are incidents requiring investigation and are defined as an incident that occurred in relation to NHS funded services and care resulting in one of the following:

- the unexpected or avoidable death of one or more patients, staff, visitors, or members of the public
- serious harm to one or more patients, staff, visitors, or members of the public or where outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm)
- a scenario that prevents, or threatens to prevent, a provider organisation's ability to continue to deliver health care services, for example, actual or potential loss of personal/organisational information, damage to property, reputation, or the environment. IT failure or incidents in population programmes like screening and immunisation where harm potentially may extend to a larger population
- allegations of abuse
- adverse media coverage or public concern for the organisation or the wider NHS
- one of the core sets of *Never Events*[4].

Further information on reporting of SIs is available on the intranet.

National Update

The NHS Patient Safety Strategy[5] was published in July 2019. This sets out how the NHS will build on two foundations: a **patient safety culture** and a **patient safety system**. Three strategic aims will support the development of both:

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information (**Insight**)
- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**Involvement**)
- designing and supporting programmes that deliver effective and sustainable change in the most important areas (**Improvement**).

There are two major changes arising from the NHS Patient Safety Strategy relating directly to Incident reporting and management. Both projects have been delayed during Covid 19 but are imminent. These are:

- New Learning from Patient Safety Events (LFPSE) – this will be a new section of Datix incident reporting system and will replace NRLS and StEIS systems. It is expected that Trusts will go live with reporting by the end of March 2023.
- New Patient Safety Incident Response Framework (PSIRF) - will replace the Serious Incident Framework. The final documentation is expected in August 2022 and from September 2022 will begin a 12-month transition period before going live in Autumn 2023.

Investigations

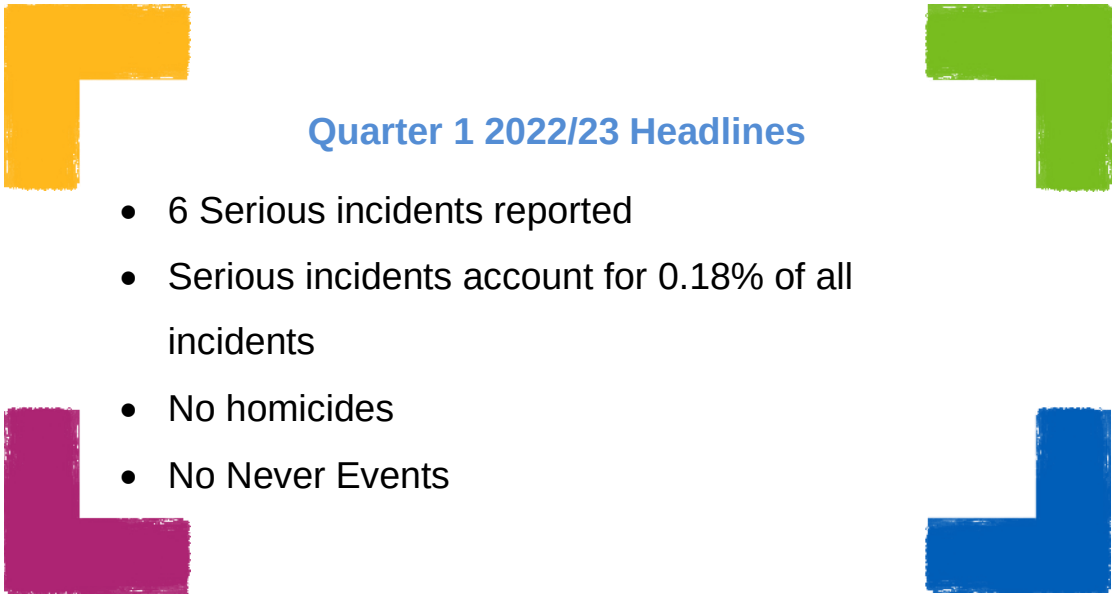
Investigations are initiated for all serious incidents in the Trust to identify any systems failure or other learning, using the principles of systems analysis. The Trust also undertakes a range of reviews to identify any themes or underlying reasons for any peaks. Most serious incidents

[4] NHS Improvement. Never Event policy and framework 2018
[5] https://improvement.nhs.uk/resources/patient-safety-strategy/

are graded amber or red on the Trust's severity grading matrix, although not all amber/red incidents are classed as serious incidents and reported on the Strategic Executive Information System (StEIS). Some incidents are reported, investigated and later de-logged from StEIS following additional information. Conversely, some incidents are reported as serious incidents on StEIS after local investigation such as where significant care and service delivery issues are identified.

Headlines

During Quarter 1 2022/23, there were **6 serious incidents reported** to the relevant Clinical Commissioning Group (CCG) or commissioning body via the NHS England Strategic Executive Information System (StEIS).



Never Events[6] are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were **no 'never event'** incidents reported by SWYPFT in Quarter 1 2022/23. The last Never Event reported by the Trust was in 2010/11. A revised list of Never Events came into effect on 01/02/2018. This is available on the Trust intranet.

Serious Incident Reporting Analysis

During Quarter 1 2022/23 there have been 6 serious incidents reported on StEIS, as shown in Figure 6 by financial quarter, with comparative data for previous financial years.

Figure 6 Serious incidents (StEIS) reported to the Commissioner by financial year and quarter up to 30/06/2022 (2018/19 – 2022/23)

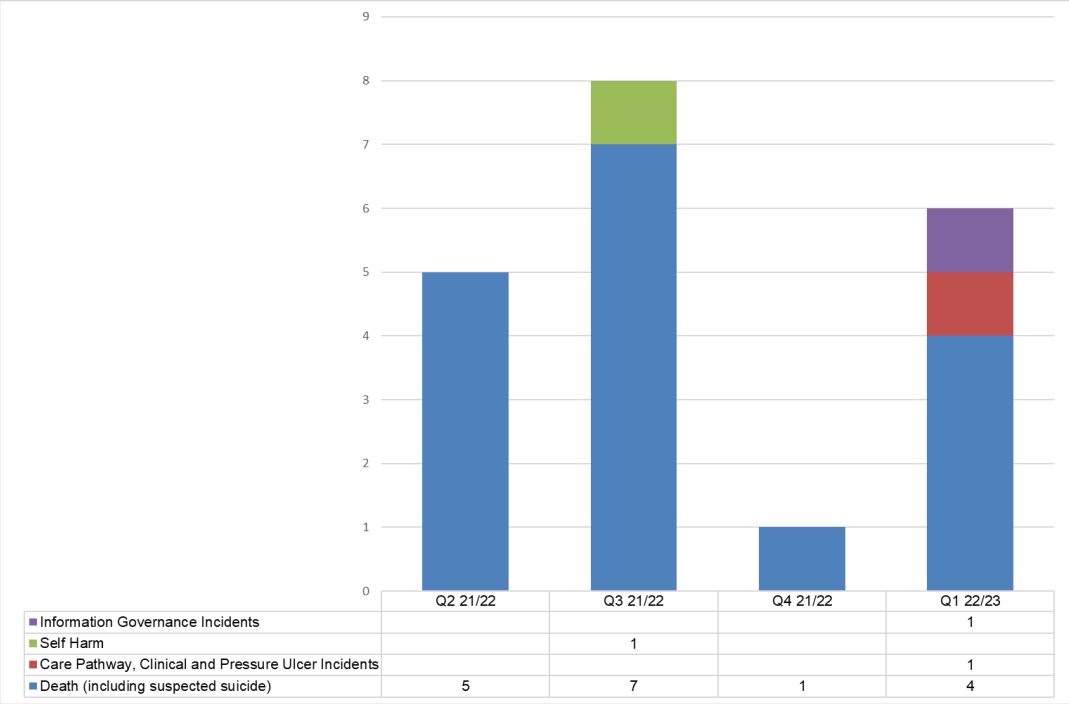
Financial Quarter	18/19	19/20	20/21	21/22	22/23
Quarter 1	8	12	8	8	6
Quarter 2	9	12	11	5	0
Quarter 3	10	8	8	8	0
Quarter 4	17	15	6	1	0
Total	44	47	33	22	6

Figure 7 shows a breakdown of the 20 serious incidents in a rolling 12-month period (01/07/2021-30/06/2022) by the type of incident and the month reported. The number of SIs

[6] NHS Improvement. Never Event policy and framework 2018

reported in any given period can vary and given the relatively small numbers involved and the broad definition of an SI, it can be difficult to identify and understand the reasons for this. However, it is important that any underlying trends or concerns are identified through analysis.

Figure 7 Types of All Serious incidents reported on STEIS in the 12-month period (01/07/2021 – 30/06/2022)



All serious incidents are subject to a manager's review within 48 hours of reporting. This is to enable any themes/trends /issues to be identified early and as close to services as possible. Figures 8 and 9 show the SI's reported in the quarter (9) by the team, type, BDU and incident category.

Figure 8 Serious incidents reported by team and BDU during Q1 2022/23

	Calderdale Community Mental Health Services	Kirklees Community Mental Health Services	Barnsley General Community Services	Trust wide (Corporate support services)	Total
Intensive Home-Based Treatment Team (Kirklees)	0	2	0	0	2
Estates and Facilities Team	0	0	0	1	1
Enhanced Calder Valley Team - Calderdale	1	0	0	0	1
Assessment and Intensive Home-Based Treatment Team / Crisis Team - Calderdale	1	0	0	0	1
Neighbourhood Team - Northeast (Barnsley)	0	0	1	0	1
Total	**2**	**2**	**1**	**1**	**6**

Figure 9 Serious incidents reported by category and BDU during Q1 2022/23

	Calderdale Community Mental Health Services	Kirklees Community Mental Health Services	Barnsley General Community Services	Trust wide (Corporate support services)	Total
Suicide (incl. apparent) - community team care - current episode	2	2	0	0	4
Lost or stolen paperwork	0	0	0	1	1
Pressure Ulcer - Category 3	0	0	1	0	1
Total	**2**	**2**	**1**	**1**	**6**

Serious Incident Investigations completed during Quarter 1 2022/23

This section of the report focusses on the serious incident investigation reports that were completed and submitted to the relevant commissioner during Quarter 1 2022/23. Please note this is not the same data as those reported in this period as investigations take several months to complete. The term 'completed' is used in this section to describe this.

Headlines

- **7** SI Investigation reports have been completed
- **3** SI investigations closed by the Commissioners
- **14** SI investigations remained under investigation (as at 08/08/2022)
- From the completed investigations, the top action themes were:
  1 Care pathway
  2 Care delivery
  3 Record keeping

The Trust works to the national guidance on serious incident reporting and management (Serious Incident Framework 2015, NHS England). This includes timescales for completion of investigations within 60 working days. While the Trust tries to achieve this, it has the support of commissioners to complete a quality report above a timely report. The Trust requests extensions from commissioners where required to agree revised dates and the investigators also keep families informed. Examples of reason for extensions may include complexity of the investigation, family questions, sign off of reports and development of action plans.

During the Covid 19 period, NHS England suspended the 60 working day timeframe, and this remains the case at the time of reporting (07/07/2022). All investigations have continued to progress, and new serious incidents have been allocated to lead investigators, demonstrated in the 7 investigations that have been completed during Q1 and sent to commissioners. Meetings, interviews, and family contacts take place through initial telephone / letter contact and meetings are either virtual or face to face depending on preference of those involved.

Of the 14 investigations that are underway (as at 08/08/2022), these are at different stages of progress. This is reported weekly into Clinical Risk Panel. Progress on serious incident investigations is monitored at the weekly investigator meeting.

Staff support

There are a range of support mechanisms in place to support staff involved in or affected by serious incidents. The service has the responsibility to provide support, this is explored through the investigation process and any unmet needs are shared with the service.

Further developments

Our staff support arrangements will be reviewed as part of our preparations for the Patient Safety Incident Response Framework that will go live in Autumn 2023. We are currently reviewing the documentation.

360 Assurance Internal Audit

During 2022, 360 Assurance undertook an internal audit of our serious incident action planning processes. The Trust received Significant Assurance. The audit resulted in three actions:

1.1 The Trust to review the arrangements in each BDU for overseeing SI action plan completion and introduce a more standardised approach across the BDUs.	We are in the process of developing a procedural document in consultation with BDU/care group colleagues. This will support both actions
2.1 The Trust to ensure that mechanisms are in place for it to be assured and be able to evidence that SI action plans are supported by appropriate and robust evidence of actions being fully addressed.	
3.1 The Trust to risk assess all overdue SI actions and develop a plan to ensure these are completed.	Work is underway, and has already included strengthening our reporting into Operational Management Group

Serious Incident learning and themes

During Quarter 1 2022/23, the number of investigations completed and sent to the commissioners was 7. There were 44 separate actions made to improve the system or process to prevent recurrence.

This excludes a standard recommendation to share learning. This is to support learning being shared across the teams, service, BDU, Trust and wider health economy. These recommendations have been removed from the analysis below.

Categorisation of recommendations/actions

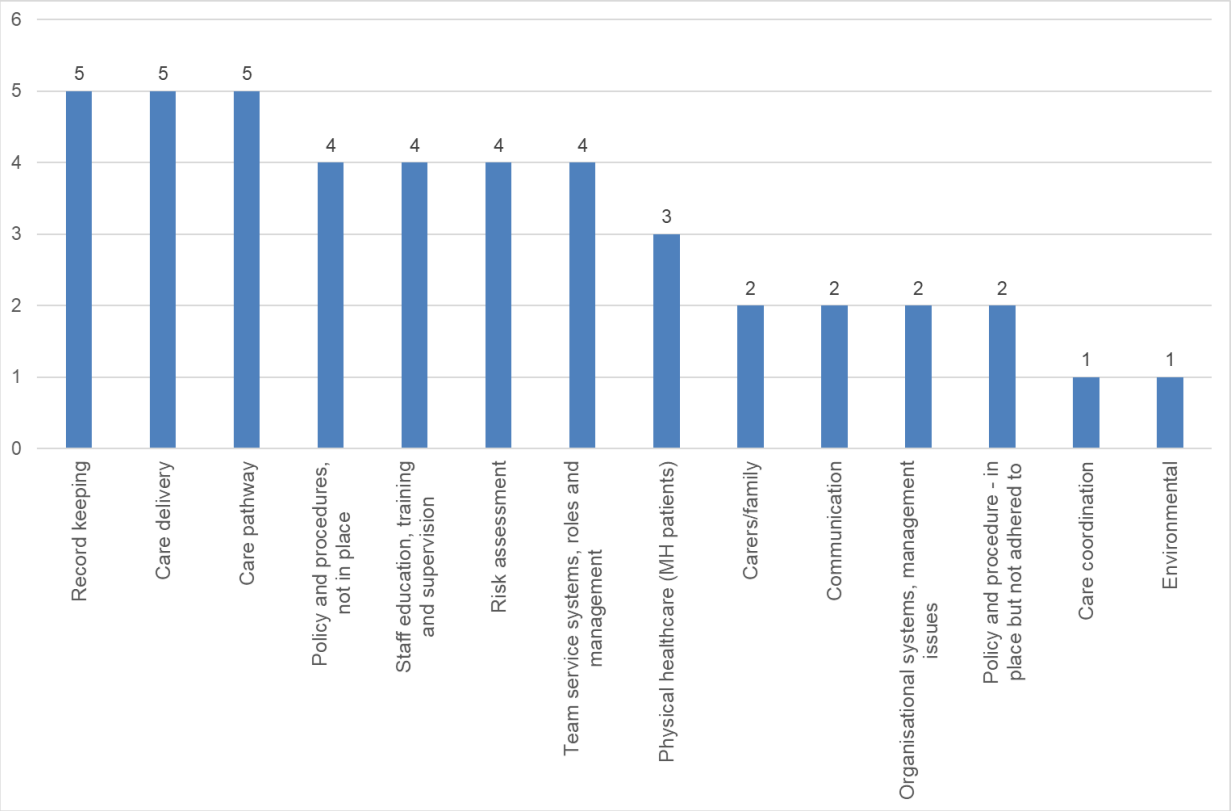
In analysing the actions, it is not always straightforward to identify which theme an action should be included in - some do not easily fit into any theme, and some could be included under more than one. The analysis undertaken has included each action under the issue/theme that seemed the best match. To gain consistency, the theming of actions is undertaken by the Lead Serious Incident Investigators.

Many actions take some time to implement. These are monitored through the Operational Management Group and BDU governance groups. Work to ensure monitoring and implementation of all Serious Incident action plans continues. An internal audit is currently underway to explore this further.

Some commissioners have requested sight of the evidence of completed actions.

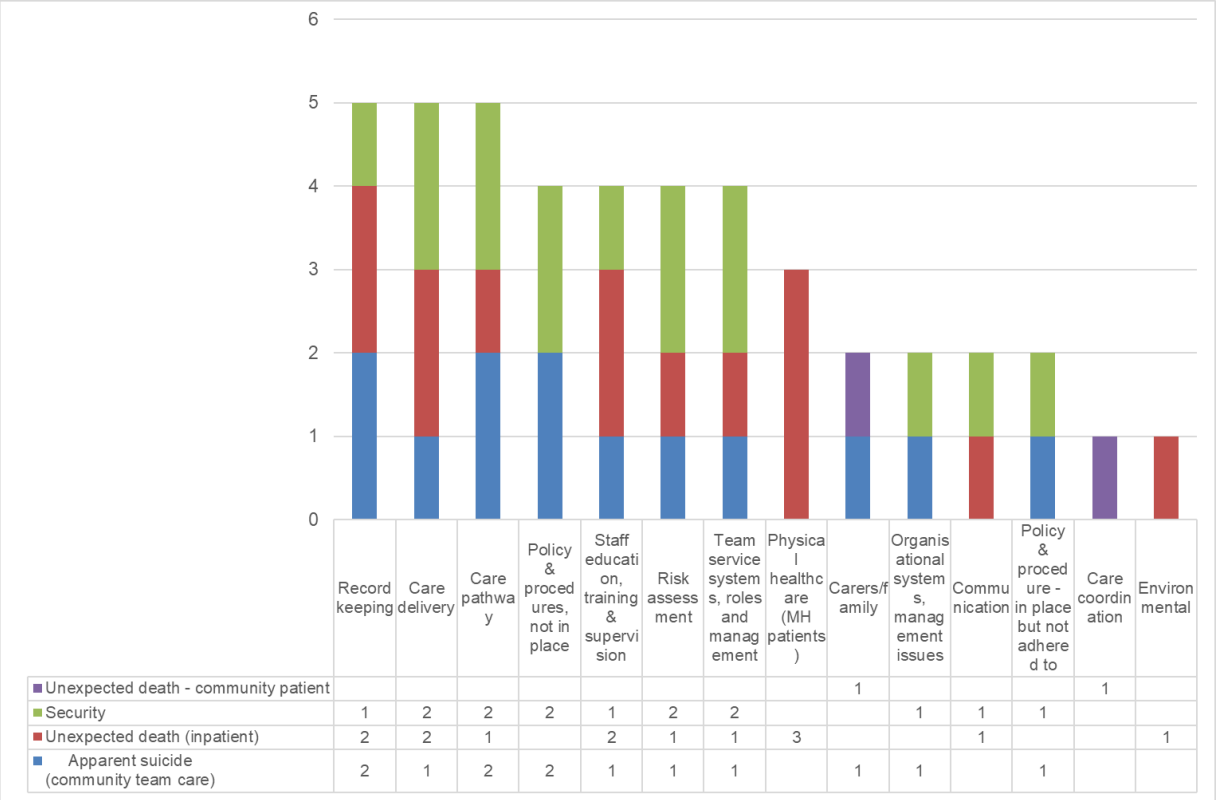
Figure 10 shows the action themes arising from the 7 serious incidents completed and sent to commissioners during Quarter 1 2022/23.

Figure 10 Quarter 1 2022/23 completed Serious Incident investigations, by action theme



As shown in Figure 11, security incidents had the largest number of actions, the actions for this incident type relate to one serious incident investigation.

Figure 11 Comparison of action themes from completed Serious Incident investigations in Quarter 1 2022/23, by action theme and serious incident type



	Record keeping	Care delivery	Care pathway	Policy & procedures, not in place	Staff education, training & supervision	Risk assessment	Team service systems, roles and management	Physical healthcare (MH patients)	Carers/family	Organisational systems, management issues	Communication	Policy & procedure - in place but not adhered to	Care coordination	Environmental
Unexpected death - community patient									1				1	
Security	1	2	2	2	1	2	2			1	1	1		
Unexpected death (inpatient)	2	2	1		2	1	1	3			1			1
Apparent suicide (community team care)	2	1	2	2	1	1	1		1	1		1		

Most of the actions from serious incident investigations apply directly to the team or BDU involved. Each BDU lead investigator works closely with the Quality and Governance Leads/Matrons and BDUs to present learning from recommendations which is included in 'Our learning journey' reports.

Top themes this quarter:
An overview of recommendation from serious incident investigations completed in Q1, are detailed below by action theme:

Care pathway

Care planning

- The ward should undertake an audit of care plans of individuals where self-harming is a patient factor to review the inclusion of the immediate care, assessment, and treatment of an individual following a self-harming incident.
- Directorate should review the care pathway and treatment options

Transitions in care

- Requests from Clinical Supervisors or Social Supervisors for out of hours input from other teams for restricted service users suspected of relapsing must not be declined. Where there is professional disagreement, this must be escalated immediately but should not prevent the necessary actions being taken in the meantime. This must be formalised in the relevant standard operating procedures.

Care Pathway

- There must be a review of the formal and informal links between general and forensic services. The review should identify:
  a) Which conditionally discharged service users must stay under the care of forensic services, which can be handed over to general services after a period of

transition and which can be safely transferred to general services on their discharge from hospital and the support available to staff in general services?

b) A clear care pathway should be established
c) Robust transfer and handover processes
d) Which staff can undertake the roles of Clinical Supervisor and Social Supervisor and the professional qualifications, level of training and experience required?
e) Training in Clinical Supervisor and Social Supervisor roles.
f) Recording of index offences in SystmOne.
g) Recording of Ministry of Justice quarterly reports on SystmOne.

Referral process

- When staff members across the Psychiatric Liaison Team or the Intensive Home-Based Treatment team identify individuals that are needing or are requesting an additional Trust service the Lead assessor must complete the referral for processing rather than rely on individuals to self-refer to Trust Single Point of Access services.

Care delivery

Care planning

- All restricted service users should have agreed specific recall thresholds and actions identified in their care and crisis and contingency plans.
- Service users with a diagnosis of substance misuse must have a care plan to address this

Other

- A task and finish group should be convened to generate improved joint-working between exercise therapy and dietetics to provide an integrated approach to weight management in secure services. An agreement should be drawn up to finalise the arrangements

MDT working and meetings

- All restricted services users in Enhanced Teams should be classified as ‘red’ irrespective of their current mental state.

Roles and Responsibilities

- Psychiatric Liaison Team practitioners should ensure that any advice they provide is based on an assessment of the service user’s clinical record and that this advice is understood by acute trust staff, particularly that of observation levels.

Record keeping

Other

- The clinical record for the date of the incident should be updated to provide a clear record of what happened by the staff involved.
- Improvements must be made to the completion of Room search documentation on Ward D so that it clearly shows whose room was searched and not just the room number
- A system should be put in place to ensure that the results from external drug analysis are recorded in SystmOne.
- The BDU should request the SystmOne team to review the accidental closure of care plans and the ability to re-open them. Consideration should be given to ensuring that care plans for community and inpatients are clearly divided to prevent accidental closure of care plans not relating to inpatient care and treatment.

Medical plan

- The service clarifies with the medical staff within the team which documentation should be completed following a consultation.

Team service systems, roles, and management

Other

- The accuracy of the information provided to the Supervision Database should be examined to ensure it accurately represents the practice of supervision on wards in Newton Lodge.

MDT working and meetings

- FACT (Flexible Assertive Community Treatment) meetings should be properly structured and recorded. The agenda should include a recorded discussion of any high-risk visits and a visit risk assessment.

Team building and Staff Development

- Further work must be undertaken to address the deep-seated problems within the Multidisciplinary Team. Responsibility for this should lie at a higher organisational level than the 'Trio' responsible for the running of the Enhanced Team and should include senior operational and medical managers.

Access to clinical information

- The service should ensure all staff who require access to the alternative clinical records of EMIS (Egton Medical Information System) are provided with guidance and support to do so.

Policy and procedures, not in place

Other

- The requirements of Ministry of Justice guidance for Clinical Supervisors and Social Supervisors must be incorporated into the relevant Trust policies and standard operating procedures including minimum monitoring requirements, identification of recall thresholds, case transfer processes and Ministry of Justice reporting.
- The Trust and the Local Authority should develop a management agreement that clearly identifies:

Operational policy

- General managers for Single Point of Access (SPA) should review the draft operational policy and procedure created for SPA services elsewhere and work towards agreement of a Trust Wide policy that helps to inform a standard for the SPA services and ensures good governance is present. This should also include clear steps for staff to take when addressing the needs of those where suicidal ideas and concerns are identified and the systems and processes in place for urgent telephone referrals.
- The SPA Standard Operating Procedure (SOP) is completed and ratified for use, as soon as possible, and shared within services and that the Core and IHBTT Standard Operating Procedures are reviewed to reflect the addition of the SPA SOP.

Staff education, training, and supervision

Other

- All Clinical Supervisors and Social Supervisors should be trained in their roles and responsibilities in line with Ministry of Justice guidance prior to taking up roles. This should include a detailed knowledge of their powers of recall and legal recall procedures.
- Review the Advanced Nurse Practitioner role and consider a shift of emphasis to supporting staff with:

- Specialist risk assessments and formulations
- Care planning for substance misuse/addition
- Liaison with specialist substance misuse services

It is also recommended that the postholder seeks to connect with regional clinical networks to share, and benefit from, best practice and treatment.

Supervision

- A plan to be put in place to address the gap between supervision policy and practice. Improvements should be made to the process of supervision with consideration given to the following:

  A) Supervision should be planned and booked in advance in a way that can be audited.
  B) The use of standard agenda items as part of supervision, for example reviewing the supervisee's:
  i. Risk assessments
  ii. Care Plans
  iii. Record keeping
  iv. Caseload
  v. Training and development needs

  Supervisors should keep a record of supervision sessions and provide a copy to the supervisee.

Operational policy

- The IHBTT practitioner is informed of the requirement and process to broker a referral for SPA, out of hours and that this process is reinforced within the wider team.

Risk assessment

Changes in risk

- The Intensive Home-Based Treatment Team needs to provide assurance that risk assessments are being updated in line with Trust policy when changes to an individual's risk are identified.

Risk assessment tools not used

- The Trust should consider the introduction of HCR-20 risk assessments for all restricted patients up to the point of absolute discharge.

Organisational systems

- The Workplace Violence Risk Assessment for Enhanced Team must be reviewed, and the controls identified must be accurate, routinely practiced, and verifiable. The Trust may want to consider reviewing other teams' workplace violence risk assessments to avoid misleading assurances.

Clinical Record Keeping - The System

- There should be a unit-wide audit of HCR-20 risk assessments to establish the extent of incomplete documentation and an action plan put in place to address the findings systematically monitored through local governance arrangements

Physical healthcare (MH patients)

Monitoring Physical Health Care

- It is recommended that a clinical audit is carried out at Newton Lodge comparing the Body Mass Index (BMI) of all current service users on admission, and at 3 months and 6 months to identify the extent of post-admission weight gain.
- The service should review "Managing a healthy weight in adult secure services – practice guidance" and "Working together to address obesity in adult mental health secure units" and put in place an action plan to implement the guidance. The action

plan should contain key measurable outcomes and be systematically monitored through local governance arrangements. The action plan should include regular clinical audits to monitor progress

- The practice of weekly physical health observations currently in place on Ward D should be replicated across the unit to facilitate the clinical audits in recommendation 4.

Communication

Other

- Service users subject to restricted discharge should have alerts on SystmOne including in primary care where the Trust will need to provide details of early warning signs and what action to take should they be detected. The nature and format of this information should be agreed in consultation with GP practices.

Communication with patient and/or family/carers

- The guidance on the use of Drug Detection Dogs contained in the Searching Patients' Property Policy should be reviewed with a view to clearly identifying the circumstances in which a search is indicated.

Carers/family

Communication with family and carers

- The notable good practice by the Psychiatric Liaison Team (PLT) Practitioner in asking the service user directly about communicating with an identified family member or significant other in safety planning should be shared across the PLT team, in keeping with the CQUIN for personalised care planning, it should also include the sharing of the guidance designed by the Zero Suicide Alliance and the Department of health on sharing information to promote positive best practice.

Lack of involvement of family in discharge planning

- Quality leads from the CKWI BDU senior leadership team to evaluate the workstreams undertaken as part of the safer discharge from hospital project to identify agreed actions and improvements; and in addition, consider any additional interventions required to promote family involvement/engagement in ward rounds/pre-discharge planning meetings, and from this evaluation and consideration to provide a summary report of insights to be shared with acute and community front-line colleagues.

Policy and procedure - in place but not adhered to

Other

- Safe visiting practice should be reviewed to identify:

a) Minimum safe visiting practice for each visit
b) Minimum safe visiting practice for service users subject to section 37/41 restrictions.
c) High-risk visit protocol (including when visits should not take place at the service user's home).
d) Use and monitoring of safety devices.
e) How compliance will be monitored.

- Recommendation to be shared with the appropriate person/persons for the relevant Trust policies.

Care coordination

CPA policy

- The BDU should review the Enhanced teams' knowledge of the carers charter information and review what carers and family's information are shared as a part of the team's engagement with families, carers and others and any wider training and education needs of

the team. This review should also include team insights to sharing information and education to families even when service users have requested that personal information is not shared.

Conduct a snap-shot audit on a random selection on case notes of no less than two service users per care co-ordinator to provide assurances that Care Programme Approach principles are evidence, updated and supported by care plans and updated risk assessments.

Provide assurance that the Enhanced team dashboard and/or present support/supervision systems are in place to assist staff recall and task completion of clinical records in keeping with best practice and operational policy and procedure

Organisational systems, management issues

Risk Assessment and Management

- The Psychiatric Liaison Service should follow the required CQUIN improvement plan relating to the provision of biopsychosocial assessments concordant with NICE guidelines for people who have self-harmed or at risk of suicide, as measured by the identified performance indicator and use the information to help shape Team developments on the assessment and management of individuals with self-harming/self-injurious behaviours.

- The Trust must establish a system to monitor the whereabouts of all restricted service users within the service, who their Clinical Supervisors and Social Supervisors are and establish a procedure for ensuring that Ministry of Justice reports are submitted regularly and on time. The reports must be included in the SystmOne clinical record.

Environmental

Other

- The current use of Drug Detection Dogs and its role in providing a safe and therapeutic environment should be reviewed.

Learning and Improvement

We have developed methods of sharing actions from SI investigations with policy leads to aid changes that may be required:

- Investigators contact policy leads to raise issues and discuss when identified
- Data from all themes from actions is extracted from Datix on a 3 monthly basis as a data resource for policy leads to use through the Trust's Clinical Policy Ratification Group.
- The Patient Safety Support Team and the Quality Improvement Assurance Team to arrange a meeting to discuss an audit in 2022/2023 to understand the impact and outcome of the learning.

Top themes

There are ongoing pieces of work in the Trust to address some of the SI themes:

- Record keeping - CQC task and finish group
- Risk assessments - CQC task and finish group
- Care planning – CQC task and finish group

The Patient Safety Incident Response Framework (PSIRF) implementation by Autumn 2023 will bring the requirement to have clear improvement plans for specific areas which may include areas such as themes from SIs. The work for PSIRF will begin in September 2022

following the launch of the final documents mid-August 2022. We will have a 12-month transition process to work through before going live.

4. Learning from Healthcare Deaths Report Annual Cumulative Report 2022/23 (covering the period 1/4/2022 – 30/6/2022)

1.1. Background context

1.1.1. Introduction

Scrutiny of healthcare deaths remains high on the Government's agenda. In line with the National Quality Board report published in 2017, the Trust has had Learning from Healthcare Deaths policy which sets out how we identify, report, investigate and learn from a patient's death. The Trust has been reporting and publishing our data on our website since October 2017.

Most people will be in receipt of care from the NHS at the time of their death and experience excellent care from the NHS for the weeks, months and years leading up to their death. However, for some people, their experience is different, and they receive poor quality care for several reasons including system failure.

The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. Therefore, it is important that organisations widen the scope of deaths which are reviewed to maximise learning.

The Confidential Inquiry into premature deaths of people with learning disabilities showed a very similar picture in terms of early deaths.

The Trust worked collaboratively with other providers in the North of England to develop our approach. The Trust will review/investigate reportable deaths in line with the policy. We aim to work with families/carers of patients who have died as they offer an invaluable source of insight to learn lessons and improve services.

The Trust has a representative from the Patient Safety Support Team who attends the Regional Mortality Meeting which are held quarterly. This meeting facilitates the dissemination of good practice around learning from deaths with sharing of processes that other trusts have in place to review deaths and improve care.

1.1.2. Scope

The Trust has systems that identify and capture the known deaths of its service users on its electronic clinical information system and on its Datix system where the death requires reporting.

The Trust Learning from Deaths policy sets out how deaths should be responded to, which deaths are reportable, how we should engage families and how reportable deaths will be reviewed. Each reported death that meets the scope criteria is reviewed in line with the three levels of scrutiny the Trust has adopted in line with the National Quality Board guidance:

In scope deaths should be reviewed using one of the 3 levels of scrutiny:		
1	Death Certification	Details of the cause of death as certified by the attending doctor.
2	Case record review	Includes: (1) Managers 48-hour review (2) Structured Judgement Review
3	Investigation	Includes: Service Level Investigation Serious Incident Investigation (reported on STEIS) Other reviews e.g., LeDeR, safeguarding.

1.1.3. Next Steps

Our work to support learning from deaths continues, and includes:

- Our work on the development of a new Family Liaison Professional post continues. A job description is being developed and will be advertised late September / early October 2022.
- Regional Mortality Meetings are being re-established hosted by the Improvement Academy to share best practice in relation to the scrutiny/review/learning from deaths
- Transition of the Mortality lead is underway from September 2022.
- We continue to review best practice and national guidance for inclusion in future iterations of the Trust's Learning from Deaths policy and being open policy alongside national developments with the Patient Safety Incident Response Framework.

1.2. Annual Cumulative Dashboard Report 2022/2023 covering the period 1/4/2022 – 30/6/2022

Figure 12 Summary of 2021/22 Annual Death reporting by financial quarter to 31/3/2022*

Reporting criteria		2021/22 total	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	2022/23 Total
1	Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death**	3473	753				**753**
2	Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	405	96				**96**
3	Total Number of deaths which were in scope	308	67				**67**
4	Total Number of deaths reported on Datix that were not in the Trust's scope	97	29				**29**

*Dashboard format and content as agreed by Northern Alliance group

**Data extracted from Business Intelligence Dashboards. Data is refreshed each quarter so figures may differ from previous reports. Data changes where records may have been amended or added within live systems

As shown in Figure 1, row 2 shows that 96 deaths were reported on Datix during Q1. This is a decrease on the previous quarter. Deaths reported are mainly deaths of those who have died in the community. All reported deaths are reviewed to understand if the death meets the critieria for being in scope for mortality review using the 3 levels as described earlier.

Figure 2 below shows a Statistical Process Control chart of all reported deaths (by reported date) between 1/7/2020-30/6/2022. There was downward trend from July 2021 to October 2021 with a slight rise above the mean in November 2021. This continued to a peak in January 2022 but has since fallen.

Figure 13 Statistical Process Control Report of all deaths reported 1/7/2020 – 31/6/2022 by date reported

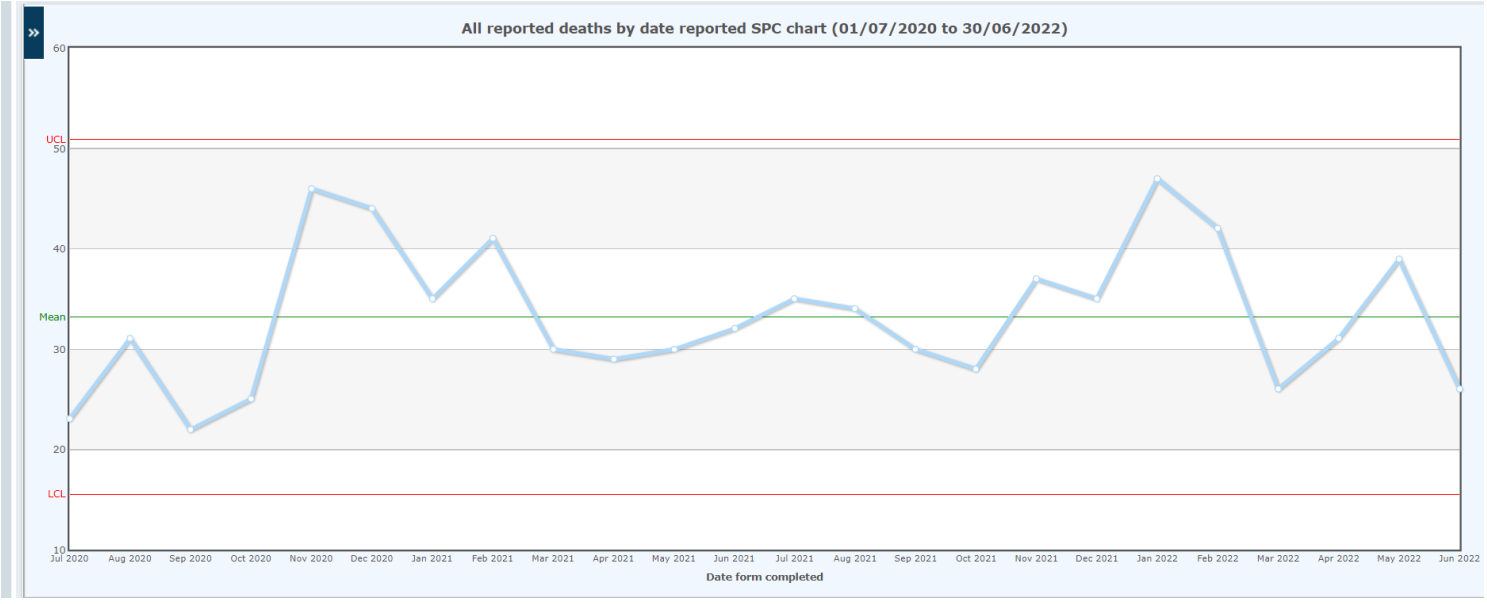


Figure 14 Breakdown of the total number of in scope deaths reviewed in 2022/23 by service area by financial quarter

Financial quarter - date reported	Barnsley General Community Services	Barnsley Community Mental Health Services	Calderdale Community Mental Health Services	Kirklees Community Mental Health Services	Wakefield Community Mental Health Services	Mental Health Inpatient Services	Forensic Services	Learning Disability services	ADHD and Autism services	Total
22/23 Q1	2	9	10	13	18	7	8	8	0	67
22/23 Q2										
22/23 Q3										
22/23 Q4										
Total	2	9	10	13	18	7	8	8	0	67

The death of any patient with a Learning Disability has to be reported to the Learning Disability Mortality Review Programme (LeDeR). It should be noted that the figures may not tally with the figures above. This is because we identify Learning Disability not just through the reporting team, but by a field on Datix to determine if any patient who died had a learning disability irrespective of where they were cared for. Figure 3 above shows there were 8 deaths reported by Learning Disability teams (all community).

Figure 15 Summary of total number of all in scope deaths in 2022/23 by the mortality review process

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review		Level 3: Investigation					Total
	Death certified	Manager's 48-hour review	Structured Judgment Review	Learning Disability Mortality Review (LeDeR)	Serious Incident Investigation	Service Level Investigation	Significant Event Analysis (SEA)	Specialist Root Cause Analysis	
22/23 Q1	11	39	6	9	2	0	0	0	67
22/23 Q2									
22/23 Q3									
22/23 Q4									
Total	**11**	**39**	**6**	9	**2**	**0**	**0**	**0**	**67**

Figure 4 above shows the total number of all in scope deaths in Q1 2022/23. The numbers of deaths in scope for Q1 (n=67) which is lower than previous quarters in 2021/22.

In line with national reporting of deaths, we are required to separate our reporting of in scope deaths into learning disability deaths and all other deaths.

Figure 5 below shows all deaths where the patient is recorded as not have a learning disability and what level of review was completed. In Q1 the majority of deaths (n=39) were reviewed by level 2 (Manager's 48 hour review) and certifcation (n=11).

Two deaths resulted in a level 3 investigation (Serious Incident investigation) at the time of reporting (8/8/22).

Figure 16 Summary of total number of in scope deaths in 2022/23 by the Review process (excluding Learning Disability deaths)

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review		Level 3: Investigation				
	Death certified	Manager's 48-hour review	Structured Judgment Review	Serious Incident Investigation	Service Level Investigation	Significant Event Analysis (SEA)	Specialist Root Cause Analysis	Total
22/23 Q1	11	39	6	2	0	0	0	**58**
22/23 Q2								
22/23 Q3								
22/23 Q4								
Total	**11**	**39**	**6**	**2**	**0**	**0**	**0**	**58**

Figure 6 below shows that the number of learning disability deaths and their status of being reported to the Learning Disability Review Programme (LeDeR).

Figure 17 Summary of total number of Learning Disability deaths in 2022/23 which were in scope

Financial quarter - date reported	Reported to LeDeR	Reported to LeDeR by another organisation	Total
22/23 Q1	9	0	**9**
22/23 Q2			
22/23 Q3			
22/23 Q4			
Total	**9**	**0**	**9**

Learning Disability Review programme (LeDeR)

The LeDeR programme summarises the lives and deaths of people with a learning disability and autistic people who died in England in annual reports. The 2021 reports were made by researchers at King's College London collaborating with academic partners at the University of Central Lancashire and Kingston-St George's University, London, copies of which can be found via the link here Learning from Lives and Deaths People with a Learning Disability and autistic people (LeDeR) (kcl.ac.uk).

A summary of the report has been prepared, see Appendix 1. A Trust action plan in response to the report is being prepared by the Learning disability service is expected to be in place by the end of September 2022. The 2021 report named our Trust's Wakefield LD team in the report. Our Wakefield LD ACE project, 'Achieving Change through Engagement', was recognised as a model of good practise. The report takes learning from LD services to promote change and improve LD services nationally.

Figure 7 below shows that over the year 2022/23 to date, there were 7 inpatient deaths reported. There were no inpatient deaths relating to Learning Disability Services.

Figure 18 Trust wide Inpatient deaths in 2021/22 by date reported

BDU	Ward	Financial quarter - date reported				Total
		Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	
Mental Health Inpatient Services	Poplars Unit, Wakefield	1				**1**
	Beechdale Ward, The Dales Unit	2				**2**
	Crofton Ward (OPS), Wakefield	2				**2**
	Willow Ward - Barnsley	1				**1**
	Ward 19 (OPS)	1				**1**
Total		**7**				**7**

Figure 8 below shows the type of deaths reported that were in scope, by each BDU. 62% (n=190) of reported deaths were confirmed as physical/natural causes at the date of reporting.

Figure 19 Type of deaths in scope 2022/23

Financial quarter - date reported	Barnsley General Community Services	Barnsley Community Mental Health Services	Calderdale Community Mental Health Services	Kirklees Community Mental Health Services	Wakefield Community Mental Health Services	Mental Health Inpatient Services	Forensic Services	Learning Disability services	ADHD and Autism Services	Total
Death - confirmed from physical/natural causes	1	4	5	7	12	5	0	7	0	41
Death - cause of death unknown/ unexplained/ awaiting confirmation	1	2	0	3	5	1	0	1	0	13
Suicide (incl. apparent) - community team care - current episode	0	2	3	3	0	0	0	0	0	8
Death - confirmed as accidental	0	0	0	0	1	1	0	0	0	2
Death - confirmed from infection	0	0	2	0	0	0	0	0	0	2

Death - confirmed related to substance misuse (drug and/or alcohol)	0	1	0	0	0	0	0	0	0	1
Total	**2**	**9**	**10**	**13**	**18**	**7**	**0**	**8**	**0**	**67**

Appendix 1 Learning Disabilities Mortality Review (LeDeR) Update – August 2022

Introduction

The Learning from Lives and Deaths - People with a Learning Disability and autistic people annual report was published in July 2022. It presents information about the deaths of people with learning disabilities aged four years and over notified to the LeDeR programme from 1st January 2021 - 31st December 2021.

From the summer of 2021 the LeDeR review underwent a significant change in the type and detail of data that was collected. Whilst focused reviews continue to be more comprehensive than initial reviews, the data collected during initial reviews after June 2021 differed in some ways to what was done previously. This has changed the amount and type of data available at different stages of data collection. Where possible comparisons have been drawn over time, important differences have been signposted in the report.

Deaths of autistic people are now included in the LeDeR programme; however, they are not included in the report because the report covers deaths from January 2021 to December 2021 and deaths of autistic people have only been reviewed since January 2022.

Key themes identified

- A total of 3,304 deaths were reported (208 children and 3,096).
- The number of initial reviews completed was 2553; plus 109 CDOP reviews for children, and the number of focused reviews completed was 139, including one review for a child.
- 56% of the recorded deaths were male.
- 6 out of 10 people living with a learning disability died before they were 65.
- 62 was the average age of death for people, compared to the general population, 82.7.
- Women died 26 years earlier; men 22 years, when compared to the general population.
- 91% were denoted as white.
- Adults with learning disabilities from Black, Asian, and Minority Ethnic (BAME) groups died younger and appear to be under-represented in notifications of deaths.
- The most reported underlying causes of death in 2021 were related to: codes for special purposes (COVID-19), diseases of the circulatory system, diseases of the respiratory system, cancers, and diseases of the nervous system. Other than COVID-19, little change in the proportion of deaths from these causes was observed between 2018 and 2021.
- In 2020 COVID-19 replaced cancer as the first leading cause of death in people with a learning disability, accounting for 22% of all deaths. The proportion of deaths due to COVID-19 decreased to 20% in 2021, although it remained the leading cause of death of those reviewed by LeDeR.
- The rate of excess deaths from COVID-19 was more than double for people with a learning disability compared to the general population.

- The percentage of respiratory deaths due to pneumonia decreased from 52% in 2018 to 21% in 2021.
- Epilepsy was the most common long-term health condition associated with an earlier age at death.
- 61% died in a hospital setting.
- People who died in a place other than their usual place of residence or hospital showed a small increase in the likelihood of dying earlier.
- There was a significant increase in the number of deaths reported during the peak periods of the COVID-19 pandemic, with a spike in deaths occurring during January 2021.
- 64% had a DNACPR decision in place
- Overall care was rated as 'good' or 'excellent' in 58% reviews of deaths in 2021.
- 7 out of 10 reviews indicated evidence of good practice.
- 9 out of 10 of reviewers indicated that the care package provided met the needs of the individual.
- Of those for whom data were available for health checks (28%), 75% had a health check in the last twelve months of their life.
- The top 5 ICD-10 categories of cause of death were, COVID-19, diseases of the
  Circulatory System, diseases of the Respiratory System, Cancers, and diseases of the Nervous System.
- 49% of deaths were rated as "avoidable" for people with a learning disability. This compares to 22% for the general population.
- 8% of avoidable deaths were linked to cancer, 14% to hypertension, 17% to diabetes
  and 17% to respiratory conditions.
- Deaths were more likely to be rated as avoidable with increasing age, peaking at the middle-aged groups before decreasing for 65+.
- Geographical regional differences in avoidable deaths were noted, with the highest rates in the Northwest (54% of deaths) and the lowest in the Southwest (42% of deaths).
- Over 50% of people with a learning disability died in areas rated as some of the most deprived in England.

Summary of Recommendation.

1. Future analysis of mortality statistics in subsequent years are required to determine whether the pandemic has had a wider and longer-term effect on mortality in people with a learning disability.
2. Research should seek to establish the barriers and facilitators associated with compliance with current Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) procedures to drive practice improvement.
3. Ways in which the reduction in deaths due to respiratory infections can be maintained should be explored.
4. Research to consider the potential impact of reducing the age of screening for bowel cancer in people with a learning disability could be useful.
5. Additional focused reviews over subsequent years will contribute to a rich dataset of comparable longitudinal data. This will allow the effect of the

COVID-19 pandemic and related service changes on the quality of care of people with a learning disability to be investigated.
6. New initiatives that aim to improve the quality of care for people with a learning disability and autistic people from countries beyond the United Kingdom should be explored for implementation, if shown to be effective.
7. Further research is required regarding ethnicity and its relation to premature deaths. This may require using alternative datasets that will allow for taking account of the population structure.
8. Improving data collection or utilising other sources of data to increase the breadth of data collected, for example prescriptions and other treatments, and long-term conditions, should be explored.
9. Identify methods to increase data collection of more marginalised groups, particularly in relation to ethnicity, to be able to draw more informed conclusions and comparisons with other groups.
10. With the new system in place for data collection, there are more limited data on clinical factors such as long-term health conditions. Ways to improve clinical data collection in future datasets should be considered.
11. Further research is required to explore the extent to which conditions other than COVID-19 contribute to excess deaths as more data become available.
12. Urgent work is required to better understand why some people with a learning disability remain unvaccinated despite being a high-risk group for COVID-19 to identify the barriers preventing people from being vaccinated, as well as to identify solutions.

Summary of Questions for Care and services.

1. How can NHS providers ensure completion and adherence to DNACPR documentation and processes in people with a learning disability?
2. How can the NHS and its partners continue efforts to monitor the long-term impact of COVID-19 on people with a learning disability?
3. How can caregivers and healthcare professionals be supported to look out for symptoms of cancers of the digestive system and consider investigation if appropriate?
4. The reviewers believed that the learning disability liaison nurse role brought benefits for people with learning disability who are admitted to hospital. How can acute trusts most effectively implement models of providing learning disability liaison care?
5. Up-to-date annual health checks and health action plans were associated with positive practice. How can professionals and services make the annual health check most accessible and maximise the proportion of eligible individuals who receive one?
6. Prompt identification and response to worsening physical health is important. What additional strategies are needed for carers to be able to recognise and respond appropriately to deteriorating physical health of people with a learning disability?
7. How can NHS and its partners best target interventions to improve the health of people from minority ethnic groups?
8. How can the NHS improve the identification and management of Long-Term Conditions (LTC's) that are associated with younger age at death (deep vein thrombosis, epilepsy)?

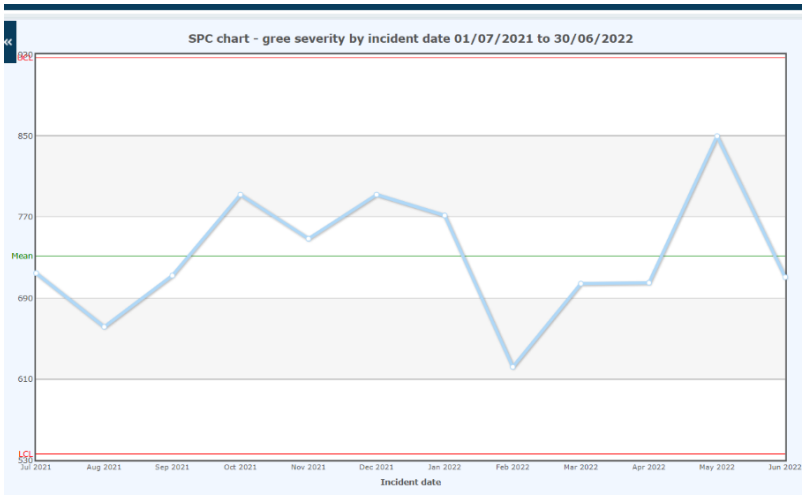
9. Avoidable deaths appear to increase towards middle age, so earlier interventions may be necessary.
10. How can prevention and care pathways of specific LTC's, such as cancer and respiratory conditions (and possibly hypertension) which are associated with higher risk of avoidable deaths, be improved?
11. How can local systems better understand the regional differences in avoidable mortality?
12. People with a learning disability should be protected against future pandemics and further waves of COVID-19 e.g., by enabling rapid implementation of methods to reduce transmission.
13. Findings suggest people with a learning disability should continue to be prioritised for vaccinations and booster vaccinations, including young adults. What mechanisms can be implemented to improve uptake of vaccinations for people with a learning disability?
14. How can excess deaths for vulnerable groups be monitored closely during pandemics so that prompt action can be taken if it remains high or increases?
15. Future reports will aim to see how the pandemic has impacted autistic people.

Actions

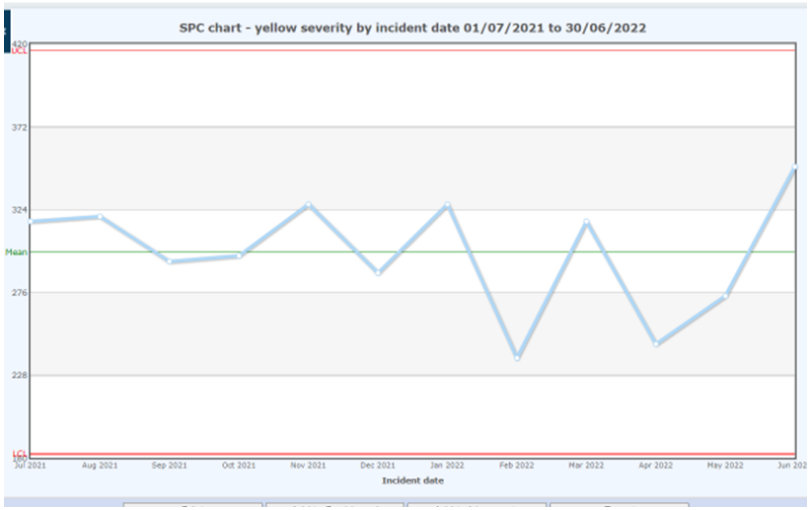
A response to the report is currently being prepared by the Learning disability service. This is expected to be in place by the end of September 2022.

Appendix 2 - All incidents reported Trust wide between 01/07/2021 – 30/06/2022 by severity SPC charts

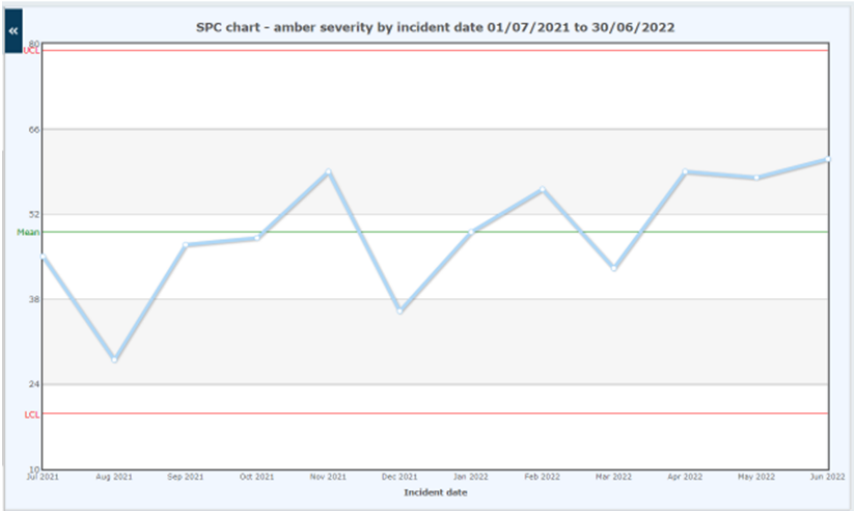
SPC chart for green severity



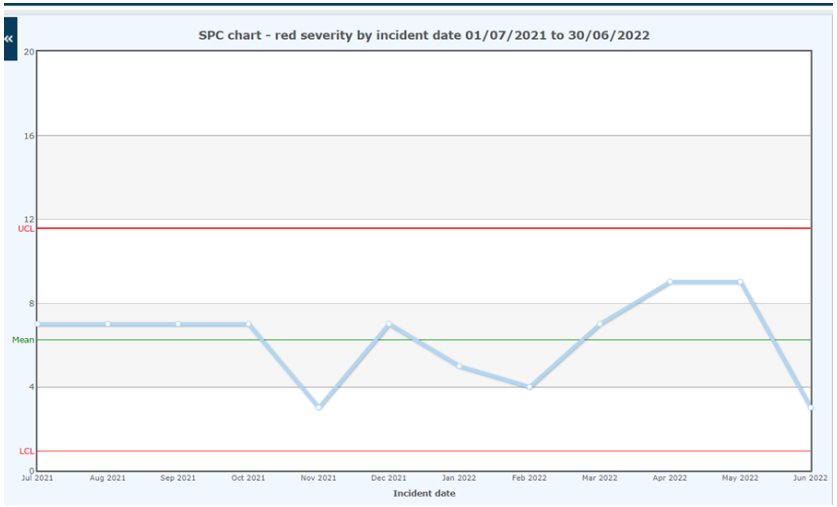
SPC chart for yellow severity



SPC chart for amber severity



SPC chart for red severity



Appendix 3 – Learning Library summaries Quarter 1 2022/23

Title	Summary	Link to full content
Summary of the Ockenden Final Report and our response	In March 2022, the Ockenden Final report was published from the independent review of maternity service at Shrewsbury and Telford Hospital NHS Trust. The report provided an immediate call to action to ensure lessons are rapidly learned: • Patterns of repeated poor care • Failure in governance and leadership **It is highly recommended that all staff read the report and the valuable lessons digested that are relevant to all care settings.** Final-Ockenden-Report-web-accessible.pdf	SBAR Ockenden report.docx
summary for National Review the Myth of Invisible Men September 2021	THE MYTH OF INVISIBLE MEN report published by the National Panel in 2021 provides an insight to the circumstances and triggers that attempt to explain the reasons why some males subject the infants in their care to Abusive Head Trauma, a type of non-accidental injury (NAI), causing significant harm and/or death. The document highlights an urgent need to improve how the system sees, responds to, and intervenes with men who may represent a risk to the babies they are caring for. The_myth_of_invisible_men_safeguardi	SBAR National review The Myth of Invisible Men
Library summary for Serious Incident 2021.3858	A serious incident investigation was conducted to review the care and treatment of a 15-year-old female who died in the community in February 2021. At the time of her death this female was not under the care of the Trust having been discharged from Child and Adolescent Mental Health Services (CAMHS) in September 2020. The initial review of care by the service identified that the discharge from the Child and Adolescent Mental Health	SBAR Learning from SI CAMHS 2021.3858

	Service had been agreed after discussion with the mother and the child did not have a voice in the decision-making process. For the purpose of this SBAR this female will be referred to as 'Z'.	
Summary for Serious Incident 2021/9570	The purpose of this SBAR is to share learning for clinicians around documentation and safe discharge of children and young people.	SBAR Learning from SI CAMHS 2021.9570
Parental consent to vaccination	In 2021 nasal flu influenza vaccination sprays were administered to three children when their respective parents had taken the decision to opt out their child from the vaccination programme.	SBAR Parental consent to vaccination.docx

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 September 2022
Agenda item 10.2

Title:	**Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) 2022**		
Paper presented by:	**Chief People Officer**		
Paper prepared by:	Claire Hartland, HRBM		
Purpose:	WRES and WDES summary reports and action plans require Trust Board sign off prior to submission and publication.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	GPTW 4.2 Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively. GPTW 4.3 Failure to support the wellbeing of staff.		
Any background papers / previously considered by:	The WRES workforce 4-point action plan and WDES action plan were considered and agreed at the WRC on 13 September 2022 and at the EIIC on 20 September 2022.		
Executive summary:	The main purpose of the WRES and the WDES is to help NHS organisations review their workforce data against the metrics, enabling organisations to produce action plans to close any gaps and improve the experience between White and Black and Ethnic minority (BAME) staff and disabled and non-disabled staff as valued members of the workforce. **WRES 2022** The results of the Trust's staff survey suggest results for BAME staff are more positive in terms of job satisfaction, support from line managers and team working compared to white staff. There has been some improvement in the majority of the WRES staff survey indicators compared to the previous year, although there continues to be areas of concern: • Bullying and Harassment of BAME staff, particularly from Service Users and Carers. • Likelihood of experiencing discrimination.		

	• Appointment from being shortlisted of BAME applicants compared to white applicants. • Career development of BAME staff. The key actions and focus for 2022/2023 building on last year's actions in terms of WRES are: • Review and redesign of the Trust's Recruitment and Selection process, removing any barriers preventing a diverse workforce and continuing with international nursing and medical recruitment. • Introducing the Flair Project, which will look at harnessing Trust data to drive racial equality by using 4 key metrics: awareness, inclusion, behaviours and diversity. • Develop the BAME Talent Pool, actively supporting career development of BAME staff and with a view to working in collaboration with West Yorkshire MH partners. • Key elements of the Great Place to Work Leadership Programme will support wellbeing for Team Managers and their teams with a focus on equality, diversity and inclusion. **WRES appendices attached**: • WRES Data (Appendix 1) • WRES Summary Final Report (Appendix 2) • WRES Action Plan (Appendix 3) **WDES 2022** The Trust's staff survey suggests that staff with a disability are less positive about their experience in the workplace than non-disabled staff. Improvements have been shown with the exception of the percentage of disabled staff saying that adequate adjustments have been made. Particular areas of concern are: • Bullying and Harassment in the workplace. • Career progression. • Support in the workplace to manage their disability/adequate adjustments being made. A comprehensive action plan for 2022/2023 has been developed, including: • Ongoing development of the Disabled Staff network. • Promoting and embedding the new staff disability and reasonable adjustments policy. • Development and introduction of disability awareness training for staff and managers and co-produced with input from the staff network. • Developing a new approach to bullying and harassment through the implementation of the just and learning principles. • Reviewing current recruitment practices which includes a focus on disability to address barriers.

	• Continuing to promote access to mentoring and talent programmes. **WDES appendices attached**: • WDES Summary Report (Appendix 4) • WDES Action Plan (Appendix 5) **Risk appetite:** This is consistent with the Trust's risk register and reflects the current risk appetite.
Recommendation:	**The Board is asked to APPROVE the WRES and WDES summary reports and action plans.**

WRES Appendix 1 data for summary report - 2022

	2020/2021				2021/22			
	Non Clinical		Clinical		Non Clinical		Clinical	
Grade	**White**	**BME**	**White**	**BME**	**White**	**BME**	**White**	**BME**
Band 1	3	0	1	0	0	0	1	0
Band 2	195	9	338	49	203	16	313	52
Band 3	376	21	507	65	389	22	476	61
Band 4	165	7	153	15	162	10	182	31
Band 5	115	4	536	90	120	9	473	81
Band 6	55	2	844	73	56	2	884	76
Band 7	44	4	389	33	57	4	419	31
Band 8a	35	2	157	7	36	3	172	8
Band 8b	17	0	52	2	17	0	48	4
Band 8c	5	0	21	1	6	0	25	1
Band 8d	8	0	10	0	7	0	10	0
Band 9	1	0	1	0	0	0	1	0
Medical & Dental Consultants			36	67			39	69
Medical & Dental Non-consultant career grade			15	32			11	30
Medical & Dental Trainee grades			5	9			9	9
VSM*	6	2			6	2		
Non-Executive Board	6	1			6	1	0	0
Grand Total	**1031**	**52**	**3065**	**443**	**1064**	**67**	**3065**	**455**
Not Stated	**6**				**10**			
Total Staff Number	**4597**				**4611**			

* **"Very Senior Managers (VSM)"** ***are defined as exclusively including:***
- **Chief executives**
- ***Executive directors, voting and non voting***
- ***Other senior managers with board level responsibility who report directly to the chief executive***

	2020/2021				2021/2022			
	Non Clinical		Clinical		Non Clinical		Clinical	
Grade	White (%)	BME (%)	White (%)	BME (%)	White (%)	BME (%)	White	BME
Band 1	0.07	0.00	0.02	0.00	0.02	0.00	0.02	0.00
Band 2	4.24	0.20	7.35	1.07	4.36	0.34	6.72	1.12
Band 3	8.18	0.46	11.03	1.41	8.35	0.47	10.21	1.31
Band 4	3.59	0.15	3.33	0.33	3.48	0.21	3.90	0.67
Band 5	2.50	0.09	11.66	1.96	2.57	0.19	10.15	1.74
Band 6	1.20	0.04	18.36	1.59	1.20	0.04	18.97	1.63
Band 7	0.96	0.09	8.46	0.72	1.22	0.09	8.99	0.67
Band 8a	0.76	0.04	3.42	0.15	0.77	0.06	3.69	0.17
Band 8b	0.37	0.00	1.13	0.04	0.36	0.00	1.03	0.09
Band 8c	0.11	0.00	0.46	0.02	0.13	0.00	0.54	0.02
Band 8d	0.17	0.00	0.22	0.00	0.17	0.00	0.21	0.00
Band 9	0.02	0.00	0.02	0.00	0.00	0.00	0.02	0.00
Medical & Dental Consultants			0.78	1.46			0.84	1.50
Medical & Dental Non-consultant career grade			0.33	0.70			0.24	0.64
Medical & Dental Trainee grades			0.11	0.20			0.19	0.19
VSM	0.13	0.04			0.13	0.04		
Non-Executive Board	0.13	0.02			0.13	0.02		
Grand Total	**22.43**	**1.13**	**66.67**	**9.64**	**65.76**	**9.76**	**22.83**	**1.44**
Not Stated	**0.13**				**0.22**			
Annual Total	**100**				**100**			

Workforce Race Equality Standard
REPORTING TEMPLATE
Template for completion

Name of provider organisation	**Date of report; month/year**	
South West Yorkshire Partnership NHS Foundation Trust	Month: August	Year: 2022
Name and title of Board Lead for the Workforce Race Equality Standard		
Greg Moores, Chief People Officer		
Name and contact details of lead manager compiling this report		
Claire Hartland, HR business manager, claire.hartland@swyt.nhs.uk 07881 008185		
Names of commissioners this report has been sent to		
Wakefield District Health & Care Partnership – NHS West Yorkshire ICB, South Yorkshire ICB – Barnsley, Kirklees Health & Care Partnership - NHS West Yorkshire ICB, Calderdale District Health & Care Partnership – NHS Yorkshire ICB, North of England & NHS Improvement, West Yorkshire Collaboratives, South Yorkshire Commissioning Hub		
Names and contact details of co-ordinating commissioner this report has been sent to		
Amanda Capper - Head of Contracts - South Yorkshire ICB - Barnsley - Amanda.capper@nhs.net Michael Bennett - Senior Contract Manager – Kirklees and Calderdale, Health & Care Partnership - NHS West Yorkshire ICB michael.bennett2@greaterhuddersfieldccg.nhs.uk Ryan Turnbull - Senior Contract Manager – Wakefield District Health & Care Partnership - NHS West Yorkshire ICB - ryan.turnbull@nhs.net Rita Thomas- Head of Mental Health North East and Yorkshire Region, NHS England and NHS Improvement rita.thomas1@nhs.net Sarah Jane Sams - West Yorkshire Provider Collaboratives sarahjane.sams1@nhs.net Michelle Fearon - SYB commissioning hub . michelle.fearon1@nhs.net		
Unique URL link on which this report will be found at: https://www.southwestyorkshire.nhs.uk/about-us-2/performance/workforce-equality/		

This report has been signed off by Greg Moores, CPO, on behalf of the Board on 30.8.22

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data
No issues

b. Any matters relating to reliability of comparisons with previous years
No issues

2. Total numbers of staff

a. Employed within this organisation at the date of the report
There were 4661 staff employed by South West Yorkshire Partnership NHS FT as at 31st March 2022

b. Proportion of BME staff employed within this organisation at the date of the report
11.2% BME staff in the workforce as at 31st March 2022

3. Self reporting

a. The proportion of total staff who have self-reported their ethnicity
100% of staff have self-reported their ethnicity

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity
The Trust uses ESR employee self-service which staff have been encouraged to use to self-report and check their own data. The reporting level is now at 100%.

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity
Self-reporting is currently at 100% but we plan to ask staff to check their personal data stored on ESR on an annual basis

4. Workforce data

a. What period does the organisation's workforce data refer to?
Years ending 2021/22 compared to 2020/21

5. Workforce Race Equality Indicators

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

	Indicator	**Data for reporting year**	**Data for previous year**	**Summary points**
	For each of these four workforce indicators, the Standard compares the metrics for White & BME staff.			
1	Percentage of staff in each for the AfC bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Percentage of staff in each of the AfC bands 1-9- or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.	Please see Appendix 1	Please see Appendix 1	The number of BME staff in the workforce has increased by headcount of 27. The total percentage BME staff in workforce now 11.2%. (Total workforce 4661 at 31.3.22)
2.	Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts	1.40	1.16	The data shows that BME applicants are less likely to be appointed from shortlisting than white applicants.
3.	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	2.37	0.79	The data shows that BME staff are far more likely to enter a formal disciplinary process that white staff and this has shifted significantly from the last reporting period. However, the overall numbers are now much smaller. This is as a result of the Trust introducing a new early Resolution process which has reduced the numbers of staff entering a formal disciplinary process which may lead to dismissal. This informal process was implemented to assist the individual/team/organisation in learning related to the area of concern and is applied as an alternative to a formal disciplinary investigation. This is seen as a more supportive experience for the individual(s) involved. The Trust has also introduced a cultural questionnaire to be completed by both the individual(s) and the manager. This looks at the individuals' cultural perspective and the culture and behaviours on the ward/service to reduce any cultural bias. This is completed

				prior to progressing to either the Resolution or formal disciplinary process. The introduction of this positive approach, however, has impacted on the relative likelihood figure for this reporting year as the numbers of staff going through a formal process has reduced by around half. This means that the numbers involved in this year's calculation are now so small that meaningful comparisons are challenging. We will continue to monitor and evaluate the new process to ensure this is not having any adverse impact on BME staff. We are also mindful that the last reporting year was based on 2 years data and the current year is based on one year's data.
4	Relative likelihood of White staff accessing non-mandatory training and CPD as compared to BME staff	0.86	0.77	The data show that BME staff are more likely to access non-mandatory training and CPD than White staff. The data includes medical staff.

	Indicator	**Data for reporting year**		**Data for previous year**		**Summary points**
	For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for White and BME staff					
5.	KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	27.1	White	26.2	The 2021 staff survey was sent to all staff in the Trust. The response rate is below average (1837 responded) at 41%. This is 2% lower than the previous year, however, we also ask staff to complete the Trust's wellbeing survey in addition to completing the quarterly NHS pulse survey which may have affected our response rate. 2021 staff survey indicates that the BME staff who responded indicated they were more likely to experience harassment and bullying from service users and carers than white staff. The position for BME staff has improved since last year and is slightly below average compared to similar organisations.
		BME	31.1	BME	39.9	

6.	KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	15.6	White	17.6	2021 staff survey indicates that the BME staff who responded indicated they were more likely to experience harassment and bullying from staff than white staff. This position has improved since last year and we are below average compared to similar organisations.
		BME	21.5	BME	26.1	
7	KF21. Percentage believing that the Trust provides equal opportunities for career progression or promotion	White	62.1	White	60.7	2021 staff survey indicates that the BME staff who responded indicated they were more negative regarding believing the Trust provides equal opportunities for career progression or promotion than white staff. This position has improved since last year and we are better than average compared to similar organisations.
		BME	53.0	BME	49.0	
8	Q17b. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White	4.1	White	5.2	2021 staff survey indicates that the BME staff who responded indicated they were more likely to experience discrimination at work from their manager/team leader or other colleagues than white staff. This position has worsened since last year; however, we remain below average compared to similar organisations
		BME	13.0	BME	10.5	
	Board representation indicator. For this indicator, compare the difference for white and BME staff					
9	Percentage difference between the organisations Board membership and its overall workforce disaggregated by: Voting membership of Board Executive membership of Board		+ 11.9% + 13.8%		+ 5.9% +14.2%	The Trust has 3 BME Voting Board members. 2022, 3 x BME 10 x White 2021, 2 x BME, 10 x white. Reporting year White workforce 88.6% BAME workforce 11.2% Previous year White workforce 89.1% BAME workforce 10.8%

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

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

Report on the WRES indicators, continued

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

The Trust also publishes a detailed Equality Workforce Monitoring Annual Report on our website, link at No 7 below. Progress regarding the Equality agenda is monitored by the Trust Board at the Equality, Inclusion and Involvement Committee

The Trust provides secure services across Yorkshire and Humber which has a different population make up compared to that of its local services.

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

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

WRES workforce 4 point action plan 2021 with Leads and Timescales

Key Action – Representative workforce/Recruitment			
WRES Indicators ***1)To increase the % of BME staff in each of the AfC bands 1-9 and VSM (inc Executive Board members) to reflect the % in the local population*** ***2) To ensure that the relative likelihood of BME staff being appointed from shortlisting across all posts is the same as that of white staff***			
Agreed Action	**Update**	**Lead**	**Timescale**
<u>Increase applications from BAME candidates</u> • International nurse recruitment and medical fellowship programme	The Trust continues to recruit nurses and medical staff from overseas and has developed and implemented a robust and well-structured pastoral support package.	HR (RB)	Ongoing
• Recruitment events support focus on encouraging candidates from local communities to increase workforce diversity	Year 1 YH&H now completed (4 quarterly fairs). Review ongoing for year 2 plan with collaborative leads. Year 1 SY&B quarterly fairs, 1 of 4 fairs completed, dates for further fairs to be confirmed by Barnsley CCG SWYFT looking at blended approach to recruitment fairs between now and March 23 (includes virtual, face to face, local and University events)	Recruitment Group	Ongoing Ongoing Ongoing
• Updated recruitment, careers portal, social media advertising and onboarding information showing a diverse workforce	Targeted nursing campaign for 2022 includes photography highlighting diverse communities. Careers portal includes photography and videos with staff from our BAME communities. We also promote the REACH network on both careers and onboarding portals. Standard wording on NHS jobs re encouraging applications from diverse backgrounds has been updated.	Recruitment Group	Ongoing
• Sustainability/Anchor organisations	In July 2022 the Trust agreed a social value and sustainability strategy including commitments to engage with local anchor networks to increase opportunities for local recruitment in deprived areas. This work will be supported by the Trust adjusting it's maths and English qualification requirement to entry level 3	HR (LJ & RB)	3-year project up to 2024

• Continue and enhance the work with universities to increase the number of students from BME communities on health-related degree courses	Regulation of ICB's from July 2022 will help inform and shape this at a system level as Trusts such as SWYFT feed into place which will aggregate approaches for doing this at ICS level. The current level of influence has been fed through HEE as part of their commissioning requirements with universities. From a SWYFT perspective we can encourage people from local communities to apply for university places when they attend recruitment events	HR & NQP (AB & Daryll & ICS/HEE)	Ongoing
• Recruiting from the Trust staff bank into the substantive workforce	The Trust is continuing to actively encourage bank staff who have been employed through its values-based recruitment process to consider moving into vacant posts in the substantive workforce following an informal interview rather than a full application process.	HR (C.Hill)	Ongoing
<u>Ensuring our recruitment processes are fair and transparent</u> • Centralised exit interviews for all staff have been approved and the process is now in operation. The feedback will be collated and reviewed by the EMT and Workforce and Remuneration Committee	The Trust has introduced an anonymous survey monkey format for exit interviews with refocussed questions, this is available each week for staff via a link on the Headlines for easy access. It can be emailed to leavers and completed retrospectively. Quarterly reporting now in place feeding into OMG and WRC as well as out to Care Groups	HR (RB)	Completed
• Review recruitment process. Look at including BAME representative on all key appointments include 8a and above. Review if there are key areas where there is under representation, e.g. corporate services bands 5 to 7 and key clinical jobs	The recruitment review working group has mapped out our recruitment process and is now looking at developing an action plan highlighting where we can improve our inclusive practice with the relevant stakeholders. The recruitment procedures and documentation will be reviewed and include a robust EIA as required. The Trust already ensures BAME representation on senior level recruitment panels with a view to moving to including 8a recruitment.	Recruitment Group & RB HR and BAME network (RB)	Ongoing Ongoing

Key Action – Representative leadership at all levels			
WRES Indicators ***4) To ensure that the relative likelihood of BME staff accessing non-mandatory training and CPD is the same as that of white staff*** ***7) To increase the numbers of BME staff believing the Trust provides equal opportunities for career progression or promotion*** ***9) To have a Trust Board whose BME voting membership reflects its overall BME workforce***			
Agreed Action	**Update**	**Lead**	**Timescale**
• Include representative workforce focus in annual workforce planning discussions with BDU's and services	E&D continues to be a focus in the annual workforce planning meetings with Care Groups	HR (RB)	Awaiting resumption in 2022 planning round
• REACH network	The Trust has a well-established race equality and cultural heritage network which receives an annual invite to Board to share staff experience. In addition, the Chair attends the EIIC along with other network Leads, where they can showcase progress and seek support as required.	Network Chair	Ongoing
• The Trust will actively promote and support BME staff onto the NHS Leadership Academy 'Stepping Up' and 'Ready Now' programmes. (These offers are incorporated in the Trust's Leaders and Managers development pathway)	Stepping Up' and 'Ready Now' programmes are embedded into our Leader & Manager Pathway and we're incorporating both programmes into our 2022/23 offer. Access for staff will continue when NHS Leadership Academy programmes resume these programmes when current restrictions are lifted. Working with our services, we continue to provide local needs-based and targeted individual and team development via our 'Health & Wellbeing' activities and both 'Building Leadership For Inclusion' (BLFI) & Organisational Development (OD) programmes	HR/OD (TBC) HR/OD (TBC)	Awaiting resumption in late Summer 22 Currently reviewing L&M framework & pathway prior to resumption in late summer 22.
• The Trust will continue to deliver the 'Moving Forward' programme in partnership with Bradford District Care, Leeds &York Partnership and Mid Yorkshire NHS Trusts	We have further developed our joint programmes as part of the West Yorkshire Mental Health Collaborative. This includes 'Moving Forward', which is now led by us here at SWYPFT and delivered in partnership with Bradford District Care Trust (BDCT), Leeds & York Partnership Foundation Trust (LYPFT), Mid-Yorkshire Hospitals FT and Wakefield CCG. The latest programme commenced in May 2021 but paused due to Covid. Due to recommence November 22	HR/OD (TBC)	Paused due to Covid. Due to recommence Nov 22

	The Trust has now incorporated the Edward Jenner programme NHS Leadership Academy e-learning on-line modules into our 'Introduction to Leading & Managing' and 'Moving Forward' programmes. It is also offered to staff completing our inaugural MLDP and Talent programmes. A 'Moving Forward Plus' pilot programme commenced, as a part of our inaugural Talent programme, but was paused due to Covid.	HR/OD (TBC) HR/OD (TBC)	Ongoing & underway Paused and due to recommence Sept 22
• Crucial conversations training/coaching to be offered to Trust participants on the Moving Forward Programme	The Trusts 'Crucial Conversations' programme includes priority places for colleagues from under-represented groups. The programme had been redesigned into digital format, however, has resumed, face-to-face, in July 22.	HR/OD (TBC)	Ongoing & underway
• Continue to deliver aspiring directors (Shadow Board) programme and executive coaching/ mentoring for senior leaders/managers	Our most recent Shadow Board programme commenced in August 2021 and completed in July 2022, this targeted at staff from under-represented communities and/or with protected characteristics. We had 3 BAME staff complete the programme out of 8 staff. Our next programme is due to commence in January 23 as a joint programme with our MH partners. Currently under evaluation.	HR/OD (TBC)	Due to commence Jan 23
• Medical leaders development programmes	We further developed the leadership programmes for medical & clinical leaders in 2021/22 including further Masterclasses, access to 'Introduction to Leading & Managing' and a 'Medical Leadership Development Programme' for new medical consultants. We also introduced a 1-1 induction for medical leaders.	HR/OD (TBC)	1st cohort completed. 2nd cohort due to commence Autumn 22
• Introduction to Leading & Managing (I2LM) programme offer to include staff from under-represented groups	The Trust continues to further develop a Trust-wide offer to all leaders and managers, reflected in a Leader & Manager Pathway. It spans 'Gateway to Leading & Managing' for first-line managers & supervisors, across 'Leading & Managing Service Teams' for operational managers, to 'Leading & Managing in Healthcare Systems' for senior managers and systems leaders. This is for both new and experienced staff and is underpinned by our Values into Behaviours.	HR/OD (TBC)	Ongoing & underway
• Coaching and Mentoring framework to include offer to staff from under-represented groups	The Trust has continued to develop its Coaching & Mentoring (C&MF) Framework. This includes the provision of coaching via 'Crucial Conversations', 360-feedback, peer coaching and executive coaching programmes to which we have added medical mentoring. We have 1 BAME coach out of the 4 coaches on our register.	HR/OD (TBC)	Ongoing & underway

	As a part of our C&MF, we are developing a register of coaches and mentors. With WYMH partners and as part of the Leeds City Wide Coaching Network we provide access to coaches/mentors and give our coaches and mentors opportunities to develop and gain supervision. We are further developing our C&MF including 1:1 coaching, mentoring, and Coaching for Inclusion. Our programme of Executive Coaching continues to be provided to Deputies and Trios, including access to the NHS Healthcare Leadership 360-degree feedback tool.	HR/OD (TBC) HR/OD (TBC)	Ongoing & underway Ongoing & underway
• Introduction of Building Leadership for Inclusion	We completed phase 4 of our 'Building Leadership For Inclusion' (BLFI) programme, supported by the NHS Leadership Academy. Our BLFI programme included extending Reciprocal Mentoring for our BAME staff into a second cohort which has now completed. The evaluation is currently underway to inform future provision. We have completed a targeted inclusion programme for our Board Members via the NHS Leadership Academy: 'Inclusive Leadership Development for Boards & Organisations (ILDBO)' programme. This is currently being evaluated to inform a further Board development plan In addition, we have also completed a targeted inclusion programme for our senior management team with our People (formerly HR & OD) Directorate. This is currently being evaluated to inform a development plan for the PLT team	HR/OD (TBC) HR/OD (TBC) HR/OD (TBC) HR/OD (TBC)	Completed Ongoing Completed Apr 2022 Completed Jul 2022
• Introduction of BAME Talent Pool	Within our BLFI programme, we established a Talent Pool and Programme targeted at our BAME colleagues. Our core programme was paused in response to the pandemic and is due to resume from September 2022. Support to our Talent Pool members throughout the pandemic allowed them to continue with their respective individual career planning and CPD activities at need. Once the restarted Talent Programme is completed, an evaluation will inform planning of future joint arrangements in developing talent in collaboration with our West Yorkshire Mental Health Collaborative partners	HR/OD (TBC)	Due to restart September 22

Key Action – Bullying and Harassment (including Race Forward)			
WRES Indicators ***3) To ensure that the relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation is the same as that of white staff*** ***5) To reduce the numbers of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months*** ***6) To reduce the numbers of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months*** ***8) To reduce the numbers of BME staff who have personally experienced discrimination at work from manager/ team leader or other colleagues in the last 12 months***			
Agreed Action	**Update**	**Lead**	**Timescale**
<u>Race Forward</u> • Re-launch the Race Forward network with a zero-tolerance approach regarding harassment and bullying from service users, carers and visitors. Reciprocal mentoring is now included in the Race Forward offer	EMT have recommitted to the programme. Daryll Thompson, Director of Nursing, Quality and Professions, is board lead. Purpose of the group re-established, and membership considered. Developing a role description to support the need to change clinical practice. Drivers and change ideas proposed includes the continuation of the reciprocal mentoring offer for BAME colleagues.	Salma/ Darryl/Greg	Ongoing
• Appointment of Equity Guardians to support staff throughout the Trust who are experiencing racial bullying and harassment from service users and carers	The Trust has now appointed 6 Equity Guardians including one medic. Work to develop a clear one-page infographic on all support offers for staff has recently been completed	HR	Completed
• Preventing Harassment and Bullying Framework to include communications programme on racially motivated B&H.	The team of bullying and harassment advisors has been expanded and the role amended to be a Civility and Respect Champion. The champions include colleagues from our staff networks including the BAME network. The champions will support early resolution of workplace issues. Work has been completed on pulling together a clear one-page infographic on support offers for staff including C&R champions.	HR (PB & EM)	Completed
	A joint HR and Staff Side working group has been established to review the Trust policy and to develop an approach based on early resolution of concerns using the	HR & Staff side (DT)	Ongoing

	Just Culture methodology to support our Trust approach. We are working on restorative practice solutions for all cases going forward.		
• Great Place to Work to focus on healthy teams including supporting BAME staff and promoting diversity	The 'Great Place to Work (GP2W)' senior leader's forum and programme was paused during the lockdown. It is now being redesigned with a focus upon supporting operational managers and system leaders in leading/managing post-pandemic and has been piloted. Key elements will be supporting the wellbeing of team managers and their teams based on our Great Place to Work pledges and a focus on equality, diversity and inclusion	HR/OD (AC & AH)	Ongoing & underway
• Flair project	This project will look at harnessing Trust data to drive racial equality by using 4 key metrics: awareness, inclusion, behaviours, and diversity. The Trust is considering expanding the project to include other protected characteristic groups.		
• Review of Disciplinary procedure will include an EIA which will consider the impact on BAME staff	A new Resolution Process has been agreed with staff side and introduced in addition to the existing process. The full procedure now includes a decision tree in line with the 'A Model Employer' strategy. Due to the numbers going through the Decision Tree process, work is being undertaken to identify and train a pool of cultural advisors for the panels to look at Cultural and environmental issues The Trust Resolution process was designed to reduce the numbers of staff entering a formal disciplinary process which may lead to dismissal. This informal process was implemented to assist the individual/team/organisation in learning related to the area of concern and is applied as an alternative to a formal disciplinary investigation. This is seen as a more supportive experience for the individual(s) involved. The impact and effectiveness of the process will be monitored and evaluated. The Trust has also introduced a cultural questionnaire to be completed by both the individual(s) and the manager. This looks at the individuals' cultural perspective and the culture and behaviours on the ward/service. This is completed prior to progressing to either the Resolution or formal disciplinary process.	HR (DT) HR (JM)	Completed Ongoing

Key Action – BAME Health and Wellbeing			
No WRES Indicators			
Agreed Action	**Update**	**Lead**	**Timescale**
• Appointment of an Equality, Inclusion and Belonging lead in the People Directorate	Demonstrating the Directorate's continuing commitment to this agenda, this post will focus on workforce equality issues including WRES, WDES, EDS, support Race Forward and develop linkages with the care groups	HR	Soon to be advertised
• Staff wellbeing survey now includes questions for WRES audit. The most recent survey was carried out April 2022.	The 2022 wellbeing results for colleagues from a BAME background were overall better than the Trust average. However, results for colleagues from a White-Irish or White-any other background ethnicity were worse than the Trust average.	HR (AH)	Completed
• Spirituality and wellbeing guidance project	A small task and finish group comprising members of the REACH network, Pastoral/Spiritual Care, HR, Occupational Health, and HWB Advisors/Champions, was established to develop guidance with the aim of clarify the Trust's approach in supporting staff to take a reasonable, but usually brief, period of time away from their working duties whilst on shift, to observe religious/spiritual practices (e.g., for prayers). The guidance will support equality, inclusion and wellbeing for all employees recognising their religion, beliefs, and non-religious beliefs.	REACH network	Spring 23
• Equality, Diversity, Inclusion, and health inequalities training	The recently updated and enhanced training package will support the development of staff understanding in this area. This programme is currently being rolled out.	DP/ZM	Ongoing

South West Yorkshire Partnership NHS Foundation Trust

SWYPFT WDES Annual Summary Report 2022

The WDES is the Workforce Disability Equality Standard that enables NHS organisations to compare experiences of disabled/non-disabled staff. It is mandated in the NHS standard contract and is made up of ten evidence based metrics. NHS organisations are required to publish the data and develop action plans. It will enable organisations to undertake year on year comparisons, highlight areas of improvement and areas where further work is needed to improve the experiences of disabled staff. The trust is required to complete and submit updated WDES data to NHS England and NHS Improvement by 31st August 2022. For ease of reading the data is duplicated below and summarised where appropriate.

The information contained in this report is based on ESR data as at 31st March 2022 and the 2019, 2020 and 2021 staff survey results.

Metric 1 – Workforce representation based on staff in post 31.03.22							
Non Clinical Staff	**Total Disabled**	**% Disabled**	**Total Non Disabled**	**% Non Disabled**	**Total Unknown**	**% Unknown**	**Total Overall**
Cluster 1 (bands 1-4)	62	7.7%	697	86.7%	45	5.6%	804
Cluster 2 (bands 5-7)	17	6.9%	225	90.7%	6	2.4%	248
Cluster 3 (bands 8a-8b)	7	12.3%	49	86%	1	1.8%	57
Cluster 4 (bands 8c-9 & VSM)	0	0%	27	96.4%	1	3.6%	28

Clinical Staff	Total Disabled	% Disabled	Total Non Disabled	% Non Disabled	Total Unknown	% Unknown	Total Overall
Cluster 1 (bands 1-4)	109	9.8%	909	81.4%	99	8.9%	1117
Cluster 2 (bands 5-7)	177	9%	1738	88.3%	53	2.7%	1968
Cluster 3 (bands 8a-8b)	22	9.4%	203	86.8%	9	3.8%	234
Cluster 4 (bands 8c-9 & VSM)	2	5.4%	34	91.9%	1	2.7%	37
Cluster 5 (medical and dental consultants)	8	7.3%	97	89%	4	3.7%	109
Cluster 6 (medical and dental, non-consultants career grade)	1	2.4%	40	97.6%	0	0%	41
Cluster 7 (medical and dental, trainee grades)	2	11.1%	16	88.9%	0	0%	18

Overall, 7.6% of the non-clinical and 9.2% of the clinical workforce (excluding medical and dental staff) have declared a disability through the NHS Electronic Staff Record.

For medical and dental staff, 11.1% of trainee grades, 2.4% of non-consultant career grade and 7.3% of consultants have declared a disability.

For the total workforce, 8.7% of staff have declared a disability.

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

Metric 2 – Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts based on recruitment data year to 31.03.22			
	Disabled		**Non disabled**
Number of shortlisted applicants	391 (315 previous year)		4418 (3999 previous year)
Number appointed from shortlisting	67 (45 previous year)		569 (845 previous year)
Relative likelihood of shortlisting/appointed	0.17 (0.14 previous year)		0.13 (0.21 previous year)
Relative likelihood of non disabled staff being appointed from shortlisting compared to disabled*		0.75 (1.48 previous year)	

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

Based on the recruitment data for the year to 31 March 2022, disabled staff are more likely to be appointed from shortlisting compared to non-disabled staff. This is a significant change from the previous year.

Metric 3 – Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. N.B Metric based on data from a two year rolling average (2020/21 and 2021/22) – number entering the formal capability process divided by 2.				
	Disabled		**Non disabled**	**Unknown**
Number of staff in workforce	407		4033	221
Number of staff entering the formal capability process	0		14.5	2
Likelihood of staff entering the formal capability process	0.00		0.004	0.009
Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff*		0		

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

There have been no disabled staff entering the formal capability process in the reporting period.

WDES 2019, 2020 & 2021 Staff Survey Data															
	2021						2020			2019				2021 Benchmarking Group average*	
Metric/Indicator	% Dis-abled	N=	% Non-disabled	N=	Trust	N=	%Dis-abled	%Non-disabled	Trust	%Dis-abled	%Non-disabled	Trust	Change from prev. year	% Dis-abled	% Non-disabled
4a) % experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	34.8	538	24.4	1270			36.7	24.0		36.6	26.8		improved	32.2	24.7
4a) % experiencing harassment, bullying or abuse from managers in the last 12 months	11.4	535	5.9	1263			12.9	8.1		16.2	8.3		improved	13.4	7.1
4a) % experiencing harassment, bullying or abuse from colleagues in the last 12 months	15.5	528	11.0	1250			19.5	11.3		21.1	12.2		improved	20.2	12.3
4b) % reporting harassment, bullying or abuse	59.4	212	62.7	346			59.1	61.2		53.5	55.5		No significant difference	59.4	61
5) % believing that the Trust provides equal opportunities for	55.7	537	63.8	1268			54.9	61.2		47.7	58.7		improved	54.4	60.2

career progression or promotion															
6) % experiencing pressure from manager to attend work when unwell	**20.2**	**371**	**13.6**	**567**			**23.9**	**16.8**		**25.2**	**15.6**		**improved**	**20.8**	**14.7**
7) % staff satisfaction with extent work is valued by organisation	**44.6**	**540**	**51.6**	**1274**			**43.3**	**53.1**		**37.1**	**50.6**		**improved**	**43.6**	**51.5**
8) % of disabled staff saying that adequate adjustments have been made	**77.2**	**307**	**n/a**	**n/a**			**80.9**	**n/a**		**71.6**	**n/a**		**worsened**	**78.8**	**n/a**
9a) staff engagement score	**6.8**	**542**	**7.2**	**1278**	**7.1**	**1837**	**6.7**	**7.2**	**7.1**	**6.6**	**7.1**	**7.0**	**improved**	**6.7**	**7.2**

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

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

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

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

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

A lower proportion of disabled staff compared to non-disabled staff believe that the trust provides equal opportunities for career progression or promotion however, this has improved since the previous year.

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

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

77.2% of disabled staff report that the trust had made adequate adjustments to enable them to carry out their work. This has worsened since the previous year when 80.9% reported that adequate adjustments had been made.

Disabled staff report a lower NHS staff survey engagement score than non-disabled staff however, this has improved since the previous year.

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

Yes. The trust continues to support the development of a staff disability network and has introduced a staff disability and reasonable adjustments policy. A "disability matters" engagement event was held on 31st August 2022 and insight from this event will be used to develop ongoing actions to support disabled staff. A follow up event is being planned to coincide with the international day of persons with disabilities in December 2022. Members of the staff disability network have again participated in an engagement and listening event with the Trust Board where they were encouraged to share their lived experiences of being a disabled member of SWYPFT staff. The staff network chair (or deputy) attends the Equality, Inclusion and Involvement committee and sub committee to provide updates and discuss matters regarding the staff network.

Metric 10 – Board representation based on ESR data as at 31.03.22			
	Disabled	**Non disabled**	**Unknown/null**
Total Board members - % by disability	0%	100%	0%
Voting Board members - % by disability	0%	100%	0%
Non Voting Board members - % by disability	0%	100%	0%

Executive Board members - % by disability	0%	100%	0%
Non Executive Board members - % by disability	0%	100%	0%
Overall workforce - % by disability	8.73%	86.53%	4.74%
Difference (Total Board – overall workforce)	-8.73%	13.47%	-4.74%
Difference (Voting membership – overall workforce)	-8.73%	13.47%	-4.74%
Difference (Executive membership – overall workforce)	-8.73%	13.47%	-4.74%

There are no board members reporting a disability.

NHS trusts are required to publish the WDES data and associated action plan by 31st October 2022, following Trust Board ratification. An action plan has been produced following discussions with the staff disability network chair and is attached as a separate document.

WDES Actions Undertaken in 2021/22

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

- The trust has taken action to encourage both staff and service users to share their equality information in our ongoing #Allofyou campaign where we acknowledge that by sharing equality data, individuals will be helping us to offer appropriate support that respects and recognises who they are.
- The trust remains committed to Project Search in partnership with Mid Yorkshire Hospitals NHS Trust. The project is a pre-employment programme which helps young people with learning disabilities gain the skills they need to obtain meaningful paid employment. Following a pilot internship, we are planning to extend the scheme and offer further placements in our Estates and Facilities department.
- The trust has continued with a guaranteed interview scheme and we include a positive statement on our careers portal for prospective applicants which states:

- The Trust is committed to equality of opportunity for all and will not discriminate on the grounds of any disability or ill health, and that includes mental ill health. We have a positive attitude towards employing staff who have disabilities. Our staff and potential employees are encouraged to be open about their health needs so we can offer the right support. If you are considering applying for a post with the Trust, having a disability including current or past experience of mental health problems will not prevent you being considered from the selection process, providing you fulfil the relevant criteria. We know there's a wealth of talent among people who have a disability and you can be confident we will support your health needs, not only those that you may have at the moment but also any future mental health needs you may have during your employment with us as the wellbeing of our staff matters to us. If you would like to discuss this further, in confidence, please contact any member of the recruitment team on 01226 434632 or email recruitment3@swyt.nhs.uk

- Engagement and listening events have continued to be held with the Trust Board which encourages members of the disability staff network to discuss and share their own lived experience.
- A "disability matters" engagement event was held on 31st August 2022 and insight from this event will be used to develop ongoing actions to support disabled staff. A follow up event is being planned to coincide with the international day of persons with disabilities in December 2022.
- Following extensive consultation and co-production we have launched our staff disability and reasonable adjustments policy which outlines 5 supportive steps to support staff with a disability. Included in this is a disability and wellness planning agreement which will support the process of implementing reasonable adjustments.
- To support the implementation and embedding of the policy we are developing disability awareness training which we anticipate to be rolled out during 2022/23.
- The trust supports the development of a staff disability network and work is ongoing to embed the network, develop an annual workplan and increase its membership.
- The trust has continued to support and develop the peer support worker role.
- Estates and facilities continue to work on accessibility schemes e.g. improving signage, upgrading disabled WC facilities, disabled parking bays etc. as part of an ongoing programme of work.
- Wellbeing conversations form part of the annual appraisal process which provides a vehicle for disability related discussions to take place.
- As a result of our commitment and the actions detailed above, the trust went through the Disability Confident validation process with support from the Shaw Trust, resulting in us being awarded Disability Confident Leader status. Insight from the validation will be used to inform future disability related action plans, also aligned to the WDES.

WDES action plan 2022/23

WDES Indicator	Action	Responsibility	Timescale
1. Percentage of staff in AfC bands or medical and dental subgroups and very senior managers compared to the percentage of staff in the overall workforce.	• Continue to encourage staff to share their disability status on ESR through the ongoing #Allofyou campaign which asks people to share their equality information.	Comms	Ongoing
2. Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts based on recruitment data year to 31.03.22	• To ensure that the review of current recruitment practices includes a focus on disability and addresses any barriers. Ensure there is ongoing review of equality impact assessments as part of the changes. • Develop and introduce disability awareness training for staff and managers linked to the staff disability and reasonable adjustments policy.	Head of Recruitment & Resourcing L&D/People Directorate Lead/Staff Network	March 23 December 22
3. Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	Very small numbers entering the formal capability process (and no staff with a reported disability during the reference period), therefore no specific action developed at this time.	n/a	n/a
4. Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:	• Identify any key patterns and trends which affect disabled staff from survey data and work with the staff network identifying other sources of insight and use this to develop appropriate action plans. • Developing a new approach to bullying and harassment through the implementation of the just and learning principles.	People Directorate Lead/Staff network Associate Director of People Ops.	March 23 March 23

i. Patients/service users, their relatives or other members of the public. ii. managers iii. other colleagues			
5. Percentage of disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression and promotion.	• To ensure that the review of current recruitment practices includes a focus on disability and addresses any barriers. Ensure there is ongoing review of equality impact assessments as part of the changes. • Promote access to mentoring and talent programmes in accordance with cohort dates • Extend the Project Search internship scheme within Estates and Facilities and review progress to identify learning & improvements	Head of Recruitment & Resourcing L&D People Directorate Lead	March 23 2023 in line with cohort dates 2022/23 in line with Project Search timescales
6. Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	• Develop and deliver engagement events to embed the new staff disability and reasonable adjustments policy encouraging the use of supportive disability and wellness planning agreements. Utilise insight gained from these events to develop action/improvement plans.	People Directorate Lead/E&I team/Staff Network	August 22 & December 22 initially
7. Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	• Develop and introduce disability awareness training for staff and managers linked to the staff disability and reasonable adjustments policy.	L&D/People Directorate Lead/Staff Network	December 22

	• Ongoing development and promotion of the staff network following the re-establishment of an active steering group • Continue to engage with the staff network to identify learning and associated actions from lived experience.	People Directorate Lead/staff network	Ongoing
8.Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work.	• Promote and embed the new staff disability and reasonable adjustments policy encouraging the use of supportive disability and wellness planning agreements. • Continue to identify schemes to improve accessibility and environment as part of the trust capital plan in conjunction with the staff network.	People Directorate Lead/Staff Network Estates/staff network	Specific events in August & December 22 and on an ongoing basis Ongoing
9a&b. Staff engagement score and action to facilitate the voices of disabled staff	• Identify and utilise opportunities to engage with disabled staff via the disability staff network • Work in partnership with the network to develop ongoing work/action plans to support the experience of disabled staff. • Promote relevant awareness dates e.g. International Day of the Disabled • Encourage disabled staff members to attend trust board meeting to share their lived experience of working in the trust. • Support the staff network to develop an annual workplan to raise the profile of the network and the experience of disabled staff.	People Directorate Lead/E&I team/staff network Company Secretary/Staff Network People Directorate Lead/Staff network steering group	Quarterly Quarterly Annually At least annually December 22 tbc

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 September 2022
Agenda item 10.3

Private/Public paper:	**Public paper**		
Title:	**Medical Appraisal/Revalidation Annual Board Report 2021-22**		
Paper presented by:	Chief Medical Officer and Responsible Officer		
Paper prepared by:	Medical Directorate Business Manager		
Purpose:	The purpose of this paper is to inform the Trust Board of progress in achieving satisfactory medical appraisal and revalidation and to support the signing of the NHSE Designated Body Annual Board Report Statement of Compliance (Annex D), which is no longer a mandatory requirement; however, the Appraisal and Revalidation Team have committed to completing this to complement the 2021-22 Annual Board report.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Risk 4.1 - Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user experience and sustainability of safer staffing levels.		
Any background papers/previously considered by:	Not applicable.		

Executive summary:	• 137 doctors had a prescribed connection with the Trust as of 31st March 2022.
	  - 96.4% of the doctors that were due to have their appraisal have successfully completed the appraisal process during 2021/22, which is a vast increase on last year, back to pre-covid levels.
	  - 13.8% of the doctors had late meetings or late submissions. 4 of these late submissions were not approved. The rest were approved by either the Associate Medical Director (AMD) for Revalidation or Responsible Officer (RO) as appropriate.
	• 35 revalidation recommendations were made between 1st April 2021 and 31st March 2022.
	  - 35 doctors had positive recommendations made.
	  - All of these recommendations led to revalidation of the doctors by the General Medical Council (GMC).
	• Post-Covid-19, medical appraisal and revalidation has reverted back to pre-pandemic processes and timescales following a period of paused appraisals.		

With all of us in mind.

	Next steps • The quality of the training delivered, as judged by feedback from new appraisers, will be monitored following the additional trainer recruitment. • The number of appraisers and appraiser trainers will continue to be monitored to ensure there is sufficient availability for appraisals to continue to take place within the timescales in order to meet compliance. • There will be an evaluation of online patient feedback, to understand uptake and whether this should be continued in future years. There will be an exploration of alternative forms of feedback for different services user populations, such as those with learning disability, to ensure that all services users are able to provide feedback about their doctor. • The Trust will formulate a response to the GMC document, *Fair to Refer,* which relates to the fair and equitable response to doctors facing complaints and/or referrals to the GMC. • The revalidation team will prepare for a comprehensive peer review by another Trust in the region in November 2022. • The Appraisal and Revalidation team will seek to train and appoint 2 further Case Investigators for the Trust. **Risk appetite** Risk identified – The Trust continues to have a good governance system of reporting and investigating incidents including serious incidents. The following are areas of potential difficulty for the Trust: • The voluntary status of the appraisers and their importance to our system is noted annually. It remains a concern that, if under pressure from other areas of work, doctors could withdraw from this role, thus threatening the appraisal process. Mitigating factors: o Appraisers have time allocated in their job plans for the role. o The workload of appraisers is regularly reviewed in the Appraiser Forum and the Revalidation Oversight Group. o Ensuring the Trust has sufficient appraisers to enable the maximum number of 7 appraisals for each appraiser per year to be maintained. Whilst Covid-19 is still prevalent, it is expected to have at least some ongoing impact on appraisal and revalidation activities, for example due to postponements related to staff being ill or isolating with covid. Due to the significant reduction in face-to-face contact with patients, it is anticipated that some doctors may still struggle to collect the minimum number of patient feedback responses; doctors are expected to continue to try and this will be assessed on an individual basis.
Recommendation:	**The Board is asked to RECEIVE this report noting that it will be shared with NHSE.** • **The Board is further asked to recognise that the resource implications of medical revalidation are likely to continue to increase year on year.** • **The Board is finally asked to APPROVE the NHSE Designated Body Annual Board Report Statement of Compliance, attached as Annex D of this report, confirming that the Trust, as a Designated Body, is in compliance with the regulations.**

NHS
South West Yorkshire Partnership
NHS Foundation Trust

MEDICAL APPRAISAL / REVALIDATION
ANNUAL BOARD REPORT 2021-22

1. Executive Summary

1.1 137 doctors had a prescribed connection with the Trust as of 31st March 2022.
- 96.4% of the doctors that were due to have their appraisal have successfully completed the appraisal process during 2021/22, which is a vast increase on last year, back to pre-covid levels.
- 13.8% of the doctors had late meetings or late submissions. 4 of these late submissions were not approved. The rest were approved by either the Associate Medical Director (AMD) for Revalidation or Responsible Officer (RO) as appropriate.

1.2 35 revalidation recommendations were made between 1st April 2021 and 31st March 2022.
- 35 doctors had positive recommendations made.
- All of these recommendations led to revalidation of the doctors by the General Medical Council (GMC).

1.3 Post-Covid-19, medical appraisal and revalidation has reverted back to pre-pandemic processes and timescales following a period of paused appraisals.

2. Purpose of Paper

This report is presented to the Board:

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

2.2 To inform of progress in medical appraisal and revalidation during 2021/22.

3. Background

3.1 2021/22 was the tenth year of medical revalidation. Launched in 2012 to strengthen the way that doctors are regulated, the aim is to improve the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical profession. As this is the tenth year, most doctors in the Trust are now in their third 5-year revalidation cycle.

3.2 L2P, the e-appraisal web-based system that the Trust utilises is based on NHS England's medical appraisal guide (MAG) model appraisal form.

With all of us in mind.

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

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

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

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

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

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

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

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

4. Governance

4.1 Trust's Revalidation Team

- Responsible Officer – Dr Subha Thiyagesh
- Associate Medical Director for Revalidation – Dr Mike Ventress
- Business Manager, Medical Directorate –Catherine Lothian (until August 2021 and Michelle Goth (interim post from 16 August 2021)
- Medical Directorate Coordinator – Charlotte Lyons
- HR Business Partner with responsibility to support Revalidation – Diane Taylor/Jane Murgatroyd

4.2 Main Tools Utilised Centrally

- L2P (web based) – e-appraisal system
- Datix (Trust system) – provision of incident, complaints and compliments data
- HR Online (Trust system) – provision of sickness data and mandatory training
- GMC Connect (web based) – designated body list

4.3 Designated Body List

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

4.4 External Oversight

The Trust is subject to the oversight of the NHS England Revalidation Team. During 2021/22, NHS England did not require the usual quarterly reporting, instead encouraging Trusts to focus on their response to the pandemic. Regardless, we continued to complete the Annual Organisational Audit/Statement of Compliance and have been submitting quarterly reports from April 2021.

4.5 Internal Oversight

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

4.5.2 The RO, AMD and Business Manager meet monthly to ensure that there is regular communication with the RO and that any issues are highlighted and acted upon. Where a meeting is not possible, email and telephone conversations take place to ensure matters are dealt with in a timely manner.

4.5.3 The Revalidation Team have Revalidation Review meetings to formally consider those doctors with a revalidation recommendation required within the following 12 months.

4.5.4 The Revalidation Oversight Group has the aims of:

- To advise the Responsible Officer of delivery of appraisal and revalidation processes and overall direction in terms of strategic, policy and performance.
- To advise the Responsible Officer of delivery of the improvements to revalidation based on the recommendations from Sir Keith Pearson's Taking Revalidation Forward [TRF] report.

The group has a volunteer lay member to provide independent scrutiny and service user input.

4.6 Independent Verification

4.6.1 Independent verification is required to be undertaken every 5 years. In November 2017 a Revalidation Peer to Peer Review was undertaken with Leeds and York Partnerships NHS

Foundation Trust and the resulting report shared with NHS England. A further peer review is planned for November 2022.

5. Medical Appraisal

5.1 Covid-19 and Medical Appraisal and Revalidation

5.1.1 In March 2020 the GMC announced, in conjunction with NHS England that all medical appraisal and revalidation activity was to cease for six months, to enable doctors to focus on Covid-19. For all doctors who were due to be appraised between April 2020 and September 2020, appraisal was be postponed by 12 months, therefore appraisal numbers were not as high as previous years, due to having only 6 months of data. However, having restarted on 1 October 2020 the figures returned to and remained at pre-pandemic levels and the appraisal and revalidation process is working effectively. A small proportion of doctors were unable to obtain the stipulated minimum number of patient feedback responses and in a number of these discretion was used to allow them to reflect on a smaller number. Where this number was clearly insufficient to usefully reflect upon, doctors were required to continue collecting responses and carry this over to the next appraisal year.

5.1 Appraisal and Revalidation Data

	Consultant		**SAS* & Trust Grade**		**Fixed Term**	
Number of doctors as of 31st March 2022 who have a prescribed connection to the Trust	83		44		10	
Number of completed appraisals during 2021/22:	82	97.6%	41	93.2%	10	100%
Number of missed/ incomplete appraisals during 2021/22(see reasons in appendix 1):	2	2.4%	3	6.8%	0	0%
Number of doctors	0	0%	0	0%	0	0%

With all of us in mind.

In remediation: *						
Number of doctors in disciplinary processes	0	0%	0	0%	0	0%

Specialty Doctors, Associate Specialist/Specialist doctors and LAS junior doctors.
***NB**:* Please note that one doctor participated in 2 appraisals with the 2021/22 financial year.

5.2 Appraisers as of 31st March 2022

5.2.1 Number of appraisers – 34 (29 consultants, 5 SAS doctors)

5.2.2 Support activities undertaken:

- A half day refresher training session was provided on 28.04.2021 for 6 and 03.03.2022 for 7 appraisers.
- New appraiser sessions facilitated on 12.10.2021 and 03.03.2022. These sessions were facilitated by experienced Trust appraisers, currently Dr Mike Ventress and Dr Khaled Mostafa. On 03.03.2022 the 3 new appraiser trainers joined the session and will facilitate future sessions.
- Appraiser forums were held on 20.05.2021 and 01.10.2021 and 25.01.2022. The forums continue to provide an opportunity for appraisers to share ideas about good practice and discuss areas of concern/difficulty.
- Continuous improvement of the appraisal process in the Trust is also an important topic for discussion in the forums, and areas of good practice and reasons for appraisals being referred back for further work are highlighted by the AMD.

5.3 Quality Assurance Processes

5.3.1 There is a portfolio minimum data set required for appraisal and the appraisers are required to check that this is uploaded or an adequate reason provided for non-inclusion.

5.3.2 The Trust utilises the multisource feedback tool embedded within L2P. This automatically flags with the doctors when they are required to undertake the colleague and patient feedback (required to be undertaken every 3 years, unless new to the Trust then required within first year). The reports are only released to the doctor if they have gained the minimum number of responses (and undertaken their self-assessments) or a request for release to the Revalidation Team is agreed.

With all of us in mind.

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

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

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

5.3.6 Each doctor is asked to provide feedback about the system and appraiser after their appraisal has been submitted (see section 5.6). This process is embedded in the L2P system. This feedback is combined with other objective measures and observations of the AMD who provides feedback in writing to appraisers on an annual basis. If any issues arise in the course of the year, the AMD will liaise with individual appraisers.

5.3.7 The reviews undertaken by the AMD and RO also often raise agenda items for the Appraiser Forums, where, for example, inconsistencies are identified.

5.3.8 The appraisers receive further group feedback during Appraiser Forum meetings.

5.3.9 Such issues are also discussed at the refresher training, which appraisers are required to attend every 2 years.

5.4 Access, security and confidentiality

5.4.1 The e-appraisal system (L2P) is required to be used by all doctors. No breaches to the system or individual portfolios were recorded during 2021/22.

5.4.2 Access to individual appraisals on L2P is restricted by login to the doctor, their appraiser, RO, Medical Director (MD), AMD and the Revalidation Team and any other person to whom the doctor provides access (via their own login).

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

5.5 Clinical Governance

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

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

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

5.6 Appraisal feedback

Of the 135 feedback questionnaires completed by doctors after their appraisal, the following is a selection of the feedback given:

Was your appraisal useful for:	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Your personal development	53% (49%)	41% (42%)	4% (7%)	1% (2%)	0% (0%)
Your professional development	56% (56%)	39% (39%)	4% (2%)	1% (3%)	0% (0%)
Your preparation for revalidation	61% (56%)	36% (41%)	4% (2%)	0% (1%)	0% (0%)
Promoting quality improvements in your work	54% (45%)	39% (48%)	7% (5%)	1% (2%)	0% (0%)
Improving patient care	53% (49%)	39% (42%)	8% (7%)	0% (2%)	1% (0%)

Number of hours	<1	1-2	2-3	3-4	>4
Duration of appraisal discussion	4% (3%)	56% (67%)	26% (15%)	9% (8%)	4% (7%)

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree

With all of us in mind.

The appraisal was satisfactory	**70% (69%)**	**26% (30%)**	**3% (1%)**	**1% (0%)**	**1% (0%)**
I was able to collect all the necessary supporting information from the organisation	**62% (57%)**	**30% (36%)**	**6% (6%)**	**1% (0%)**	**1% (1%)**

***() are the 2020/21 results.**

98% of the doctors either agreed or strongly agreed that they would be happy to have the same appraiser again.

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

6. Revalidation Recommendations (1.4.21 to 31.3.22)

Number of recommendations	35
Recommendations completed on time	35
Positive recommendations	35
Deferral requests	0
Non engagement notifications	0

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

6.2 As an outcome of this process, 100% of recommendations due in 2021/22 were submitted on time.

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

6.4 No recommendations were made late (within GMC category of late 7 days and under).

With all of us in mind.

See Appendix 3; Audit of revalidation recommendations

7. Recruitment and engagement background checks

7.1 Substantive and Fixed Term appointments

During 2021/22, 6 substantive doctors were employed and 4 doctors were employed on temporary contracts. These figures exclude medical trainees.

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

7.1.2 For consultants, all interviewees are required to complete a 16PF (16 personality factors) questionnaire and the resulting assessment report is considered by the Advisory Appointment Committee.

7.1.3 For consultants, an assessment centre is held if more than 1 candidate for the role is to be interviewed.

7.1.4 Where appropriate, Medical HR checks the national database for Approved Clinician and Section 12 status. GMC registration is also checked.

7.1.5 Reference checks from the previous 3 years of employment are undertaken by Medical HR and the Appointing Officer confirms that they are satisfied with the references. The references will be checked for the correct dates and that the person giving them is the relevant person to provide.

7.1.6 Medical HR would normally meet with the doctor to verify their ID using the acceptable documents list. However due to the pandemic, they have requested that copies are sent and the original documents are checked, copied, signed and scanned by the clinical lead on the doctors first day.

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

7.1.8 The MD checks and approves the final offer letter prior to sending.

7.1.9 If a doctor is recruited with GMC conditions, further information from the GMC is requested.
* if requests for RO information have not been responded to after 4 weeks, the Trust's RO will contact the GMC Employment Liaison Advisor to flag but recruitment will continue to ensure posts are filled as soon as possible.

7.2 Agency Locum appointments

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

7.2.2 The Trust engages with PlusUs which offers a Direct Engagement service solution through a system which will source the market for available doctors across the framework suppliers and a direct engagement service which provides a temporary Trust contract that does not attract VAT. They also provide an on-line portal which advertises / searches temporary clinical roles across the full range of approved framework suppliers.

7.2.3 The Medical Clinical Lead/Medical Manager usually leads on the securing of locum doctors for their areas.

7.2.4 PlusUs provides suitable CVs and references through an online portal.

7.2.5 If a locum doctor's appraisal is over 24 months overdue, then it is recommended the doctor is not engaged.

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

7.2.7 In line with the Trust guidance on booking locum doctors, the internal lead is then required to undertake a telephone interview prior to commencement.

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

8. Monitoring Performance

8.1 Doctors are generally monitored through their team management structures.

8.2 In addition, a doctor's performance is monitored via the appraisal system, which includes a requirement for feedback from service users and 360° feedback from colleagues on a three-yearly basis.

8.3 Information in relation to whether a doctor is involved in serious incidents or subject to complaints is also included in the appraisal system.

8.4 Serious incidents are investigated using the Trust investigation procedures, carried out by trained investigators.

8.5 In the event that any concerns are raised, these are referred to the MD who can instigate various levels of investigation and take to the Responding to Concerns Advisory Group as appropriate.

9. Responding to Concerns and Remediation

9.1. The Trust has a Responding to Concerns and Remediation Policy which was approved in June 2018 and reviewed and approved in September 2021.

9.2. As at 31.3.22 the Trust had 1 trained Case Manager and 1 trained Case Investigator, both of whom are medical consultants.

9.3. A Responding to Concerns Advisory Group meets monthly. It is chaired by the RO and is also attended by the Medical Director (currently both roles are held as one), Director of Human Resources, Organisational Development and Estates, the AMD for Revalidation, Director of Nursing and Quality and Medical Directorate Business Manager. Relevant general management representatives may attend as and when required. This approach ensures a consistent and open approach is taken across the Trust in the investigation of concerns in relation to doctors. The group's terms of reference are included in the Responding to Concerns and Remediation Policy.

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

10. Risk and Issues

The following are areas of potential difficulty for the Trust:

10.1 The voluntary status of the appraisers and their importance to our system is noted annually. It remains a concern that, if under pressure from other areas of work, doctors could withdraw from this role, thus threatening the appraisal process.

Mitigating factors:

- Appraisers have time allocated in their job plans for the role.
- The workload of appraisers is regularly reviewed in the Appraiser Forum and the Revalidation Oversight Group.
- Ensuring the Trust has sufficient appraisers to enable the maximum number of 7 appraisals for each appraiser per year to be maintained.

10.2 Whilst Covid-19 is still prevalent, it is expected to have at least some ongoing impact on appraisal and revalidation activities , for example due to postponements related to staff being ill or isolating with covid Due to the significant reduction in face to face contact with patients, it is anticipated that some doctors may still struggle to collect the minimum number of patient feedback responses; doctors are expected to continue to try and this will be assessed on an individual basis.

11. Actions, Improvements and Next Steps

An action plan for medical appraisal/revalidation is regularly reviewed and updated by the AMD and Business Manager and periodically reviewed with the RO.

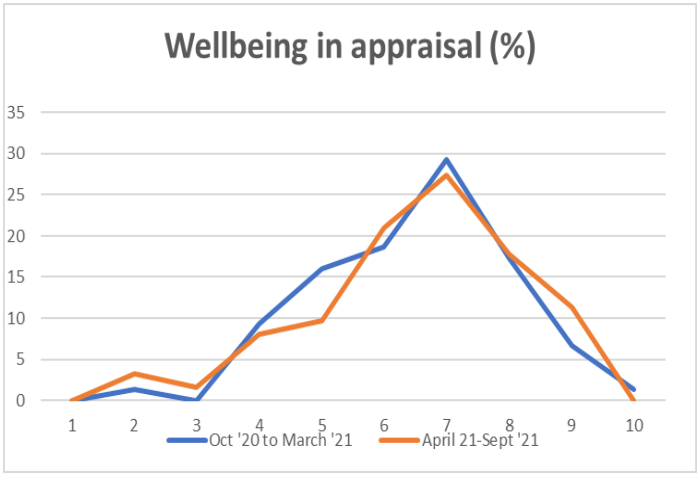
11.1 Improvements Implemented 2021-22

11.1.1 Ensuring the quality of appraiser training is maintained with the introduction of new trainers, the AMD has been leading on training in 2021/22 and has continued to recruit new appraiser trainers. It is expected that in 2022/23, the AMD will be in a position to hand over appraiser training to the new trainers and have minimal involvement with future training sessions, whilst maintaining oversight to ensure effectiveness, and reviewing activities as and when required.

11.1.2 As more and more face-to-face activities have been reintroduced, the
difficulties with doctors obtaining multi-source feedback (MSF) have now been minimised and is no longer seen to be an issue to specifically focus on. The appraisal process has been continually reviewed in light of Covid-19 and the implications this has had. Appraisal processes recommenced in October 2020 following a pause between April-September 2020. Following the advice of the GMC with a focus on ‘wellbeing’, an additional section was added during 2020 and continued. Nationally, this led to an increased focus on wellbeing, with doctors being asked to rate their wellbeing and this being a particular focus of the appraisal meeting and the continuation of this has been welcomed by all involved in the appraisal process. Appraisers have signposted doctors to appropriate resources, when required. Doctors were asked to rate their overall level of well-being at the time of the appraisal and to describe the impact of the pandemic on them, how they maintained their health and well-being and the extent to which they needed support (and whether this was available). This was further expanded upon in the appraisal discussion itself.

11.1.3 In order to better understand the potential impact of the pandemic on doctors in the Trust, the AMD reviewed the well-being section of all appraisals completed over a year from that October 2020, separating them into two 6-month periods, hypothesising that given the easing of the pandemic to some extent by then, the second period might show higher reports of overall well-being. In addition, free text comments were reviewed, in order to see whether any themes were prominent, which might give an insight into the needs of doctors.

11.1.4 The bar chart below gives a visual representation of doctors' well-being scores by percentage of doctors appraised in each 6-month period. The shape of the graphs is broadly similar, suggesting that there was no real change in perception of well-being as the year progressed. There are no data available prior to the pandemic, to judge whether well-being overall was scored lower as a direct result of the pandemic.



A number of themes in particular were prominent across the whole period which mainly focussed on the extent to which doctors felt professionally isolated, an increase in workload and the impact on their mental health. The appraisal and revalidation team are considering as part of next steps and actions, how these might be addressed more broadly in support of doctors' wellbeing.

11.2 Next Steps (2022-23 Actions)

11.2.1 The quality of the training delivered, as judged by feedback from new appraisers, will be monitored following the additional trainer recruitment.

11.2.2 The number of appraisers and appraiser trainers will continue to be monitored to ensure there is sufficient availability for appraisals to continue to take place within the timescales in order to meet compliance.

11.2.3 There will be an evaluation of online patient feedback, to understand uptake and whether this should be continued in future years. There will be an exploration of alternative forms of feedback for different services user populations, such as those with learning disability, to ensure that all services users are able to provide feedback about their doctor.

11.2.4 The Trust will formulate a response to the GMC document *Fair to Refer,* which relates to the fair and equitable response to doctors facing complaints and/or referrals to the GMC.

11.2.5 The revalidation team will prepare for a comprehensive peer review by another trust in the region in November 2022.

11.2.6 The Appraisal and Revalidation team will seek to train and appoint 2 further Case Investigators for the Trust.

12. Recommendations

12.1 The Board is asked to receive this report, noting that it will be shared with NHSEI.

12.2 The Board is further asked to recognise that the resource implications of medical revalidation are likely to continue to increase year on year.

With **all of us** in mind.

APPENDIX 1
AUDIT OF LATE APPRAISALS DURING 2021/22

DOCTOR FACTORS	**CONSULTANT**	**SAS/TRUST GRADE**
Parental Leave during the majority of the appraisal period	0	0
Sickness Absence during the majority of the appraisal period	1	1
Prolonged Leave during the majority of the appraisal period	0	0
Suspension during the majority of the appraisal period	0	0
New starter	0	0
Postponed due to incomplete portfolio / insufficient supporting information	0	0
Lack of time of doctor	2	0
Lack of engagement of doctor	0	0
Other doctor factor e.g. bereavement, sickness, or other time factors not applicable elsewhere	3	0
APPRAISER FACTORS	**NUMBER**	
Unplanned absence of appraiser	0	0
Lack of time of appraiser	2	0
Other appraiser factor (describe)	6	1
ORGANISATION FACTORS	**NUMBER**	
Administration or management factors	0	1
Failure of electronic information systems	0	0
Insufficient numbers of trained appraisers	0	0
Other organisational factors (describe) – suspension of appraisal due to Covid-19	1	1

With all of us in mind.

APPENDIX 2
QUALITY ASSURANCE AUDIT OF APPRAISAL INPUTS AND OUTPUTS

TOTAL NUMBER OF APPRAISALS COMPLETED – 138		
	NUMBER OF APPRAISAL PORTFOLIOS AUDITED (1.4.21-31.3.22)	**NUMBER OF APPRAISAL PORTFOLIOS DEEMED TO BE ACCEPTABLE AGAINST THE STANDARDS**
APPRAISAL INPUTS		
Scope of work	138	138
Is continuing professional development compliant with GMC requirements?	138	138
Is quality improvement activity compliant with GMC requirements?	138	138
Has a patient feedback exercise been completed?	137	137
Has a colleague feedback exercise been completed?	138	138
Have all complaints been included and appropriately reflected on?	138	138
Have all significant events been included and appropriately reflected on?	138	138
Is there sufficient supporting information from all the doctor's roles and places of work?	138	138
Is the portfolio sufficiently complete for the stage of the revalidation cycle?	138	138
Other reason	138	138
APPRAISAL OUTPUTS		
Appraisal summary	138	138
Appraiser statement	138	138
PDP	138	138

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

With all of us in mind.

APPENDIX 3
AUDIT OF REVALIDATION RECOMMENDATIONS (1st April 2021 to 31 March 2022)

Recommendations completed on time (within GMC recommendation window)	35
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	35
PRIMARY REASON FOR LATE/MISSED RECOMMENDATIONS	
No Responsible Officer in post	0
New starter / new prescribed connection established within 2 weeks of revalidation due date	0
New starter / new prescribed connection established more than 2 weeks of revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible Officer error	0
Inadequate resources or support for the Responsible Officer role	0
Other (describe)	0
TOTAL (sum of late and missed)	0

With all of us in mind.

APPENDIX 4
AUDIT OF CONCERNS ABOUT A DOCTOR'S PRACTICE

CONCERNS	HIGH LEVEL	MEDIUM LEVEL	LOW LEVEL	TOTAL
NUMBER OF DOCTORS WITH CONCERNS ABOUT THEIR PRACTICE IN THE LAST 12 MONTHS				
Capability concerns (as primary category)	0	0	0	0
Conduct concerns (as primary category)	0	2* (to include an ongoing case from 2020/21)	0	2
Health concerns (as primary category)	0	0	0	0
REMEDIATION/RESKILLING/RETRAINING/REHABILITATION				
Number of doctors who have undergone formal remediation				0
Consultants (permanent, employed staff)				0
Staff grade, associate specialist, specialty doctor (permanent, employed staff)				0
Temporary or short-term contract holders				0
OTHER ACTIONS / INTERVENTIONS				
LOCAL ACTIONS				
Number of doctors who were suspended/ excluded (commenced or completed between 1.4.20 and 31.3.21)				1
Number of doctors who have had local restrictions placed on their practice in the last 12 months				2*
GMC ACTIONS				
Number of doctors referred to the GMC between 1.4.21 and 31.3.22				1
Number of doctors who underwent or undergoing GMC Fitness to Practice procedures between 1.4.21 and 31.3.22				1
Number of doctors who had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1.4.21 and 31.3.22				0
Number of doctors who had their registration / licence suspended by the GMC between 1.4.21 and 31.3.22				0
Number of doctors who were erased from the GMC register between 1.4.21and 31.3.22				0
NHS Resolution ACTIONS				
Number of doctors about whom NHS Resolution has been contacted between 1.4.21 and 31.3.22				1 (ongoing case from 2020/21)
Reason for contacts:				
For advice				1 (ongoing

With all of us in mind.

	case from 2021/21)
For investigation	0
For assessment	0
Number of NCAS investigations performed	0
Number of NCAS assessments performed	0

Please note that one case is in relation to a locum agency doctor and one case resulted in dismissal from the Trust in July 2021.

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

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:.....2
Designated Body Annual Board Report.....4
Section 1 – General:.....4
Section 2a – Effective Appraisal.....65
Section 2b – Appraisal Data.....97
Section 3 – Recommendations to the GMC 97
Section 4 – Medical governance 108
Section 5 – Employment Checks.....1310
Section 6 – Summary of comments, and overall conclusion 1310
Section 7 – Statement of Compliance: 1411

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2021 – 31 March 2022 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of South West Yorkshire Partnership NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: N/A Comments: The Medical Director of the Trust is also the Responsible Officer Action for next year: N/A

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: Monitor demand on current resources Comments: No requirements have come to light with regard to additional resources Action for next year: To continue to monitor and address as required

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: N/A Comments: The Revalidation Team ensure that the designated body list of doctors is accurate. The formal list of the Trust's prescribed connections is recorded on the GMC Connect portal and regularly monitored to account for new starters and leavers, and given that individual doctors can add themselves to GMC. To facilitate this, the Revalidation admin team liaises with payroll and Medical HR to continuously obtain accurate information. Action for next year: N/A

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: N/A Comments: Medical Appraisal Policy approved May 2021 and Responding to Concerns & Remediation Policy approved September 2021. These policies will be routinely reviewed in 2024 unless local or national changes need addressing earlier. Action for next year: N/A

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year Comments: The last revalidation peer review took place in November 2017 with Leeds and York Partnerships NHS Foundation Trust and the resulting report shared with NHSE Action for next year: A peer review has been scheduled for November 2022.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: N/A Comments: All doctors working in the Trust, work under the Trust's governance processes. The Trust's processes to engage agency locums includes appraisal and revalidation checks. Doctors on short-term contracts within the Trust undertake appraisal within the Trust's processes and have access to study leave as per substantive doctors. Action for next year: N/A

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: To liaise with L2P to ensure appraisals flag the requirement for doctors to declare work outside of the Trust.

Comments: All doctors are provided with a PDF formatted record (including a nil response if appropriate) of their Incidents, Complaints and Sickness for their appraisal year from the Revalidation Team. This data is directly uploaded to the doctor's electronic appraisal record. Those doctors who also undertake work outside of the Trust are required to provide supporting information from their other places of work.

Action for next year: Continuing to work with L2P with regard to appropriate rewording to capture all eventualities, including the option of sharing elements of appraisal with job planning participants and vice versa.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/A

Comments: Where this supporting information is missing, this is picked up in the review process (all appraisals are reviewed by the Associate Medical Director for revalidation and the Responsible Officer) and the doctor would be asked to provide the information or explain the reason for its absence.

Action for next year: N/A

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: N/A

Comments: Approved by Executive Management Team in May 2021, review due May 2024.

Action for next year: N/A

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Continue to monitor the requirement for additional appraisers and take action accordingly as and when required.

Comments: The AMD and revalidation team continue to promote opportunities to recruit new appraisers and identify individuals that are keen and show interest at their own appraisals. The Revalidation Team is happy with the number of appraisers currently and the processes are working effectively. However, any potential risks to recruitment of appraisers and retention are monitored.

Action for next year: N/A

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: N/A

Comments: Appraiser Forums are held 3 times a year. It is an expectation that appraiser attend a minimum of 50% of appraiser forums across a ~~2 year~~2-year period (i.e. 3 per 24 months) in order to be deemed suitable to continue appraising. A designated refresher training session is also expected to be attended every 2 years. In addition, the AMD for Appraisal and Revalidation provides individual annual feedback to each appraiser.

Action for next year: N/A

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: N/A Comments: A comprehensive annual appraisal/revalidation board report is submitted, which details the Quality Assurance processes in place. There is also a revalidation oversight group with a lay representative in attendance, to monitor performance and quality of the appraisal and revalidation processes. Action for next year: N/A

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2022	**137**
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	**133**
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	**5**
Total number of agreed exceptions	**5**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: N/A Comments: A process is in place within the Revalidation Team to ensure timely recommendations are made. No late recommendations were made in 2021/22.

Action for next year: N/A

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: N/A

Comments: The RO / AMD confirms with the doctor if a deferral is to be recommended, providing the reasons for this decision – in most cases discussions will have already been taking place with the doctor around a possible deferral. In the case of non-engagement, a specific process is followed, involving extensive efforts to assist the doctor in engaging, in an effort to avoid such an outcome. The individual would be fully informed that a non-engagement recommendation was about to be made.

Action for next year: N/A

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: N/A

Comments: Clinical Governance for doctors is overseen by the Trust's Clinical Governance and Safety Committee. The committee's remit is to provide assurance to the Trust Board that appropriate and effective clinical governance arrangements are in place throughout the organisation, through receipt of exception reports from relevant Directors to demonstrate that they have discharged their accountability for parts of their portfolios relating to clinical governance. This covers the areas of practice effectiveness, drugs and therapeutics, infection prevention and control, diversity, information governance and clinical documentation, managing violence and aggression, medical education, safeguarding children, research and development, compliance, and health and safety.

Action for next year: N/A

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: N/A Comments: The Medical Directorate collates information from reporting systems for complaints and significant incidents relating to doctors. This together with sickness data is uploaded to a doctor's appraisal document. Other relevant information, such as involvement with coroners' inquests, is also noted on the document. Doctors are also required to upload their mandatory training matrix to their appraisal document. Job planning is now completed on the same electronic system to allow easier sharing of information across the two processes. Colleague and patient feedback occurs at least every 3 years and is automatically uploaded to the appraisal form. Triangulation of all above data and review of content of appraisal occurs before sign-off by the RO. Action for next year: N/A

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: N/A Comments: The Trust has a Responding to Concerns and Remediation Policy. A Responding to Concerns Advisory Group meets monthly wherever possible/required. It is chaired by the RO/Chief Medical Officer (formerly Medical Director) and also includes the Chief People Officer (formerly Director of Human Resources), the Associate Medical Director for Appraisal and Revalidation, Director of Nursing, Quality and Professions, and the Medical Director Business Manager. Relevant general management representatives attend as and when required. This ensures there is a consistent and open approach taken across the Trust in the investigation of concerns relating to doctors. The meeting group terms of reference are included in the Responding to Concerns and Remediation policy. Action for next year: N/A

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and

outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: N/A Comments: There is a pathway to receive concerns which includes the Chief Medical Officer (formerly Medical Director) and RO. The Responding to Concerns Advisory Group ensures there is consistency in the investigations and management of concerns across the Trust. The annual appraisal and revalidation report is submitted to Clinical Governance and Clinical Safety Committee and Trust Board, and includes a table detailing numbers, types and outcomes of concerns. Action for next year: N/A

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: A new form was developed for the transfer of information and this would be used where concerns need to be transferred. Comments: Nil Action for next year: N/A

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: N/A Comments: An Equality Impact Assessment was undertaken in developing the Responding to Concerns & Remediation Policy. The Responding to Concerns Advisory Group monitors all processes relating to concerns about

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

doctors' practice; however, the low numbers involved precludes meaningful analysis.

Action for next year: N/A

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: N/A

Comments: The People Directorate undertakes pre-employment checks for all employed doctors in line with Trust agreed procedures. CVs and references are required for agency locum staff, together with a telephone interview.

Action for next year: N/A

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report: N/A**
- **Actions still outstanding: N/A**
- **Current Issues: N/A**
- **New Actions:**
  - **To continue to monitor demand on current resources and take appropriate action**
  - **To participate in a peer review of Appraisal and Revalidation processes, which is scheduled for November 2022**
    To continue to work with L2P, the platform used for Appraisal and Revalidation in the Trust, with regard to appropriate minor adjustments to ensure this platform continues to provide an optimal service for the ~~Trust.~~ Trust.

Overall conclusion: This has been a very positive year both in terms of performance of the appraisal and revalidation system and the incremental development of the process despite the challenges of the pandemic. Appraisee feedback continues to remain positive as does the AMD feedback to appraisers. We have continuously reviewed our processes to ensure appropriate systems are in place to support our

doctors in their journey to remain up to date, provide high quality patient care and be able to be revalidated.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

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This publication can be made available in a number of other formats on request.

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South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 September 2022
Agenda item 10.4

Private/Public paper:	**Public**		
Title:	**Community Safer Staffing Update**		
Paper presented by:	**Chief Nurse/Director of Quality and Professions**		
Paper prepared by:	Associate Director of Nursing, Quality and Professions		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Risk 4.1 - Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user experience and the inability to sustain safer staffing levels.		
Any background papers/previously considered by:	The contents of this report have been reviewed in Clinical Governance and Clinical Safety Committee (CGCSC).		
Executive summary:	• The focus of Safer Staffing within the Trust has mainly been focused on inpatient areas, using the electronic health roster system. • The Trust has received capital funding for system licences from NHSE/I as part of a collaborative bid with other Trusts, to progress implementation of the e-Rostering system to all clinical teams within the Trust. • Safer staffing business continuity plans are in development for community teams. • Work is underway to improve Bank colleague support. • Community vacancies are being monitored and our approach includes identifying opportunities to recruit via our attendance at recruitment fayres and our centralised recruitment process. • The community and inpatient safer staffing groups are merging given their shared agenda.		
Recommendation:	**The Trust Board is asked to RECEIVE and COMMENT on the report.**		

With all of us in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board

Community Safer Staffing Update September 2022

Background

The focus of Safer Staffing within the trust has mainly been focused on inpatient areas. Currently our community teams are not all on the electronic health roster system, which can cause difficulties with understanding their current staffing (capacity) to deal with the demand (acuity). However, the Trust has received capital funding for system licences from NHSE/I as part of a collaborative bid with other Trusts, to progress implementation of the e-Rostering system to all clinical teams within the Trust. Resources required to support the implementation of this are currently being considered. Staffing tools are available, and the Trust Safer Staffing Specialist Advisor is meeting with the mental health community Care Groups to determine which model will be consistently used going forward.

A community focused Safer Staffing meeting has been established, although it is in a state of infancy and will merge with the inpatient safer staffing meeting from October 2022, given their shared agenda. Business Continuity Plans are in place, but these do not currently include Safer Staffing escalation plans. Also, the requirement of bank staff to support community teams in a meaningful way still requires additional work to be fully understood, and availability of appropriately trained agency staff to fill vacant posts/long term absences has been minimal.

Current work in progress

The requirement to have the right people, in the right place, at the right time and with the right skills is equally important within our community teams as it is in inpatients. To ensure this our plans include:

- Develop Safer Staffing escalation plans in line with the inpatient model.
- Ensure a dedicated resource is available within the staff bank team to deal efficiently with locum requests whilst ensuring compliance guidelines are followed.
- Organise individual meetings with General Managers in September to understand temporary staffing requirement.
- Make successful applicants from the centralised recruitment process available to community teams when the candidate has expressed community as a preference.
- Understand the requirements of a peripatetic worker within the community services to ensure a core number of that workforce can also support our community colleagues when required.
- Support the development of new roles or adapting existing ones to support the skill mix required to deliver a safe and effective standard of care.
- Spot test various staffing models across teams from different areas to ensure appropriateness of model pending a wider review of staffing profiles. (August and September 2022)
- Complete the revision of the terms of reference for the Safer Staffing group for inpatients and community by the end of September 2022.
- Review membership of the meeting and ensure that it is appropriate by the end of September 2022.

Summary

Attendance at the Community Safer Staffing group has been good and spread throughout all areas within the trust. Community vacancies are being monitored and steps are being implemented, including representation at recruitment fairs and centralised recruitment, to improve their effectiveness. A more robust understanding of the issues facing our community teams regarding safer staffing has already been established and a pathway of support for responding to these issues will be developed with our Care Group colleagues.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 September 2022
Agenda item 10.5 – Assurance from Trust Board Committees

Collaborative Committee

Date	4 August 2022
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Assure:** • This was the second meeting of the Collaborative Committee • For the first time, the meeting reviewed material from the South Yorkshire Provider Collaborative • The format/agenda of the meeting is maturing but we will review the effectiveness of the meeting and the appropriateness of the Terms of Reference in a few months' time **Advise:** • The key areas of focus remain 1. Level of Out of Area Beds 2. Commissioning intentions 3. Contracting arrangements 4. Quality **Alert:** • Work continues to address the issues at Cygnet Bierley following the receipt of their "inadequate" CQC report. Further update to be given at Board
Approved Minutes of previous meeting/s for receiving	Minutes will be presented in Private Board due to being commercial in confidence.

Clinical Governance & Clinical Safety Committee

Date	13 September 2022
Presented by	Nat McMillan Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	**Alert** • The committee received the report on Delivery of Clinical Services with recognition of the ongoing pressures and risks that are detailed on the BAF. • The pressure in clinical services remains significant and the risk continues to be managed and mitigated by the TRIO. The committee received the SI quarterly report and continue to raise concerns about the impact on our staff with the significant levels of physical aggression and violence being experienced. **Assure** • The performance around the percentage of service users being offered a copy of their care plan continues to be a challenge and an area of focus for improvement. The committee were advised about

	an interim fix regarding the reporting process and whilst assured that this demonstrates action being taken, will be seeking a trajectory for this improvement to be able to monitor the impact of the interim change to process. • Learning and Disability training is now a requirement for all staff coming into effect from 1 July 2022. • The committee received the Annual Report for Quality Monitoring Visits with the full report identifying key themes including record-keeping, waiting lists and more visibility of senior leaders across Older People Services and Community Learning Disability Teams. Overall themes included issues with the ESR system for mandatory training and workload for staff with the workforce pressures. Positive themes included teamwork and ongoing quality improvement. The Chair of the committee will consider how to provide feedback to our governors who support these visits to share how this is being managed. • The committee received the report on the Mental Health Inpatient Service User survey 2021/22. The Trust scores are mainly in the intermediate range with the remainder in the top 20%. The committee were assured to hear this about our service users experience given the challenges around workforce and increasing demand and an assurance that this risk is being managed and mitigated in terms of the quality of care. The committee received the Complex Case Review Report and was assured by the level of oversight it received. The committee received the Choking Thematic Review and noted the learning that has taken place from the external review. The committee received the Annual Drugs and Therapeutics Report and recommended it for board approval. The committee received the Medical Appraisal/Medical Revalidation Annual Report 2021 -22 and recommended it for board approval **<u>Advise</u>** • We heard from the Community Learning Disability team who had received an Excellence Award for their outstanding care during Covid and definitely going the extra mile to deliver patient centred care based around individual needs. • The committee agreed an extension to the Quality Strategy and the new completion date of December 2022.
Approved Minutes of previous meeting/s for receiving	7 June 2022 7.6.2022 CGCS minute.doc

Equality, Inclusion and Involvement Committee

Date	15 June 2022

Presented by	Marie Burnham, (Chair of Committee)
Key items to raise at Trust Board	**Alert:** • Identify **support for middle managers** on the EI&I agenda to ensure information is cascading down and they are equipped to support the agenda. • **Insight report continues to flag up issues with SPA**, more work required to understand if there is a problem. Continue to promote choose well for sign posting. • CAMHS - care group received with work underway to diversify team. To pick up a conversation with the care group leads and NEDS about waiting times outside the meeting. • Suggested **internal audit for equality in 2023/2024** - focus on Accessible Information Policy – to be agreed by Audit Committee. **Advise:** • **BDU update on CAMHS** reported on the care group work to ensure EI&I is embedded. The group reported on a specific piece of work to address under representation in North Kirklees CAMHS and literature translations as some of the many achievements to remain inclusive. • Progress on Trust approach to disability - **Elaine Shelton, chair of the staff disabled network,** provided an overview of the achievements of the staff network, which included a 'Disability Matters' event in August. Key messages are to overcome barriers and focus on recruiting talent rather than making reasonable adjustments. • **EDS2 will continue this year**, with a report and grading by Winter 2023. The Trust are planning for the delivery of the new **EDS2022** which will commence in April 2023. • **WRES and WDES reports presented and identified some challenges** with the data. Looking at how these reports provide assurance to wider Trust efforts rather than standalone reports. • **Transgender policy reviewed** and accepted with some minor changes to wording. Embedding the policy requires a service improvement approach. • **Progress on the Equality dashboard and metrics** continues with a revised dashboard. The key focus will be on BAME and deprivation for people who use services in line with NHSE/I. For workforce, a focus on Ethnicity, LGBT and Disability will be rotated. The focus this month was on Ethnicity. • An example of one equality film, **'Angie's story' on neurodiversity,** was shared. These films will be delivered through monthly half hour lunch box sessions, open to all staff. **Assure:** • The **EI&I exception and highlight report provided assurance** that the Trust continue to deliver on the Trust wide strategy action plans for both equality and involvement. • National, local and regional updates which include legislation and publications are presented at every EIIC. The **Committee were assured that the Trust is embedding any recommendations, good practice and has sight of any policy or legislative changes** through the correct channels. • TOR agreed to include updates related to Social Responsibility and Sustainability strategy. • EIIC action plans mid-year review presented little time for discussion - to bring back to next meeting with a focus on strategy. **Risks discussed:**

	Risk register and recent changes already agreed by Trust Board were reported and agreed by EIIC.
Approved Minutes of previous meeting/s for receiving	15 June 2022 Minutes from EII meeting 15.6.22 appr

Finance, Investment & Performance Committee

Date	22 August / 26 September 2022
Presented by	David Webster, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert:** Agency target now set; we require circa 3.5% of spend to deliver this with current month at 4.6%. The options are being worked through, however, there may still be issues in delivering, which could result in some inflationary funding being removed. **Advise:** • Inflationary pressures are continuing to be monitored • Mental Health Investment Standard was reviewed, and we are trending well, the main gaps are recruitment, however, do not believe anything currently would put risk of losing funding **Assure:** • Pay award impact being worked through, as not fully funded Verbal update for 26 September to be provided during the Board meeting.
Approved Minutes of previous meeting/s for receiving	23 May / 27 June 2022 Item 4 FIP minutes 23 May 22 FIP 27.06.2 Item 4 FIP draft minutes 27 June 22 FI

Mental Health Act Committee

Date	16 August 2022
Presented by	Kate Quail (Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Advise:** • Mental Capacity Act/ Liberty Protection Safeguards: Code of Practice and Regulations consultation - Trust submitted response after detailed consultation with staff, service users and carers. Current implementation timescale - October 2023 (realistically spring 2024). 6 month lead in time required for workforce training. • Bill of Rights Bill - Potential impact on Mental Capacity Act (MCA) and Mental Health Act (MHA). The Bill proposes to change or remove provisions of the Human Rights Act which could see an erosion of rights for the most vulnerable people. The Trust Human Rights Act statement will need to be reviewed/ updated, as will Trust policies underpinned by the Human Rights Act.

	Assure: • CAMHS service user journey. CAMHS teams - good understanding and use of key legal frameworks that they work within. Secure provision can be very challenging environment for staff - teams use restorative supervision as part of Secure Stairs. • Strong partnership working ensuring patients' rights upheld, as reported by Hospital Managers. • 'Monitoring the MHA 2020/21 CQC annual report' benchmarking. Gaps identified and built into quality groups' work, with good links to MHA office. • Performance Monitoring information Q1 – Overall, good assurance of compliance. Of note: Section17 Leave Compliance - Cancellations - • Working Age Adults, Older People's Services & Rehab: Q1 - 99% of granted leave was taken. 3 cancelled. Forensics & Specialist Services: 1816 periods of leave granted in Q1, 208 of these were cancelled due to staffing deficits, skill mix, re-allocated staff, unit lockdowns and cancelled appointments. 86% of granted leave was taken. Cancelled leave is reported in Datix and included in staff supervision. Consistent themes are escalated through general management processes. • Assurance from Mandatory Training compliance (standard is 80%). MCA/DoLS training compliance - 93.43% • MHA training compliance - 89.44%. • Deep Dive - Section 132 (patients' rights) – found compliance rate of rights read to service users increased from 83% to 95% over the last 12 months and compliance rate of rights read to patients subject to a CTO increased from 83% to 87% over last 12 months. • Of note – 3 years ago this compliance was invariably approx. 43%. • Advocacy services report – the last 12-18 months has seen a significant increase in compliance, i.e. improvement in access to advocacy services, following development of strong partnership working with Advocacy organisations and great work of MHA office. • Restricted High-Risk People in the Community - report on the good work undertaken to date and the progress made. Good assurance that the Trust is compliant and successfully managing these very complex cases. • Care Quality Commission MHA visits – One visit in Q1. • Throughout the Trust, only one overdue action - relates to Mid Yorkshire Hospitals ICE system - being progressed through their governance process. **Risks discussed:** • Organisational Risk Register risks with a potential impact on the application of the MHA; relate to staffing, bed availability and national shortage of clinical staff. Currently no risks on Mental Health Act Committee risk register.
Approved Minutes of previous meeting/s for receiving	10 May 2022 PDF MHA Committee minutes 10 May 2022

Members' Council

Date	16 August 2022
Presented by	Mike Ford Non-Executive Director (Chair of Committee for Marie Burnham)
Key items to raise at Trust Board	**Key points:** • Members' Council received the report on the Trust ISO 260 audit of accounts 2021/22 • Members' Council received the Integrated Performance Report • Members' Council received the Quality account and external assurance 2021/22 • Members' Council received the Social Responsibility and Sustainability strategy and update. • Members' Council received and discussed the presentation on; Child Adolescent Mental Health Services (CAMHS) including "a day in the life" of a Clinical Lead, Wakefield CAMHS, Eating Disorder Team
Approved Minutes of previous meeting/s for receiving	10 May 2022 Final MC minutes 10.05.22.pdf

Workforce and Remuneration Committee

Date	13 September 2022
Presented by	Mandy Griffin (Non-Executive Director) (Chair of Committee)
Key items to raise at Trust Board	**Alert:** To escalate an issue that requires further discussion or action 1. There was concern on the overall compliance rate for appraisals at 56.7% and the impact this could have on staff well-being and retention 2. There is still an overall concern around recruitment and retention whilst there are a number of initiatives taking place, the board still see this as high risk. **Advise:** To highlight an issue that may require further monitoring (by the Committee) over a period of time 1. Absence numbers have increased, this is mainly due to the consolidation of COVID and non-COVID absence it is now running at 5.53% against a target of 4.4% COVID is at its lowest at 1.30% 2. The committee received the guardian of safe working report for first time, normally presented at FIP. The committee was made aware of some of the recruitment gaps. 3. There was some challenge around the overall Mandatory training compliance target of 80% further discussions are scheduled around this 4. The inpatient recruitment plan was received, it was noted that the 50% reduction of vacancies target could be a challeng. The overall recruitment plan will be presented to the committee in November. 5. The Consultants pay award was approved this involved 6 consultants

	6. In the private section of the meeting the Directors pay award was approved. **Assure:** 1. WRES and WDES action plans were received the committee asked that in order to ensure full accountability for the actions that the leads on key actions are confirmed quickly, also that some of the actions that are described as ongoing should be allocated a completion date where appropriate. 2. An update on the staff survey was received. The report lacked assurance on impact of actions taken. It was agreed that this should be reflected in next year's survey with clear actions and measurements agreed. **Risk Register**: reviewed risks. The committee reviewed all risks, a number of new risks were discussed and deferred to EMT before being approved at board level. This did include the disruption around industrial action
Approved Minutes of previous meeting/s for receiving	5 July 2022 WRC Minutes of 05.07.22 final TB 27.0

WYMHLDA Collaborative Committees in Common

Date	26 September 2022
Presented by	Marie Burnham
Key items to raise at Trust Board	Verbal update to be provided during the Board meeting.
Approved Minutes of previous meeting/s for receiving	To be approved.

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

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee held on 7 June 2022 Via MS Teams (COVID-19)

Present:	Nat McMillan (NM)	Non-Executive Director (Chair of the Committee)
	Darryl Thompson (DT)	Director of Nursing, Quality and Professions (Lead Director)
	Dr Subha Thiyagesh (ST)	Medical Director
	Kate Quail (KQ)	Non-Executive Director
	Marie Burnham (MB)	Chair of the Trust
	Carol Harris (CH)	Director of Operations
In attendance:	Sarah Harrison (SH)	PA to Director of Nursing Quality & Professions (author)
	Fareena Rasaq (FR)	Service Manager LD Services (for item 20 & 22)
	Tom Jackson (TJ)	Trust Lead for Learning Disabilities (for item 20 & 22)
Apologies:	Greg Moores (GM)	Chief People Officer
	Nick Phillips (NP)	Head of Estates and Facilities
	Carmain Gibson-Holmes (CGH)	Deputy Director of Nursing, Quality and Professions
	Yvonne French (YF)	Assistant Director of Legal Services
	Lindsay Jensen (LJ)	Deputy Director of Human Resources and Organisational Development
	Julie Williams (JW)	Assistant Director of Corporate Governance & Risk

CG/22/75 Welcome, introductions and apologies (agenda item 1)

The Chair, Nat McMillan (NM) welcomed everyone to the meeting, invited introductions and noted the apologies, as above.

It was noted that due notice had been given to those entitled to receive it and that, with quorum present, the meeting could proceed.

CG/22/76 Declaration of interest (agenda item 2)

The Committee noted that there were no further declarations over and above those made in the annual return to Trust Board in March 2022 or subsequently.

CG/22/77 Minutes of previous meeting held on 17 May 2022 (agenda item 3)

The notes were approved as an accurate record.

It was RESOLVED to APPROVE the minutes of the meeting held on 17 May 2022.

With all of us in mind.

CG/22/78 Matters Arising (agenda item 4)

NM informed the Committee that the workplan is with Corporate Governance at the moment who are going through this to ensure that the Committee is aligned to Trust Board as the frequency of the meetings has changed. NM will chase this up.

Action: NM

CG/22/78a Any matters arising/actions from Trust Board (agenda item 4.1)
Long Term Segregation is on the agenda today.

CG/22/78b Action log (agenda item 4.2)
The Committee noted the action points and updates.

CG/22/39 Quality Monitoring Arrangements – NM asked if the visits will be resumed between September 22 and March 23. DT confirmed that they would resume and also that if any risk based concerns were raised in the meantime, a visit would take place.

CG/22/41 Waiting lists update – work is underway with the Performance & Information Team and the report will be considered at the Operational Management Group (OMG) meetings. Carol Harris (CH) will obtain an example which will look at the impacts of waits in Barnsley CAMHS. CH will bring this to a future Committee once ready. Complete

Action: CH

CG/22/62 Safer staffing – (Complete on the action log) Kate Quail (KQ) was aware that this action was complete and noted that it was helpful to learn that the Trust used planned establishment to report our fill rates. KQ was aware, however, that there were different ways that Trusts report on staffing and that some Trusts use budgeted reporting and some Trusts use clinically required reporting. KQ raised that the issue with our Trust's reporting is that it would not be accurate as the fill rates data on the IPR of over 100% frequently reported does not provide assurance that staffing was adequate on a shift by shift basis. KQ added that it is clear, however, when a calculation uses planned staffing as clinically required and suggested that to strengthen assurance in SWYPFT, both calculations should be used. KQ also noted that Safecare runs a census twice a day to gain a real time oversight of staffing which is a red flag system.

DT agreed that fill rates in themselves do not provide assurance however once Safecare is established it would provide a live view of staffing versus acuity. In the interim DT will be meeting with Deputy Directors who oversee inpatients, together with Safer Staffing colleagues to discuss how best to capture any significant staffing incidents and how to provide the level of assurance needed for Committee and Trust Board.

CH and DT confirmed that Forensics are implementing Safecare this month.

Committee want to keep an oversight of Safecare and this will be kept on the action log.

Action: SLH

CG/22/79 Review of Committee Related Risks, including a focus on COVID 19 related risks – update following Board discussion (agenda item 5)

DT informed the Committee of a request to review and agree two risks, RISK ID 1612 and RISK ID 1536 currently owned by the Chief People Officer. Committee were asked to agree the merging of the risks, a new description, measure and risk score. This is to be discussed later on the risk paper.

New RISK ID 1711 – Staffing at the Poplars in Hemsworth. NM wasn't clear whether the risk was around the shortage of staff or the environmental risk. CH informed the Committee that this risk may need to be considered on the private risk register however informed the Committee that the environmental risk was that the Poplars is a geographically isolated unit that due to the acuity of the patients that are there, should be near to an acute hospital or mental health wards. There are some plans to move this unit should an emergency arise, together with discussions about the unit's future in the medium to longer. CH noted that this was a live risk and there are serious concerns about the mid and longer term use of the Poplars as it can be difficult to recruit staff to work in the unit. it. Staff also have to use the 999 ambulance service for patients if needed due to the isolated location.

Subha Thiyagesh (ST) went on to advise the Committee that a number of discussions had taken place regarding this risk both with the Executive Trio and Older Peoples Transformation. From a clinical point of view the risks are as highlighted above and the use of the unit has changed over time to become more acute. The unit is also overlooked residentially and there is no outside space. The unit was originally a step-down unit from Crofton Ward, however its current use is not in line with what was originally commissioned.

Marie Burnham (MB) queried that if the unit is clinically unsafe it cannot continue and patients should be transferred. Also, in relation to a business case for the Poplars to redefine the purpose, what has been commissioned is not what is provided as the Trust provide a more complex level of care.

CH informed the Committee that at the moment the unit is clinically safe however due to staffing, within 6 months this might not be the case. There will be a paper going to Executive Management Team (EMT) on Thursday to discuss a plan to move service users from the Poplars to Crofton Ward at Fieldhead.

Committee accepted the risk level, noting that it is a dynamic risk and MB noted that the Trio are happy with the level. The committee also noted that the Trio are measuring the level of risk on the complexity of people within the Poplars and not what the Poplars was commissioned for.

The Committee are accepting the level of risk and assurance from the Trio that the people within the Poplars are of a client base that is higher than what is commissioned for.

RISK ID 1568 – To review and consider - seclusion. KQ queried whether the seclusion rooms were now in action. CH informed that this remained a risk. There is a plan in place. The work has started on the seclusion rooms to ensure standards are met. To remain on the register.

RISK ID 1612 and 1536 –To consider a merge. These risks currently sit with the Chief People Officer and the Committee are asked to agree the merge, agree new description, measure and risk score

The Committee agreed in principle to combine the two risks but given that they both currently sit with the Chief People Officer, and there is a clinical aspect to them, DT will meet with Greg Moores (GM) to agree a new, shared risk which will be taken to EMT, and then to come back to CGCSC at a later date.

Action: DT

The Committee noted the removal of RISK ID 1523 and RISK ID 1537.

The Committee REVIEWED and CONSIDERED the risks associated with the Clinical Governance & Clinical Safety Committee.

CG/22/80 Director of Nursing, Quality and Professions update report (agenda item 6)

DT gave a general update to the Committee.

- Document taken as read.
- National student nurse placements have increased year on year in recent years and DT informed that this included Mental Health.
- Tendable – NM queried whether this would replace the Quality Scheme, DT confirmed that it would not. Tendable provided data that would be helpful for the quality scheme going forward. NM would like more clarity on this.

  Action: DT
- MB would like the offer of 'golden handcuffs' to be given to trainees – DT and GM to discuss and action this and to obtain numbers.

  Action: DT
- The committee noted the recent recruitment of four band 6 colleagues in learning disability services, and the team's positive approach to how these were advertised.

The Committee RECEIVED the update.

CG/22/81 The Quality Account (agenda item 7)

No further update as this was discussed at the last meeting and has been taken to Trust Board.

The Committee NOTED.

CG/22/82 Clinical Audit and Service Effectiveness (CASE) Annual Plan (agenda item 8)

DT informed that this was a summary of the audit work of the Quality Improvement & Assurance Team (QIAT), and noted that this work included Infection Prevention and Control (IPC) and Safeguarding requirements.

NM queried if the clinical record keeping commenced in April and also if any findings would be available before March 2023. DT confirmed that it had commenced in April and he would obtain an interim position for the Committee before then.

Action: DT

The Committee NOTED and APPROVED the annual plan.

CG/22/83 Consideration of external audit report and Trust Quality Account (agenda item 9)

DT informed the Committee of one external audit which will be coming to the Committee in due course when it has been signed off, in relation to oversight of the completion of serious incident actions. Improvement actions in response to initial learning from this audit are already underway.

The Committee RECEIVED and NOTED the update.

CG/22/84 CQC Fundamental Standards of Care, Improvement Plan, Preparations, MHA (agenda item 10)

DT reported that this report included both the self-assessment by CQC registered service, and our preparation of teams for any future CQC visitwas an update on CQC assessment structures for each area. It also shows progress against actions from QM visits.

The Committee questioned the lack of assurance given within this document in reference to the outcome of any assessment against fundamental standards of care.

The Committee felt that the CQC strategic approach should not just be considered within this Committee and that it should be Trustwide and that the Trio should take to EMT and a Board paper developed to give the Board assurance.

Action: Trio

DT informed Committee that the background to reporting this as fundamental standards of care was to highlight our commitment to clinical quality, not that this is something that is done just as part of CQC preparations. Therefore, there might be a potential mismatch with the title of the report and its content.

Committee agreed that more details and specifics were needed throughout and would like this to be brought back at a later date.

Action: DT

The Committee NOTED and suggested improvements.

CG/22/85 Quality Focus:- Patient Experience (agenda item 11)

There continues to be a focus on the work required to improve patient experience and triangulate data across Clinical services, Operational services and Corporate services. Collaborations between these services have seen some key developments progress.

NM noted that to improve this paper further, it would be helpful to be explicit that the recent changes in reporting of protected characteristics of not just the complainant, but also who they are complaining on behalf of, is as a direct result of a previous challenge from this committee.

KQ wanted the report to explicitly acknowledge that patient experience is the vital key metric to the quality and safety of care.

MB felt that the report was a good signposting report and would like to see the triangulation of evidence.

The Committee NOTED the update.

CG/22/86 Patient Safety Strategy (agenda item12)

NM noted that this was a returning report having previously been discussed at the April Committee meeting where the Committee did not feel assured. DT advised that this was an evolving, rather than evolved report. More detail and depth had been added, however more work needs to be undertaken and DT would welcome comments to enable this.

NM was pleased to see the additional detail within the report, and that it was recognized to be still evolving.

NM queried any requirement for committee to formally approve this report and by when, DT will check with Andy Lister.

Action: DT

KQ acknowledged that it was a work in progress and more work was needed on the involvement part of the report.

Committee acknowledged the changes and improvements, more work is needed but it is moving in the right direction. DT will bring back in July.

Action: DT

The Committee RECEIVED the report and accepted it provided assurance that the Patient Safety Strategy Group continue to progress with the work plan.

CG/22/87 Workforce update – staffing escalations (agenda item 13)

The Poplars was discussed above. No further specific escalations.

CG/22/88 Delivery of Clinical Services Report (agenda item 14)

CH gave an overview of the key points from the report:

- CH advised the Committee again of the growing problem around neurodevelopmental diagnostic waits for children in Calderdale and Kirklees. Since the last meeting more detailed work had been undertaken and the findings have shown that there had been issues in the way referrals have been sent to the Trust. The large increase in referrals looked like a significant change in demand over and above recently commissioned activity. However, following drill down, it is now believed to be related to a build-up of referrals. Once this issue is addressed, demand is expected to stabilise broadly to commissioned levels.

  Waiting list initiatives remain in place working towards a balanced position in 2023. It was noted that this may complete later in the year beyond the original aim of March 2023.

- Concerns have been raised anonymously regarding Johnson Ward and Corporate Services are undertaking a review. Once the report and findings have been received, this will come to Committee with an action plan.

- MB queried as to whether any risks mentioned within the report correlate back to the risks within the risk register. CH confirmed that was the case and MB asked that this is reflected within the report.

The Committee RECEIVED and NOTED the update.

CG/22/89 Serious Incident Report Q4 and Annual Report (agenda item15)

DT gave a brief overview to the Committee on the routine Serious Incidents Annual Report which included the Q4 information, that this includes all incidents, all serious incidents and learning from healthcare deaths. It is published alongside the Our Learning Journey report and the Apparent Suicides report, both of which will be published in September.

DT informed that there continues to be a high level of reporting of incidents and high proportion of low and no harm incidents. There was still some disparity noted between Kirklees and some other BDUs in the reporting. No Never Events had been reported and there were two Duty of Candour breaches.

NM raised a query in relation to the new sexual safety incidents reporting and asked if this was in response to incidents. DT confirmed that this was in response to an emerging number of incidents that had come through to the Clinical Risk Panel.

The Committee noted that physical aggression still remains very high however noted a slight decrease in patient-on-patient aggression and queried whether there was any learning to be taken from this. DT informed that this was a slight reduction.

The Committee agreed that this was a very good report and felt well sighted.

DT informed that the nailing down of some of the narrative within the report would be taken on board.

The Committee RECEIVED, NOTED and COMMENTED on next steps.

CG/22/90 Internal Audit Report (agenda item 16)

It was noted that there was nothing to report at this time.

CG/22/91 Annual Reports (agenda item 17)

NICE Annual Report

The report is to inform and assure the Committee of oversight of emerging guidelines and was taken as read.

The Committee would like to see updates more frequently of the annual reports and this will be considered in the workplan review. NM and DT to discuss outside of the Committee.

Action: DT / NM

MB highlighted that these are guidelines and are not mandatory and the Trust has to show that they have been considered.

The Committee APROVED the annual report.

RRPI (deferred)

Safeguarding (deferred)

CG/22/92 Customer Services Policy (agenda item 18)

DRAFT

DT informed the Committee that this was deferred until the autumn.

CG/22/93 BDU Governance Report (agenda item 19)

CH asked the Committee for clarity of what is required for this report as it was an historic report that came with updates from the BDUs. Committee considered and agreed that this could now be removed from the workplan as updates are incorporated within other reports that the Committee received.

CG/22/94 Long Term Segregation (agenda item 20)

CH informed the Committee that Fareena Rasaq (FR) and Tom Jackson (TJ) would speak to the paper. The paper was taken as read.

TJ informed the Committee of:-

- How long-term segregation differs from seclusion.
- Overview of the circumstances where long term segregation can be used, including the number of times that this had been used over the last six months within the service.
- Explanation of the frameworks that provided assurance and information on the review of the process and procedures against legislation, Trust policies, documentation, and audits.

MB acknowledged that this is a good report, but noted the need to look at access to outside space for the three individuals mentioned in the report as a matter urgency. FR informed that Estates colleagues are looking at this currently and will inform the Committee of any issues.

KQ noted the thorough report and that an autism friendly environment is needed and a need for a comprehensive approach to autism. TJ informed that the autism friendly environment would need to be flexible to meet the differing needs of the patients. KQ also felt concerned that there was not an external review of our approach, and noted the position on the independent care and treatment reviews as these were supposed to be every six months. TJ confirmed in regards of the external review that requests have gone out to get this underway. In relation to Care and Treatment Reviews (CTR) and Care, Education and Treatment Reviews (CETR) these do happen in line with the right standards and timescales. KQ would find it helpful to receive some update or brief on this to come back to Committee.

Action: CH

NM made a final point in relation to family advocacy views being recorded as recording seems to be an issue which is across the board and NM would like to raise this as an ongoing concern.

Committee noted the great progress made but needs to see further progress on actions.

The Committee COMMENTED and NOTED the progress made.

CG/22/95 Complex Case Review Report (agenda item 21)

DT informed Committee that as there was no Private Trust Board in May this report was being seen here first. The report shows the Trust's oversight of complex serious incidents, our involvement in local safeguarding reviews and our progress against the choking action plan.

Incidents that have had a recent high profile within the Trust:-

2018 /19023 – narrative verdict referred to neglect.
2019 /7184 – Ward 18, death on rail tracks.

2021/9224 – noted that this might attract media interest – absconding from escorted leave.

Choking report – shows immediate changes that have been made in response to the learning, and our overall progress against our action plan.

The Committee felt that this is considered thoroughly at Board and in this Committee and felt updated and sighted. The report was clear and provided assurance. To develop this further, Committee asked for learning to be added within the report.

The Committee RECEIVED and NOTED the report.

CG/22/96 Learning Disability Referrals Report (agenda item 22)

CH informed the Committee that FR and TJ would speak to the paper and noted that the paper had been prepared for EMT and updated for Committee purposes. The paper was taken as read.

Key points to note:

- No service users have been admitted to the assessment and treatment unit as a result of care being delayed whilst on a waiting list.
- Performance has consistently not achieved the 90% threshold throughout 2021/22
- At the end of 2021/22 our performance with regards people receiving a completed assessment, care package, and be in receipt of service delivery within 18 weeks, was 86.5%, against a target of 90%.

Issues that impact on the waiting times include:

- Increased referrals and increased level of need
- Challenges in recruitment and the availability of people to recruit
- The way teams worked created artificial barriers between disciplines
- Lack of access to other services, such as day provision

Actions in place to address these include:

- Pro-active recruitment, including reviewing roles and making changes to pathways
- Improved oversight and management of demand
- Routine welfare checks for service users
- Steps to better understand demand

FR gave further information which was not contained in the report in relation to the impact of other providers on our demand, particularly where providers had changed or stopped delivery during COVID. FR also identified that there was an emerging concern that as providers had returned post-covid, their offers may have changed, which has led to our assessments needing to be repeated or done differently. The full impact of this is not yet fully understood.

MB raised a concern in relation to the further detail that FR and TJ gave above what was included in the briefing and noted that it needed to be included in the report given the

severity of the situation and the impact on our service users. MB would like FR and TJ to revisit the report with CH to prepare a business case for Trust Board.

ACTION: CH

NM noted that the briefing provided had good content and advised that some aspects align to the FIP Committee. NM noted that the CGCS Committee had requested information on the impact of people waiting and the impact on them, and this had been included. Further evidence to support this would be helpful. CH confirmed that discussions had been had with the P&I teams in relation to what other indicators could be included, to demonstrate the impact on quality of care for people waiting.

FR informed the Committee a welfare check is given at around 14/15 weeks of a person's wait. This is recorded on their healthcare record, and if an urgent need is identified, appropriate actions are taken.

The Committee was pleased to see progress and the quality aspect considered.

The Committee RECEIVED and COMMENTED on the briefing.

CG/22/97 Reports from Formal Sub-Committees – exception reporting (agenda item 23)

The reports were taken as read.

Drug & Therapeutic (agenda item 23.1)
The update was received and noted.

Infection, Prevention & Control (agenda item 23.2)
The update was received and noted.

Joint Safeguarding (agenda item 23.3)
No further update since last Committee.

Reducing Restrictive Physical Interventions (agenda item 23.4)
No further update since the last Committee.

Improving Clinical Information Governance Group (agenda item 23.5)
The update was received and noted.

Clinical Governance Group (agenda item 23.6)
The updated was received and noted.

Clinical Ethics Advisory Group (agenda item 23.7)
No further update since the last Committee.

QUIT (agenda item 23.8)
No further update since the last Committee.

Safer Staffing (agenda item 23.9)
The update was received and noted.

Physical Health (agenda item 23.10)
The update was received and noted.

DRAFT

CG/22/98 Serious Incidents Update (agenda item 24)

DT informed the Committee of two incidents that were taken to the Clinical Risk Panel.

Two Community colleagues had been involved with incidents involving weapons, one involving an air rifle and one with a knife. Both colleagues have been supported.

Also, we have spoken in Committee previously about identifying the potetnail quality impact of acuity and availability of beds. There has been a recent incident where person was identified as requiring a bed under the Mental Health Act and whilst the search for the bed was underway the person took their own life. This has since been reported to the Strategic Executive Information System (StEIS) and an investigation is underway.

CG/22/99 Issues and items to be brought to the attention of Trust Board and other Committees (agenda item 25)

The following points were agreed as issues and items to be brought to the attention of Trust Board and other Committees:

Alert

- The Poplars – clinical safety
- Outside space for long term segregation
- Recording - long term segregation compliance

- Assurance
- Received long term segregation report
- Learning Disabiiity waits – this is an evolving situation
- Serious incident Annual Report inc Q4

- Advise
- Patient Safety Strategy – report received, further work required

CG/22/100 Risk Register Review (agenda item 26)

CH to confirm that Learning Disability Services have recorded the risk in relation to external providers in their Risk Register.

Action: CH

CG/22/101 Work Programme Review (agenda item 27)

As above.

CG/22/102 Date of next meeting (agenda item 28)

The next meeting will be held on 19 July 2022.

DRAFT

Glossary

ACP	Advanced clinical practitioner
ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DoV	Deed of Variation
DoC	Duty of Candour
DQ	Data Quality
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FOT	Forecast Outturn
FT	Foundation Trust
FYFV	Five Year Forward View

HEE	Health Education England
HONOS	Health of the Nation Outcome Scales
HR	Human Resources
HSJ	Health Service Journal
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
IBCF	Improved Better Care Fund
ICD10	International Statistical Classification of Diseases and Related Health Problems
ICO	Information Commissioner's Office
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IPC	Infection Prevention Control
IWMS	Integrated Weight Management Service
JAPS	Joint academic psychiatric seminar
KPIs	Key Performance Indicators
LA	Local Authority
LD	Learning Disability
MARAC	Multi Agency Risk Assessment Conference
Mgt	Management
MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus Aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NHS TDA	National Health Service Trust Development Authority
NHSE	National Health Service England
NHSI	NHS Improvement

NICE	National Institute for Clinical Excellence
NK	North Kirklees
NMoC	New Models of Care
OOA	Out of Area
OPS	Older People's Services
ORCHA	Preparatory website (Organisation for the review of care and health applications) for health related applications
PbR	Payment by Results
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
SIs	Serious Incidents
S BDU	Specialist Services Business Delivery Unit
SK	South Kirklees
SMU	Substance Misuse Unit
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Plans
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TB	Tuberculosis
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YHAHSN	Yorkshire and Humber Academic Health Science
YTD	Year to Date

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of Equality, Inclusion and Involvement Committee held on 15 June 2022 Via Microsoft Teams

Present:	Marie Burnham (MBu)	Chair of the Trust (Chair of Committee)
	Mark Brooks (MB)	Chief Executive
	Darryl Thompson (DT)	Director of Nursing, Quality & Professions
	Salma Yasmeen (SY)	Director of Strategy (Lead Director)/Deputy Chief Executive
	Mike Ford (MF)	Non-Executive Director
	Erfana Mahmood (EM)	Non-Executive Director
Apologies:	Greg Moores (GM)	Chief People Officer
In attendance	Rachel Irwin (RI)	PA to Director of Strategy/Deputy Chief Executive (author)
	Dawn Pearson (DP)	Communications, Engagement, Equality and Inclusion Lead
	Darren Dooler (DD)	Governor
	Manreesh Bains (MBa)	BAME network Chair/Consultant Clinical Psychologist
	Sue Threadgold (ST)	Deputy Director
	Aboobaker Bhana (AB)	Equality & Involvement Manager
	David Webster (DW)	Non-Executive Director
	Paul Brown (PB)	HR Business Partner
	Lindsay Jensen (LJ)	Deputy Chief People Officer
	Donna Somers (DS)	LGBT+ staff network Chair/Ward Manager
	Melissa Harvey (MH)	General Manager
	Mike Garnham (MG)	Health Intelligence Analyst/Information Manager
Apologies Attendees:	Noma Ndhlovu (NN)	BAME staff network Vice Chair/Ward Manager
	Cherill Watterston (CW)	WRES OD Lead/Specialist Physiotherapist
	Chris Lennox (CL)	Deputy Director of Operations

Section 1 – Standing Opening Items

EIC/22/24 Welcome, introductions and apologies (agenda item 1)

The Chair, Marie Burnham (MBu), welcomed everyone to the meeting. Apologies were noted.

EIC/22/25 Declarations of Interest (agenda item 2)

Mike Ford (MF) mentioned that he had a new role as Chair of Audit Committee for West Yorkshire Police. MF has already advised Andy Lister and this is noted on the register of interests.

EIC/22/26 Minutes of previous meeting held on 15 March 2022 (agenda item 3)

The minutes were agreed as an accurate record.

It was AGREED to APPROVE the minutes as an accurate record of the meeting held on 15 March 2022.

MF mentioned the staff network report and discussion around lack of membership of the LGBT+ network at the last meeting but couldn't see this on the matters arising/action log.

With all of us in mind.

Donna Somers (DS) advised that the LGBT+ network now had over 80 members. Dawn Pearson (DP) advised that they were going to do a push around membership of all networks over the summer. MF suggested noting this as a further action. Salma Yasmeen (SY) confirmed that we would continue to work on developing and supporting all networks with the network leads.

Action: Dawn Pearson/Paul Brown

EIC/22/27 Matters arising from previous meeting and action log (agenda item 4)
MBu advised that most items were either on the agenda or had already been picked up and it was pleasing to see that many of the actions had been completed.

Mark Brooks (MB) mentioned an action which had been given to all but felt it should have been MF ie. possible internal audit work on equality for 22/23. MF advised there was currently nothing in the plan for this year and it had been a few years since this had been done. MB advised that this could be discussed further at Audit Committee and something to look at in 23/24.

EIC/22/28 Actions from Trust Board (agenda item 5)
MBu advised that there were no specific actions. Additional training on equality and diversity to Board members had taken place yesterday which she had found helpful and thought provoking about what we needed to do throughout the Trust to support staff and ensure we recognised not only diversity but equity. MBu also wanted to see this linking in with our Board development and OD programmes. DP confirmed that this training would be rolled out across the Trust.

EIC/22/29 Review of Committee related risks and any exception reports as required (agenda item 6)
SY advised there were 3 risks specific to this Committee which had also been discussed previously at Board. One recommendation was to merge Risk 1536 and 1612. SY had met with Darryl Thompson (DT) and Greg Moores (GM) and they were reviewing - revised version will be going to EMT and Board.

The Committee were asked to consider the risk score for Risk 1531 with a view to reducing the consequence from 4 to 3. MB agreed that the risk should be reduced given all actions taken over the last couple of years.

MB also mentioned Risk 1689 and the expected timeline for completion and whether it was likely we could reduce this from 4 to 3 by March 2023. MB suggested spending some time at the next Committee meeting discussing to see if the actions we are taking are sufficient to reduce the level of risk by that date – SY to add to agenda for September.

Action: Salma Yasmeen

MB also mentioned Risk 1157 and confirmed that SY and himself had discussed and one area where we are weaker is the Band 7-8d level and therefore this risk may need additional action or slightly rewording.

DT agreed that we were in a position to reduce the risk on 1531 and would ensure the Moving Forward group maintain vigilance regarding people from a BAME background.

MF mentioned Risk 1531 and reducing the likelihood but recommendation was to reduce the consequence. MB confirmed that it was both the likelihood and consequence. MF was happy to support.

Aboobaker Bhana (AB) asked how we linked consequences and actions on service users/end users where we know that health inequalities might have led to worse outcomes. AB mentioned a recent incident and whether there were any inequalities considerations which led to the outcome or whether if there had been earlier interventions, this could have reduced the risk. AB would like to see on the risk register whether there were any inequality factors that led to the worsening of the risk/consequence and in future whether we are able to grade incidents with an EDI lens. MB advised that we needed to understand whether there was a risk which needed to go on the register which wasn't already covered. MB advised that Andy Lister and the team could take AB through the organisational risk register process.

Action: Aboobaker Bhana/Andy Lister

MB also asked DT and his team to consider how we grade complex incidents and if we have an appropriate equality lens on them.

Action: Darryl Thompson

The Committee DISCUSSED and COMMENTED on the current risks and APPROVED merging Risk 1536 and Risk 1612.

EIC/22/30 Context report – National, ICS and Trust level (agenda item 7)
DP advised that all the insight which comes through to Committee is fed through to OMG and the BDU's and it is stored in a bank on the intranet.

DP provided a few highlights:-

- Covid still quite prevalent in reports, particularly around the impact on people still living with Covid, long Covid and on mental health.
- King's Fund film about new NHS landscape – useful animation and something which can be used with communities.
- Draft Mental Health Act Reform in response to 2018 Mental Health Act – still white paper – Trust have fed into the consultation and NHS Confederation think the reforms will help to address health inequalities.
- Response to Race and Health Observatory (RHO) – rapid review into ethnic inequalities in healthcare.
- Institute of Health Equity - how we think about equity in terms of pay, working hours, job security etc.
- Physical and mental health – bridging the gaps.
- Individual articles around disability, NHS as an employer, women's health (older women and menopause), life expectancy, poverty, maternity disparity.

MBu felt the slides were very useful in terms of what's going on and where we are nationally and wondered whether it was worth adding a further slide to show how national policy or guidance is being taken forward in the Trust or what it means for us. DP advised that she could add a tracker/RAG rating. MB asked if DP was confident about where we needed to focus our efforts given so much was happening. SY confirmed that we had clear action plans, considered any new research and reviewed whether we needed to shift any of our priorities and that mostly, the information coming out just reinforced what we already had in these plans.

The Committee NOTED the contents of the context report.

Section 2 – Insight, feedback and programme updates

EIC/22/31 Staff Network Report (agenda item 8)

REACH presentation
SY advised this was a new format to ensure we have a deep dive and focus on each of the networks once a year to strengthen the involvement of the networks in the Committee in a more structured way.

Manreesh Bains (MBa) provided an overview as Chair of REACH staff network. Currently 185 members – longest running network and quite established. MBa has been the Chair for just over a year and will step down after 2-year term at the end of this year. Gained 42 members in the steering group having worked hard to increase membership.

Key highlights:-

- Change of name – previously BAME (Black Asian & Minority Ethnic) staff network group but now REACH (Race Equality & Cultural Heritage). Have rebranded and will be getting pens and lanyards produced which will hopefully get people talking and asking what the network is all about and generate more membership and engagement across the Trust. Has been a challenge to engage members from the wider network, possibly be due to having to work virtually rather than face to face so have had to be more creative ie. Facebook and Twitter.
- Supported many members of the steering group in the recruitment process - involved with senior appointments.
- Wellbeing sessions by Charlene.
- Worked last year with canteen/hospitality staff at Fieldhead to look at the food we provide and be more diverse - celebrated South Asian Heritage month and Black History month and will look to repeat this year.
- Working more closely with other staff network chairs. Joint events last year and this year for staff networks. Had Trustwide event on 11th May around visible and viable voices.
- REACH network were invited to Trust Board on 24th May – shared experiences of what it was like to work in the organisation and the feedback was both positive and constructive.
- Event to be held on 30th June – 'Exposed' – screening a documentary that combines the stories of 19 black, brown and migrant nurses and midwives to speak about their powerful experiences of racism before, during and after the pandemic.
- Shortlisted for Excellence Award and won the runner up award.
- Ramadan food/care packs – need to look at getting funding in place sooner for next year.
- MoveMoreSwypftly Bollywood dance sessions were well received and looking to work further with Desi Nach in the future.
- Vaccine – huge involvement from the steering group over the last 12-18 months offering support and education sessions.
- Supporting Race Forward to ensure the network voices are included.
- Held quality improvement session to consider what's working and what's not.

MBa's key message was that racial equity was not just down to the network and that being an ally was something they were looking to promote and all could play their part.

The network were concerned about a couple of areas – one being the sustainability of the wellbeing post, which has been extended temporarily, and also Cherill Watterston's (CW) departure. MBu thanked MBa for her presentation and advised that MB and SY would pick up the concern regarding the two posts outside of the meeting.

Action: Mark Brooks/Salma Yasmeen

Erfana Mahmood (EM) mentioned the Ramadan packs and that she was happy to support future applications via EyUp! and advised MBa to get an application submitted for next year.

EM also mentioned lack of opportunity and support to attend the network and asked whether this was the general feeling of the network. MBa advised that some people still felt like this, although not as widespread. Sue Threadgold (ST) was disappointed that some staff found it difficult to access the network meetings etc and would share this with colleagues. She acknowledged that it had been difficult due to pressure on wards but suggested the networks coming to the services and having their meetings. ST and MBa to pursue a conversation outside the meeting.

Action: Sue Threadgold/Manreesh Bains

MF asked how the Committee could educate, support and promote allyship in the Trust. MBa confirmed that Charlene was putting on some allyship sessions and that they were also trying to do things differently, even down to the design of the logo. MBu mentioned having a lanyard which incorporated all the network logos but SY advised that the branding, #allofus, was the Trust branding.

AB mentioned that REACH network had supported colleagues in getting time off to do their prayers and also HR colleagues had provided some guidance around Ramadan. AB felt it would also be good to look at retention, promotion, opportunities, learning development for BAME staff to progress in their careers.

The Committee NOTED the presentation and thanked the Chair and network members for their positive contributions to the Trust.

EIC/22/32 BDU Report (agenda item 9)
ST provided an update covering Forensics, Learning Disability, ADHD and Autism:-

EIA actions in progress - have identified those actions which came from the latest round of EIAs – all RAG rated amber. Plans in place to address all of these. Recent discussion concerning Forensics in particular around the number of action plans there are and are considering a different approach for the next round in September. Overall position in terms of EIAs – 1 outstanding red for Horizon (some work has been undertaken but not yet signed off) – 19 green.

Equality highlights:-

- Well attended E&I forum which involves all the services including linked charities and plenty of input in the agenda.
- LD services have successfully introduced strategic health facilitators in three out of the four localities and progressing a post in Barnsley. These individuals work with primary care to ensure the annual health checks are completed.
- LD services updating and refreshing their easy read documentation making it more contemporary.
- FCAMHS service have undertaken a literature and data review relating to referral and access to FCAMHS services.
- Some challenges in Forensics with hate incidents and crime – service users against staff. Continuing to work to develop care plans and assist staff who deal with these incidents on the ward.
- Respect Project – Service has seen some trends in negative relationships across wards with significant negative behaviours, particularly around ethnicity, sexual orientation, and gender. Working with service users and staff to promote positive

relationships. Set each ward an art challenge and will hopefully produce some of the work and share across the organisation.

Involvement highlights:-

- Involving BAME staff in the development of care plan to address inappropriate behaviour/development of a support package for staff.
- Yorkshire and Humber service user network – good reputation for strong representation from the BDU.
- SeQuIn – service user set of standards which we benchmark our services against.
- Culture Calendar - celebration of cultural events led by a different ward each month and spread across the Forensic BDU.

ST asked Committee to consider the EIAs which are due for renewal in September. ST confirmed that they would be done but hoped in future to reduce the number of action plans and possibly have more meaningful and consistent plans across services.

ST mentioned temporary staffing and wanting to include more data in the EIAs related to this. MBu advised that it wasn't possible to have a long conversation about temporary staffing and that this was something which could be picked up outside of the meeting.

MBu felt the report needed some refinement which could be discussed further with SY to ensure it was more succinct. SY felt Forensics was an area we needed to focus on as a Trust as there was an over representation of people from BAME communities and also they were more likely to be admitted by a specialist secure unit The BDUs are trying to ensure they are delivering cultural, spiritual and gender sensitive support but we will need to measure the impact and outcomes.

MB was concerned about Horizon and the red EIA. ST confirmed it would be complete by the end of the month and will make sure the next report reflects this. Currently looking at improvement and development plan.

ST asked whether to include the linked charities in future papers for Committee but this is not required.

The Committee NOTED the contents of the BDU report.

EIC/22/33 Patient/public story (film) (agenda item 10)

DP shared a film from one of the 12 currently being developed – 'Friends of Dorothy'. This will be used in development sessions throughout the year ie. 30-minute lunch box session where staff can watch the film hopefully alongside the community member.

The Committee NOTED the film and extended their thanks to the community group that had co-produced this with the team.

Section 3 – Strategy and Policy

EIC/22/34 Accessible Information Policy (agenda item 11)

DP advised Committee that the policy was actually for comment and not approval at this stage. This policy was aimed at people who use our services and part of a national drive to make sure people with a disability, impairment or sensory loss receive information in a way that they can access and understand and any communication support that they need is identified and provided. Comments are required from all to DP by 1st July before it goes to EMT.

Action: All

MF wondered whether this was a possible area to have an internal audit on in the future to see if we are compliant with this new policy.

The Committee NOTED the policy and that comments were required by 1st July 2022.

Section 4 – Performance Reports

EIC/22/35 Equality dashboard (agenda item 12)

SY advised that this work was ongoing ie. developing the infrastructure to see our data, aligning to Core20plus5 national work and then trying to analyse and draw insight from what the data was telling us. The case study provided had been through the Mental Health Act Committee and to EI&I Committee previously but was now more developed.

Lindsay Jensen (LJ) updated on the workforce data and advised that they had tried to streamline after the feedback from the last Committee meeting. Had focused on disciplinaries, training and recruitment and brought in new Resolution Process which has been refined over the last 6-9 months to include:-

- A decision tree – to ensure we are not putting things through formal processes which we don't need to.
- Cultural and environmental issues will be considered by a panel, including a cultural advisor, in determining next steps ie. formal process. Need to expand number of people who can sit on these panels. Working well but will continue to monitor and review.
- Continuing to work with staff networks sharing the data and solutions. Greg has met the network chairs and will be part of the network groups.
- Reviewing recruitment and selection training to ensure it is more inclusive.
- Leadership and training opportunities.
- Reviewing recruitment & resourcing across the organisation and how to do it.
- Working with staff networks and others around action planning to support recruitment and retention.
- Race forward – thinking about different clinical leadership to move this forward.
- Raising concerns at work approach – working with Estelle.
- Ongoing work to monitor WRES and WDES action plans.

Darren Dooler (DD) asked about the time frame for disciplinary procedures. LJ confirmed that the aim was 6 weeks to 2 months in terms of completion but depends on the level of complexity. A key element of focus for improvement is the resolution process and reducing time spent on those that did not proceed to the formal level. LJ will be looking at those time scales and will monitor them to ensure they are timely as occasionally these are too long. LJ and DD to pick up some current issues outside of the meeting.

Action: Lindsay Jensen & Darren Dooler

EM mentioned the number of BAME staff below Band 7. LJ confirmed that they needed to look at the Leadership Programmes. Have been using the Moving Forward Programme but it was on the agenda and Greg is reviewing the workforce, OD and leadership strategy.

MB felt that there wasn't equal representation when you looked at Band 7-8d and that we needed to think carefully around how we could use positive interventions to make a difference in the short term and also the likelihood of disciplinary action being taken wasn't good enough, therefore, there were some challenges to consider and actions to take as an organisation to address and these needed to be discussed further outside of the meeting.

Action: Mark Brooks

DT mentioned staff being stuck at Band 5 and not being able to progress and suggested when advertising senior roles to make sure we recruit in a visibly open way to senior BAME colleagues from outside the organisation and do whatever we can to develop BAME staff to get a future pathway. EM asked about adding into the IPR so can get sight at Board level.

Action: Greg Moores

DP advised that work was progressing to align with the Core20Plus5 approach to addressing health inequalities and improving the quality of data. The SPC charts provided were to highlight how we felt we were performing against the metrics. Mike Garnham (MG) advised that you couldn't just look at the high level but needed to drill down by BDU and what was happening in different age groups and also culturally. SPC charts are useful only when an intervention has been made and we can identify if this has made any change. The charts demonstrate we have the data available to show what the position is but still needs detailed analysis – case study is an example of how this has been done.

MBu felt we were good at presenting data but not always so good at analysis and determining what we were going to do with it and we needed to link into our policies and procedures. MB felt it was very positive that we now had this information and appreciated the work which had been undertaken so far and agreed that we needed to agree how far we went and also whether the subcommittee could ensure the EI&I Committee got distilled information in future. MB was also keen to know how the information was being used across the Trust and also how we were going to use it to determine what our workforce models look like and what our services provide to reflect the needs of individual communities.

SY advised that this was a hugely complex area and there was an awful lot of data and the issue of how we use it across the organisation to drive improvements is key and are trying to align the way we use the inequalities data and equalities data alongside so we don't have different approaches going on. The onus is on clinical and operational teams to use this. There is a paper going to EMT Time Out around this.

The Committee NOTED the contents of the Dashboard and progress made.

EIC/22/36 Equality, Involvement, Communication and Membership strategy implementation action plan highlight report (agenda item 13)
DP provided some highlights:-

- 2 exceptions reported for equality, none for involvement.
  - How we update our Census data – deadline was June but we have been told the information won't be available until Autumn so will have to extend the deadline.
  - New board training was due in May but was delivered yesterday.
- Improving signing off EIA's - moving from red to amber and green zone. No-one as yet going through new grading but will start to report on this in September.
- Mandatory training remains compliant.
- 12 equality films with sessions planned to share.
- Trust wide mental health EIA will be published on the intranet this week.
- Work ongoing to transition from ED2 to EDS3 and will be discussing this further at subcommittee.
- The Trust now accredited as Disability Confident and Carer Confident.
- Work progressing with Race Forward.
- Working and developing our relationship with the third sector.

- Volunteers are now returning to the services.
- Refresh of Trust transgender policy.
- Equality and involvement team attended and engaged the deaf society in Wakefield. The team worked in partnership with IT services to gain feedback on the 'patient knows best' system.
- Quarterly reports will now be bi-annual into Committee but will also go through subcommittee.

MF mentioned the KPI's. DP confirmed these had just been signed off and would start to bring them to Committee from September.

The Committee NOTED and COMMENTED on the report and APPROVED the recommendations.

Staff Survey – Quarterly Update
Results presented. First time broken down into various groups and interesting to see what staff experience is from these and can determine how and what we need to do about this within teams and BDUs.

LJ also mentioned bank staff and their value and importance in our workforce model and that they are going to be included in the staff survey going forward to get their views which will help us to support them.

Inclusive Leadership & Development Programme Update
LJ provided a verbal update as currently looking at workforce strategy and OD strategy and what we need in terms of OD resource so would prefer to bring something more defined to the next Committee meeting rather than discussing where we currently are.

Many of the Leadership Programmes are continuing as part of reset and recovery but also have recognised through staff survey and feedback from various committees that OD support is key for individuals and teams across the organisation and will build this to manage expectations and deliver improvements. Work ongoing.

The Committee NOTED the updates provided on the staff survey and inclusive leadership and development programmes.

Race Forward update
The paper provided an update on the approach being taken to address systemic racism, racial inequity and racism. DT attended Race Forward wellbeing check in on 9th March. Report highlights 6 aspects being taken forward and the groups established to accomplish this. One thing to note – unable to appoint a clinical lead and could possibly be due to some colleagues being stuck at Band 5. LJ, GM and DT are reviewing what the clinical leadership model might look like.

MBu asked if MBa had been involved in this. MBa confirmed she had worked with CW around how the model might be set up, trying to be as inclusive as possible. Had advertised the position for a clinical lead a couple of times and tried to encourage people to apply but concerned that someone was offered the role but couldn't be released from their service to take up this offer. The network were aware of this and this could be an obstacle to recruitment. MBa also concerned that with CW leaving, the focus on this agenda may be lost. MBu concerned about the issue of not letting staff be released to develop their careers. MB felt it was the process that needed to be looked at.

EIC/22/37 Equality Standard updates (WRES, WDES) (agenda item 14)
LJ provided an update.

- Positive feedback on 4 kickstart young people working in admin in Kirklees. Looking at opportunities/vacancies for them to join the Trust.
- Working with Job Centre Plus around Barnsley – getting long term unemployed people in work experience in our facilities team.
- Working with Prince's Trust around Barnsley Academy.
- Awarded Disability Confident Level 3.
- Will be looking at staff survey data to see where we need to move forward and will work with networks and other colleagues to resolve issues.

MB mentioned disability and that he had received a couple of recent complaints regarding accessibility within our estate and was looking forward to that network attending Committee. SY confirmed that if we had concerns, the order could be moved around for the Disability network to attend the next meeting in September.

MF asked about the various action plans and whether we duplicated any work. SY advised that there were some elements of the bigger plan which sit under the strategy and then the sub elements were actions around workforce, those we are committed to doing about data and insight to drive improvements around equitable service delivery and addressing some concerns linked to experiences about staff from different protected characteristics and then there is also Race Forward, which will eventually have its own action plan which subcommittee will support with.

The Committee NOTED the update.

EIC/22/38 Internal Audit Reports (agenda item 15)
Nil.

Section 5 – Annual Items
EIC/22/39 Annual Items (agenda item 16)
Nil.

Section 6 – Governance
EIC/22/40 Governance (agenda item 17)
Nil.

Section 7 – Standard Closing Items
EIC/22/41 Review of risks (agenda item 18)
MB mentioned the risk around having a representative workforce and making this more explicit about all levels with all professions. Will ask EMT to look at this.

Action: Mark Brooks

EIC/22/42 Work Programme (agenda item 19)
The work programme was approved. SY confirmed that discussions would take place with the chair of the Disability network for them to attend and provide their update at the next meeting in September.

Action: Salma Yasmeen

EIC/22/43 Items to bring to the attention of Trust Board or other Committees (agenda item 20)
The assurance form would be submitted to Trust Board.

EIC/22/44 Any Other Business (agenda item 21)
MBu felt this was one of the best and most important Committees and was pleased to chair it and thanked everyone involved for their work.

EIC/22/45 Date of next meeting (agenda item 22)
The next meeting will be 20 September 2022.

South West Yorkshire Partnership NHS Foundation Trust

Finance, Investment & Performance (FIP) Committee
Monday 23 May 2022
Virtual meeting, via Microsoft Teams

Present	**Apologies**
Mark Brooks (MB) Carol Harris (CH) Natalie McMillan (NM) James Sabin (JS) Darryl Thompson (DT) David Webster (Chair)	Rob Adamson (RA) Kate Quail (KQ)

Item no.	Item/area	Progress and actions/decisions	Lead	Action
1	Meeting behaviours	David Webster (DW) recently appointed Non-Executive Director and Chair of the Committee opened the meeting and advised members that the meeting would be recorded for audit and record purposes.	DW	
2	Welcome and apologies	DW welcomed everyone to the meeting. Apologies were received from Rob Adamson and Kate Quail	DW	
3	Declarations of interest	There were no declarations of interest.	DW	
4	Notes/minutes of previous meeting	The notes/minutes from the FIP meeting held on 25 April 2022 were presented. The FIPC reviewed and APPROVED the minutes of 25 April 2022	DW	
5	Matters arising and Action Log	**Actions closed** DW confirmed he was happy with the actions that had been closed **Actions remain open** **Action 130 Financial performance -** JS referred to a previous conversation that had taken place at the FIPC meeting in May around the increased focus on agency controls and agency spend and he raised the question of whether the members thought there was wider support to request a specific agency action plan update at	DW	

With all of us in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		the meeting in July, or alternatively would the be happy for this to fall into the overall wider financial sustainability plan progress update. MB commented that the pressure on NHS finance and the oversight from the regulators was going to increase with one of the areas being agency. He explained that historically finance had updated a government checklist for agency controls every 2/3 years which had been brought to FIPC. He suggested finance take into account what is sensible and then marry it up with any updated guidance received which is due shortly, once this is complete the control checklist along with finance's own self-certification against this could be brought back to the July FIPC meeting. **Action 126 - 2021/22 Month 11 Financial performance** <u>Provide story board in ready for meeting with regulator</u> MB requested the owner of this action be updated to CH and not himself as currently noted on the action log. <u>Staffing report</u> JS confirmed this report would be refined in M2 and an update brought back to the July meeting		**JW** **JS**
f6	Action delegated from Board (new standing item)	JS stated there were no actions to report	**JS**	
7	Committee related risks	JS presented the update confirming that a detailed review of the risk register had taken place at Trust Board on the 26 April. He confirmed there were no 15+ risks aligned to the FIPC, although there are a number of risks below 15 but outside of the current risk appetite: - JS commented that there had been quite an improvement in a number of the risks as a result of concluding the planning process for 22/23. Key headlines: - • Risk 1214 was closed by Trust Board relating to risk of tendering • Risk 1077 reduced risk score which is now within the risk appetite • 1114 is also likely to reduce going forward		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• Risks 1585 and 522 have been reduced and now fall within the risk appetite • Risk 151, now that the Provider Collaborative meeting has been set up the committee need to decide if this risk needs moving to this committee, or to remain here. This could also be monitored in both. MB stated his preference would be that Risk 151 remained with FIPC as it has overall control over all financial issues. MB commented on the capital risk for next year, he stated potentially there is £2m the trust may want to spend to resolve one of the quality risks by potentially looking at the Poplars. He suggested the committee might want to look at actions to identify what the Trust needs to do with ICS colleagues to ensure they get the right level of influence and engagement with CCGs, also with a view to increasing the budget for next year. On the same principle, he stated the committee need to keep an oversight on how much is being spent on the Bretton Centre this year so that if there are any changes in terms of cost or profile of spend, we can react quickly. NM commented on risk 275 and the fact that Kirklees CCG had placed itself into formal financial recovery, she asked what this meant for the trust as CCGs are not going to exist after July. JS replied that this is a significant financial challenge for the system and does impact the Trust. He confirmed there had been an announcement earlier in the week that there will be more money flowing into the NHS and there was going to be a subsequent planning round which will include an additional £1.5b. He confirmed that part of the money is aimed at CCGs, particularly those with the biggest challenges which would help Kirklees CCG. JS confirmed Kirklees CCG would have to formally give the Trust a 12 month notice period as a minimum before fundamentally changing anything so there was no immediate threat of decommissioning this year, however, place based targeted savings will be forthcoming as we move into 23/24 to help close the recurrent underlying financial gaps across the wider ICB system. MB requested that committee members do not use acronyms as it was very difficult to understand, especially for DW who was new to the Trust and NHS.		

With all of us in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		MB stated there is an excellent commissioner in Kirklees who really promotes and sponsors investment in mental health. MB asked JS if the £1.5b was additional or reallocated monies. JS replied that there had been no national announcement about putting money into NHS, so this is likely to be from within existing national resources. DW confirmed specific requests noting: - Risk 1214 was closed Risk 1077 - JS will look at reducing this going forward Risk 1114 - Holding off until July and will potentially reduce at that point. Risk 1585 - Action to engage the ICS for future planning, Risk 1567 & Risk 522 - happy with expected completion dates. Risk 1511 - MB suggested keeping this with FIPC. NM supported this decision. JS confirmed he would ensure Provider Collaborative have sight of this but will continue on this basis. **The Finance, Investment and Performance Committee DISCUSSED the current Trust-wide corporate/organisational level risks, relevant to this Committee and were ASSURED that the current risk level is appropriate.** **Further, it was AGREED to remove/de-escalate**		
8	Financial performance	JS presented the update, key headlines included: - • Month 1 report is a lighter report than normal • An overall breakeven plan has been agreed for 2022 / 23. This included a profile with surpluses in Q1 and Q2 which turn into monthly deficits in Q3 and Q4. • Key performance indicators have been updated to reflect those included in the new 22/23 IPR. New metrics have been agreed and included which include agency as a percentage of workforce and ones linked to sustainability and overheads. • The finance report reflected the position at the end of month 1. This is a surplus position of £0.6m which is ahead of plan and analysis continues to understand the reasons, drivers, and importantly actions behind	JS	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		this led by changes in workforce remains the key financial variable. There has been a reduction on worked WTE in month compared to previously and additional information has been requested from the Workforce team. (partly assumed linked to the easter holidays) • The plan did include an assumption around additional recruitment and in April there were 58 WTE worked less than funded (once including bank, agency, overtime and additional hours etc). Teams are working to assess recruitment plans and ensure that these are reflected in forecasts (assumed re as above). • Non pay trends are significantly impacted by the Adult Secure Collaboratives. Out of Area placements remain a pressure although bed days are slightly lower than March. • Cash remains positive. This has reduced slightly from the year end due to the high value of invoices paid in April. Debtors are higher than previously. This is viewed as a month 1 timing issue but will be reassessed for month 2. • Capital spend is profiled mainly in Q3 and Q4 with the largest scheme being the commencement of the Bretton Centre scheduled to start in quarter 3. However, where possible we are progressing approved developments as quickly as possible. DT commented that the reduction in wte worked does seem to align with what he is hearing around bank staff from the front line. MB asked JS if he knew how substantive staff moved month on month. JS replied that there had been a significant reduction in substantive employed staff and it is the WTE of individuals working extra hours. CH stated that it was not possible to track individuals who have moved but that she has asked for work to be undertaken on tracking individuals moving within services. .DW questioned whether a deep dive into this would be helpful at the next meeting. MB commented that at this stage he did not feel this was necessary and suggested briefing DW further on this matter outside the meeting. MB asked JS if he knew how the rest of the West Yorkshire ICS had performed in Month 1. JS replied that no one had shared their M1 position as yet. He explained that the ICS had asked Trusts to complete a return on pay run rates, following this they had looked at the Aprils run rate and compared it to plans to see how far adrift trusts were. From a SWY perspective, we looked ok and were not an outlier like some others. MB stated it was important that FIPC had oversight of the Bretton Centre should there be any changes. He also asked JS for an update on contracts as he had only received one contract for signature which was		**MB**

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		Barnsley. JS explained that nationally a deadline of 31st March had been given to agree contract signatures and as NHSI had not been checking or asking for any evidence this had resulted in the majority of the CCGs not pushing forward with preparing contract paperwork. He confirmed that Calderdale & Kirklees had been delayed as they wanted to take their MH investment standard request through their governing bodies, with both meetings taking place in May. JS stated that following these meetings both Calderdale and Kirklees were now in a position to progress to formal contract signature stage. Wakefield have also now agreed the investments via the alliance and were progressing to contract signature.		
9	Post planning submission update	JS presented the update informing the committee that a number of planning submissions had been submitted to the Integrated Care Board and NHS Improvement without having much time to discuss the detail around these at the various sub committees and boards. He confirmed the paper had been brought back to FIPC to wrap up the break-even planning assumptions and included more detail. Key headlines: - • Delivery of the plan is based upon an efficiency / cost reduction requirement of £2.8m (c. 0.8% of income) being achieved. Although CIP delivery has not been the focus for the past 24 months the basis of the historical financial sustainability plan remains valid. The rest is linked to continued increased vacancy factors. • 2022/23 Income includes the full year effect of the West Yorkshire Adult Secure provider collaborative and SY Adult Secure provider collaborative being added in from May 2022. • Depreciation has reduced in 2022/23 due to prior year assets fully depreciated as of March 2022. • The Trust plan shows a surplus position for the first half of the year as a result of the current levels of vacancies. As we start to expand our workforce through initiatives such as international recruitment and due to the phasing of revenue project spend, the Trust is forecast to deliver a deficit from M8 onwards. • COVID and system funding will continue in 2022/23, although this is significantly reduced and is one of the main drivers of the movement from a surplus position to breakeven planned position with ongoing out of area spend the biggest risk.	JS	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• 2% pay uplift has been assumed in line with guidance. 1.25% uplift factored in for the changes to National Insurance. Any pay award approved nationally above 2% is anticipated to come with additional central funding. Nationally they have a pot for a further 1% i.e assumed 3% pay award, any award above this may lead to further risks re funding. • The focus will now shift to longer term planning and ensuring we have workforce and sustainability plans to support this. A 3 year long term financial plan is under development and will come through FIPC during quarter 2. MB commented that there was a likelihood there may well be challenges in Barnsley Place to contribute to the South Yorkshire deficit and he asked JS if he knew if the Trusts potential contribution to Barnsley was recognised within West Yorkshire. JS confirmed that this issue had been regularly raised with the ICS and that they would have to consider this when doing any rebasing exercise. MB felt this could become a sensitive issue later in the year. DW raised a question around the 2% pay award and given the fact that people are tired was this increase nationally going to cause issues. JS replied that people are used to poor pay awards but there is an expectation that it needs to be higher than in previous years. He confirmed there was a possibility the increase could be 3% but that it could be September by the time it is received as there had been another delay. DW asked if this could lead to individuals leaving jobs which could then lead to extra job pressures. JS commented there were still incentives to work for the bank and some people will always choose to work flexibly and there will always be competition with competitors. DT stated this will definitely be a challenge and the reality of this is it will not land well. He stated the Trust were also living with the fact that our private provider competitors are in a position to offer significant increased pay packages with medical colleagues and so this was a challenge. DW commented that this was something the FIPC need to keep a close eye on as the knock on financial impact could be significant. JS replied that as part of the recruitment and retention strategy there was a lot of work being undertaken on the offer beyond the salary, and trying to make it as attractive with other perks and benefit enhancements.		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		JS confirmed the Trust were still in a very comfortable position in regard to the plan. **The Finance, Investment and Performance Committee DISCUSSED and COMMENTED on the 2022/23 Post planning submission update**		
10	Investment appraisal update	JS provided the update on progress against the various investment streams agreed within the Trust annual plan submission. Key headlines: - • Agreed Phase 1 investments back in February. • OMG non recurrent allocations have started. There was a good level of scrutiny and challenge of requests made. • Progress on phase 2 potential investments has also been requested and is progressing via OMG to EMT. • New emerging asks are progressing at pace and will go to EMT in the next few weeks. • Quarterly reports to FIPC regarding the progress of all the investments will commence for 22/23. • Need to work on benefit realisation aspects ensuring we are making it clear, we are clear on the outcomes expected and seeing the deliverables expected. This will be the focus of future reporting. MB stated that he felt the committee needed to recognise this level of reporting exists and take the appropriate assurance. He felt it was a huge amount of detail for a board committee and very operational but that it was also helpful that we can demonstrate the level of control and oversight we have over it. It was agreed that JS would provide a summarised update at the July meeting also focusing on the outcome and benefits of the investment decisions made. It was recognised, there will be more to report on in terms of benefits and outcomes as we progress throughout the year. **The Finance, Investment and Performance Committee DISCUSSED and COMMENTED on the Financial Sustainability Plan**		**JS**

With all of us in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
11	Covid-19 benchmarking update	CH presented the update stating this was the end of year NHS covid-19 benchmarking report from NHS benchmarking agency. CH confirmed there was an internal benchmarking group that meets monthly to consider benchmarking reports that come into the organisation and that unfortunately it was cancelled this month so this report had not been to this group. Key headlines:- • Referral acceptance rates in IAPT have been higher during 22/23 and continue to remain at a high level. • Face to face contacts have recently seen an increase in virtually all services. • Community mental health referral rates at SWYPFT remain 11% down on 19/20 levels however well above the national average. • The position for SWYPFT in adult community services is higher than the national trend with contact rates remaining in the upper quartile nationally and 31% above 2019/2020 rates. • The SWYPFT position for crisis services is also in the upper quartile nationally though is 7% down on 2019/20 rates in March. • Nationally the number of adult acute admission per 100,000 registered population has seen a slight increase in March 2022 though is still -18% on 2019/20. Whilst the SWYPFT figure of 12.6 is not an outlier nationally, it is -7% on 2019/20. • In SWYPFT the number of referrals per 100,000 population in March 2022 was 60% above 2019/20 levels. However, numbers waiting remains in the lower quartile despite being high. • LD and ASD adult community services in SWYPFT have seen a sharp drop in referral rates in 2022 and we are now below the national average of 21 per 100,000 at 17. • The Trust's use of digital means for contacts with service users continues to remain at lower than national averages but appears to be settling down to a new norm, now restrictions have been lifted. NM commented that there was a lot of information in the report, and when was it realistic to say this committee would see something. CH replied that there was a lot of information in the report and stated she was confident we have our processes right and that a running log was kept in the benchmarking report.		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		NM raised the question of was this something she needed to be worried about or not from her perspective as a NED. DW commented that he would like to see a summary of what action is being taken MB stated that this report was introduced by Claire Murdoch at the outset of the pandemic to help trusts understand if they were in line with other changes that were happening, so it was quite limited. He felt unless in depth work was carried out with other organisations it did not really tell us anything. MB felt that when the benchmarking team had time he would like them to be able triangulate the activity with the pressures in the workforce. He stated that given the impact of long covid and other impacts from the pandemic we are seeing people more acutely unwell in the community so there was a different level of response to what had been previously. He stated the committee have to be cognisant that benchmarking in itself is not the end result. MB suggested the committee spend some time on benchmarking separately. It was agreed that JS & CH would meet to review and agree what this committee needs to review in terms of benchmarking. JS commented that he had received the timeline for the national submissions of the corporate benchmarking for last year and that this would be added to the workplan. **The Finance, Investment and Performance Committee DISCUSSED and COMMENTED on the Investment appraisal update**		**JS/CH** **JS**
12	Any other business	There were no items to discuss		
13	Confirmations	**Meeting effectiveness** It was agreed that the meeting had been effective, and thanks was also given to those who prepared papers. **Significant issues to report to the Board of Directors**		

With all of us in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• Keep track of finance collaborative side of things • Ahead of budget in M1 • Delays to pay reward, do not expect it to land positively once received. • Deficits in South and West Yorkshire ICS will lead to further pressure on SWYP but the revised planning process will reaffirm the updated challenge.		
14	Next meeting	**Next meeting** Monday 27th June 2022 09:30 – 11:30 Via MS Teams		

With all of us in mind.

South West Yorkshire Partnership NHS Foundation Trust

Finance, Investment & Performance (FIP) Committee
Monday 27 June 2022
Virtual meeting, via Microsoft Teams

Present	**Apologies**
Rob Adamson (RA) Mark Brooks (MB) Carol Harris (CH) Natalie McMillan (NM) Kate Quail (KQ) James Sabin (JS) Darryl Thompson (DT) David Webster (Chair)	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
1	Meeting behaviours	David Webster (DW) Non-Executive Director and Chair of the Committee opened the meeting and advised members that the meeting would be recorded for audit and record purposes.	DW	
2	Welcome and apologies	DW welcomed everyone to the meeting. There were no apologies received	DW	
3	Declarations of interest	There were no declarations of interest.	DW	
4	Notes/minutes of previous meeting	The notes/minutes from the FIP meeting held on 23 May 2022 were presented. The FIPC reviewed and APPROVED the minutes of 23 May 2022	DW	
5	Matters arising and Action Log	JS informed the committee that the majority of the actions were for next month, with the exception of two being extended to July, these centred around relooking at the workplan particularly around some of the national benchmarking submissions and when they all fall as dates have been moved frequently over the last couple of years. He confirmed the remaining actions were all on track and should fall back in line with original timelines. In relation to action 126 JS asked MB whether there was a need for further papers to come to FIP. MB	DW	

With all of us in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		commented that this meeting would not take place before August and he suggested no separate report was needed and that we continue to bring regular updates through the normal financial and IPR reporting channels. DW agreed with this way forward and confirmed this action can be closed going forward. DW commented that a high number of actions still had JS initials at the side of them and as he is due to leave the Trust on the 30 June could these be updated with RAs initials going forward or as otherwise needed.		**JS** **JW**
6	Action delegated from Board (new standing item)	JS stated there were no new actions to report delegated from Board	**JS**	
7	Committee related risks	JS presented the update, confirming that a detailed review of the risk register had taken place at Trust Board on the 23 May and confirmed there were no 15+ risks aligned to the FIPC, although there are a number of risks below 15 but outside of the current risk appetite: - The committee agreed to: • Move risk 275 to the CG&CSC NM commented that as chair of CG&CSC she felt risk 275 was less aligned with FIP and raised the question of whether this should be a stand-alone risk. CH felt this should sit with CG&CSC and explained there was an action for Learning Disability team to carry out a more detailed review. Once this was complete a decision could be made as to whether this should be a stand-alone risk. NM requested this risk remain open until the next meeting following discussions at the forthcoming CG&CS meeting on 20 July. DW and DT agreed with this approach. • Remove risk 522 • Remove risk 1077 (risk scoring is now within risk appetite) • Discuss and review the recommendation from Trust Board for risk 1114 • Agree the reduction of risk score for risk 1114 KQ commented in relation to the link to growing inflationary risk and cost of living pressures did finance have a sense of what the impact will be of the inflation and cost of living increases.		

With all of us in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		JS responded that £0.5m had been built into the plan for in year inflation risks and that there are currently no concerns and that this would continue to be monitored carefully. He stated that capital was still an area for concern around increasing construction costs linked to inflation. He confirmed whilst there had been additional revenue funding given from the government to address the inflation in cost pressures and funding gaps, there has been no additional money on our CDEL capital limit which means that capital funding will not go as far as it would have done 12 months ago which could present a major system challenge particularly when we are working up the Bretton design. KQ stated she felt this was an area the Committee definitely needed to keep a close eye on. • Discuss and review the recommendation from Trust Board for risk 1585 • Agree the reduction of risk score for risk 1585 • Agree reduction of risk score for risk 1567 • Discuss and review risk 1567 and agree to incorporate within an existing risk under CG&CSC or WRC risk. DW agreed that other committees take relevant parts and then this can be closed off at the July FIP meeting. MB commented that he agreed with JS and that when we established this risk two and a half years ago we were in a very different place and he fully supported MB commented that there might be a slight issue on wording when it comes to talking about the removal of risks from the organisational risk register. He agreed there were a couple, or more, risks too many on the organisational risk register and suggested these be kept on the local risk register. One example he gave was national funding which he stated could change in a year's time and this was one he felt the committee needed to keep an eye on. **The Finance, Investment and Performance Committee DISCUSSED the current Trust-wide corporate/organisational level risks, relevant to this Committee and were ASSURED that the current risk level is appropriate.** **Further, it was AGREED to remove/de-escalate risks 522 & 1077**		

With all of us in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
8	Financial performance	RA presented the financial performance update, key headlines included: - **2021/22 - year end report (attached)** RA stated the paper outlined a couple of technical adjustments that have been made since it was presented to FIP and the Board back in April. This is provided to the committee for clarity and confirmation of the overall year end position. As a result of these adjustments the Trust reported an increased surplus position of £7.9m. **2022/23 – Month 2 Report** • The 2021/22 year end audit is being concluded with submission required on 22nd June 2022. There has been a movement from the unaudited accounts position; improved surplus from £7.4m to £7.9m due to release of the ICO penalty provision. • Additional planning guidance has been received resulting in a plan resubmission on 20th June 2022. This improved the overall financial position from breakeven to £3.2m surplus. A paper outlining the movements will be presented to Board on 28th June. This is a combination of tariff pass through and further one-off savings. This will contribute to the West Yorkshire ICS position moving towards breakeven. • The revised plan included revised assumptions on workforce and vacancies. A £1m reduction has been applied non-recurrently against pay in the early part of the year. As such actual spend is broadly in line with plan for the year to date and the number of vacancies is showing as less than historically. • Forecasting, especially on the planned increase in staff numbers, continues to be reviewed with teams and workforce leads. • The year to date non pay position flags continued financial pressures relating to out of area bed placements and general inflationary costs pressures (over and above the assumptions included at the time of original plan submission). This is across all spend areas but the standout movement at this stage relates to utilities costs. Service leads will continue to work with providers to understand cost implications and forecast as far as practical. • Cash remains positive although creditors are high which is normal at this time of the year as invoices for the whole financial year are received and are going through the validation and approval process.	JS	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• Capital spend is profiled mainly in Q3 and Q4 with the largest scheme being the commencement of the Bretton Centre scheduled to start in quarter 3. • Pay spend feels like it is the biggest risk and has seen increases in May compared to April and compared to last year. • Assumed 2% pay award which is in the model. DW raised the question of whether the pay award would be back dated. RA replied that it would be backdated to April, it has been confirmed nationally that if 3% is agreed the government will provide the extra 1%. • Income agreed with commissioners for the year, work is progressing on getting final contracts signed. This should be concluded in July. DW raised a question in relation to premises, and what is driving the adversity. RA replied that the largest movement is trying to understand what the impact of IFR16, and leases is. He stated there is still some validation of contracts required and what that means, and that finance are still looking at this. DW asked if the NEDs understood IFR16 at all. MB commented that he did not feel they needed to understand the intricacies of accounting standards and the committee just need to recognise there is a technical change in accounting for leases. In relation to education and training, RA commented that where the Trust continue to be under the budget that has been set for this year, the finance team are currently working on what costs are being committed to, as this links into workforce and as people are off undertaking training courses which we are keen to support there will definitely be a backfill requirement and finance need to make that connection between the two. JS commented that given in the year end audit it was flagged about having £1m Health Education England income deferred, which was predominantly linked to the fact that nurse training has been paused over the last couple of years. He stated finance do need to work on getting the Health Education England training back on track as the trust are going to be under pressure to release that income and spend it this year in addition to the expenditure budget.		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		RA stated that in relation to OOA beds, we have seen exceptional high costs and usage at the start of year which had been factored into the revised plan , but it is reducing across the course of the year in terms of the plan and finance are making sure this is still deliverable and what the risks will be. RA commented that in relation to capital the Trust is planning to spend £13.1m in this year, and that finance are trying to ensure programmes are progressing as intended. He stated the biggest risk is still Bretton in terms of agreeing ultimately what the costs will be and also when it can start and how it is going to develop. KQ commented on OOA beds and that fact that a decision had been made to use it as a pressure valve which was the right decision. KQ felt the real issue now is how do we stop doing this if acuity and demand keep increasing and this could become a real cost pressure going forward. She stated it is currently a quality of care risk and questioned if this should be a separate financial risk. JS explained that this is a key financial risk considered as part of the financial planning. He stated that finance is aware that NHSI has the spotlight on this area and they have modelled a reduction on the expectation that the trust will need to send less people out of town as it recovers from Covid. He explained there was still a lot of flexibility in the plan with the ability to manage some risks, also that there are currently some positive messages coming out of the services. CH commented that for quarter end they have revised the trajectory by about 10% above where they thought it would be this quarter. She confirmed there was also a lot of work being carried out on patient flow to focus on discharges as well as all the work that has been carried out to date in the community to keep people out of hospital. CH stated there was a meeting due to take place in August with Claire Murdoch and that they will definitely keep pace with OOA. KQ stated she was happy that OOA was included within other risks. MB commented that he felt the forecast is absolutely key now and that if we have a really strong recruitment uplift then OOA could become a problem in terms of meeting the overall plan and he stated he would rather we spend money on additional staffing to support service demand. He explained it is essential we have a robust forecast as we are likely to come under pressure in both our integrated care systems and places because we are working in places where acute hospitals have significant financial challenges, so there is a		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		likelihood that we will need to offset some of the challenges some of the acute trusts might have, so we need to be really clear on what our likely outturn position is going to be. MB stated he was also very concerned that we do not have contracts signed for our West Yorkshire commissioners stating part of his challenge is what is going to happen on Friday, and who exactly are we agreeing a contract with, is it with a CCG that gets novated to an ICB, will it be a contract directly with an ICB, or are we going to have two different contracts, MB stated this has caused him a little bit of confusion. RA commented that he needed to check with Annette Taylor, head of contracting, but the intention is to sign this week and then novate across. JS stated that they had agreed financial schedules and agreed numbers so there is very little risk. He commented that there is one ICS widely owned risk regarding the contracts which is around the Falls income but other than that everything else is secure and will novate across to the ICBs. He confirmed the plan had always been to produce a robust forecast from Q1 and then monthly from that point onwards. He stated the ICS will expect monthly forecasts starting from next month, and he confirmed that the first forecast will be in excess of plan and it is managing that. MB commented on financial reporting for adults secure and he asked how that was going to work. RA replied that previously there was a separate breakdown for this and that he did need to factor this in again. JS confirmed this was also being reported in through the new provider collaborative committee and various other sub groups.		
9	Annual planning Resubmission update - 2022/23	JS presented the update, stating that the Trust was required to make an updated annual plan submission in June 2022. This has resulted in change from the previously agreed breakeven financial position. Key headlines:- ➢ Additional national funding, c. £1.5bn nationally, has been provided to support inflationary cost pressures. This is specifically for those cost pressures already identified in May 2022 plan submissions as such: o Funding was required to flow directly to bottom lines. For SWYPFT this means an improvement from breakeven to surplus. o No new or additional cost pressures should be included in plans	JS	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		➢ As the ICS, with this additional funding, still had a deficit position all Trusts were asked to identify any further upsides. These had been discussed and agreed with the Executive Team. ➢ The outcome is a revised plan of £3.2m surplus for 2022 / 23 which was approved in line with the delegated authority agreed at Board. JS confirmed that turnaround on this additional request has been tight and there has been no Trust Board meeting between request and submission to allow for full detailed discussion.		
10	Waiting List project – progress report	JS provided the update on progress in relation to the waiting list project. Key headlines: - • Effectively got 31% of services using waiting list functionality. Those that have this in operation have live waiting lists. • Project has been given an increase in resource through to the end of March 2023 to help see this project through • Working with operations to work out how services are prioritise that need to come on line focusing on the most important first • OMG helping to coordinate a consistent approach whilst removing any variation from the approaches. • Detail of paper explains this is around MH only, it does exclude IAPT and this would be a separate project if we wanted to do something similar across all our community services • It does also flag that some services have declined initially to utilise this initial waiting list functionality and this is being reviewed to ensure it is appropriate and we are looking to feed back the rationale for this decision being taken • Proposal is to provide another progress update in October, this is discussed and reported through OMG.and also went to EMT last week.		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		JS stated this was an informative piece and helps assure the committee we are putting in place the resources to see through the progress in this area and ensure we have the full functionality of having the live waiting lists data to help answer some of the questions around how we tackle inequalities and how we manage the growing demand and make informed decisions. NM stated it was good to see the progress around this, and she was interested in the kind of decline JS touched on, she asked if there is an organisational position on we expect you to look at this and where is the opportunity to decline. MB commented that this was discussed at EMT last week and he felt this was too detailed for this committee and felt this did not need raising at this meeting. He felt the use of word 'decline' is taking it a little out of context and it is more about the appropriateness of using SystmOne for specific services. He explained we were struggling with pulling together all the waiting list data we have in the organisation, some of it is on system already, some of it is on other systems and some is done manually. The purpose of this programme is to bring it all together using SystmOne and ensure that when we are recording and understanding our waiting lists, we are doing this fairly and consistently. Trust management have fed back the same question, as they also did not understand the context of why some teams are declining, MB suspected it is more about the appropriateness of SystmOne and not wanting to calculate waiting lists. NM thanked MB for the updated clarity and said it was very useful. KQ felt there needed to be an addendum in the minutes to change the word decline in the sense of refusing to do it is more around the unsuitability of the system. KQ commented that she felt it was good that particular groups are not disadvantaged and it is good that we can see that in the waiting lists. JS asked if the committee are happy with the next update coming to the October meeting. NM replied that she would prefer the update sooner, so an update in September would be the preferred option. DW agreed with this approach.		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		The Finance, Investment and Performance Committee DISCUSSED and COMMENTED on the Financial Sustainability Plan		
11	Horizon Update	JS presented the update, key headlines were:- The ICS has collated the initial ICS wide draft capital plans for 2023/24. This highlights collective plans of c. £70.1m more than the ICS allocated capital allocation for 2023/24. (£206.1m compared to £136.0m allocation). At present, the draft allocation for SWYP is £7.7m. Given the expected continuation of the Bretton development, very little flexibility exists for other developments. This remains a major concern and ongoing risk that the Trust will have to scale back its capital plans and will not be able to utilise its cash holdings as quickly as desired for capital developments. All Trusts have been asked to revisit plans (date to be confirmed – likely late summer 2022) and assess actual capital requirements. National funding, for 2022 / 23 and future years, remains unclear. A bid is being prepared to access Urgent and Emergency Care Mental Health capital funding. Current indications is that there will be no new bids from SWYPFT but attempt to source external funding for existing schemes **The Finance, Investment and Performance Committee DISCUSSED and COMMENTED on the Investment appraisal update**		
12	Any other business	JS presented the Bretton Centre update with key headlines as follows:- • Since the last update a full re-design of the M&E (mechanical and Engineering) provisions of the scheme has been undertaken and a sustainable proposal developed. The unit has been re-designed to include Photo Voltaic panels (Solar Power) as well as air source heat pumps reducing reliance on gas. • As a result, a new planning permission is required. The target date for the new planning submission is 28th June. This will be a full 12-week process following validation of the application. • The previous application did not raise any concerns and the new design reflects units already on the Fieldhead site. As such it is not anticipated that there will be an issue obtaining planning permission.		

With all of us in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		Engagement with neighbours will be sought (as per the previous application) to ensure clear lines of communication and ensure that there are no areas of concern • The programme has been refined and key dates for the current programme are Phase 1 Construction - November 2022 – 8 months Phase 2 Construction - 7 months Phase 3 Construction - 4 months In summary, 19 months of construction completing in May 2024 • JS stated that these changes and redesign on the sustainability front and general condition of the market will mean costs are highly likely to increase and this will need to come back through FIP and Board for formal approval when the final costs are known. He explained there was one thing to be cautious of and this is if the costs rise above £15m there is an additional level of beurocracy regarding submitting the business case to NHSI and getting external sign off which normally takes 12 weeks, and which could lead to the timeline being at risk. JS confirmed Nick Phillips would be invited back to a future meeting to update the committee further. He stated that a project group had been established which was a previous request of FIP and that they met regularly to progress this project. MB thanked JS for outlining the risk so eloquently, he stated he still wanted to reemphasise the risk for all members of the committee, that should the costs rise above £15m it would need board approval and NHSEI approval and would probably mean we the trust would not spend our capital allocation for this year and that we have just heard that the ICB allocation for next year is nowhere as large as the demand for capital which could put this project at risk and could delay it significantly further. He explained the committee needed to be mindful as to when this project starts as we do need to spend this year's allocations if possible KQ commented on the project board and the assurance around this piece of work. MB confirmed the trust had conducted many pieces of work and had a tried and tested governance process, he stated they were following the same process. He stated there is a full risk and management processes and oversight and the FIP oversight is additional compared to what we have had previously, and he stated he would expect the		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		committee to do the same as any other board committee in terms of seeking assurance from adherence to plan and risk management NM commented that although the update was informative, she agreed with KQ in that looking ahead focus needs to be given to whatever quality of report is brought to the meeting so that the committee receive the level of assurance required. MB stated that until there is a defined programme of work. DW asked if the teams were ready to go once the revised planning permission is signed off. JS replied yes they were, and the builders are on standby. MB confirmed that Trust Board had agreed the contractor.		
13	Confirmations	**Meeting effectiveness** It was agreed that the meeting had been effective, and thanks was also given to those who prepared papers. **Significant issues to report to the Board of Directors** • Action – there will not be a gap when James leaves the trust, Rob Adamson will pick up the bulk of the key actions and other leads cover off any relevant outside of finance. • Surplus for last year going from £7.4m to £7.9m • Revised plan submitted of £3.2m. • Balance sheet is going to look different from this year due to accounting standard change. • Artificially underspending due to vacancies • Alert regarding potential future risk around ICBs looking for our surplus, however they have submitted balance plans. • Assure, expect to land the £3.2m plan and most likely over-achieve linked to continued vacancies. • OOA beds, extra costing planned due to Covid catch up, plan to reduce this as year goes on.		
14	Next meeting	**Next meeting** Monday 25th July 2022 09:30 – 11:30		

With all of us in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		Via MS Teams		

With all of us in mind.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Mental Health Act Committee Meeting held Virtually via Microsoft Teams on 10 May 2022

Present:	Kate Quail	Non-Executive Director (Chair)
	Dr Subha Thiyagesh	Medical Director (lead Director)
	Carol Harris	Director of Operations
	Erfana Mahmood	Non-Executive Director
	Darryl Thompson	Director of Nursing, Quality and Professions
Apologies:	Members	
	Mandy Griffin	Non-Executive Director
	Attendees	
	Shirley Atkinson	Professional Development Support Manager (Barnsley) – local authority representative
	Richard Bunn	Matron for Complex Needs, Mid Yorkshire Hospitals NHS Trust
	Andrea Dauris	Associate Director of Nursing (Corporate), Calderdale & Huddersfield NHS FT
	Marie Gibb	Named Nurse Safeguarding Adults, Mid Yorkshire Hospitals NHS Trust
	Terry Hevicon-Nixon	Operations Manager - Working Age Mental Health (Calderdale) – local authority representative
	Gillian Pepper	Head of Safeguarding, Barnsley Hospital NHS FT
	Stephen Thomas	MCA/MHA Team Manager (Wakefield) – local authority representative
	Gordon Walker	Independent Associate Hospital Manager, Chair of the Hospital Manager Forum
In attendance:	Julie Carr	Clinical Legislation Manager
	Nancy Cartwright	Independent Associate Hospital Manager, Vice Chair of the Hospital Manager Forum
	Alison Edwards	Head of Safeguarding, Calderdale & Huddersfield NHS FT
	Yvonne French	Assistant Director, Legal Services
	Mike Garnham	Health Intelligence Analyst/information Manager (for item 2)
	Chris Lennox	Deputy Director of Operations
	April Ramsden	AMHP Team Leader (Kirklees) – local authority representative
	Kelly Reittie	MHA/MCA Lead for Calderdale and Kirklees
	Carly Thimm	Mental Health Act / Mental Capacity Act Manager
	Gemma Williamson	MHA/MCA Lead for Barnsley and Wakefield
	Sarah Millar	PA to Medical Director (author)

With all of us in mind.

MHAC/22/15 Welcome, Introductions and Apologies (agenda item 1)
The Chair, Kate Quail (KQ) welcomed everyone to the meeting. The apologies, as above, were noted.

It was noted that due notice had been given to those entitled to receive it and that, with quorum present, the meeting could proceed.

There were no declarations of interest to record.

MHAC/22/16 The Act in Practice (agenda item 2)
MHAC/22/16a BAME groups and inequalities related to accessing SWYPFT mental health services (agenda item 2.1)
Presentation from Mike Garnham (MG) on BAME groups and inequalities related to accessing SWYPFT mental health services.

Subha Thiyagesh (ST) referred to previous discussions at Mental Heath Act Committee (MHAC) which had led to a request for MG to further analyse the available data and to summarise the differences in relation to prevalence, access and outcomes for service users from BAME communities within the SYYPFT footprint compared with national benchmarking and published data.

Erfana Mahmood (EM) raised that sadly the findings confirmed what the Committee had already known on some level and that some areas were unfortunately worse. EM indicated that the presentation also highlighted that when people are admitted to our services, we need to hear their voices. EM queried how the findings would help to inform our strategy.

MG advised that whilst the figures were disappointing, they were no worse or possibly slightly better than the national statistics suggest. The length of stay data was reassuring and indicated that people from a BAME background did not stay in services any longer than other groups even though they were more likely to be detained. MG added, however, that the mental health of those from ethnic minority groups had often deteriorated more by the time they reach our services, and they are therefore more likely to be sectioned. This indicates that work needs to be done in the community to improve access to services and tackle the stigma of mental illness.

ST raised that the prevalence of mental illness and schizophrenia in ethnic minority groups in the UK is not reflective of the figures in other countries and there is a social and cultural context as well as misconceptions of symptoms in people from different backgrounds. ST suggested that next steps should include transcultural awareness training and updating the strategy.

KQ indicated that there was overlap with the work of the Equality, Inclusion and Involvement Committee (EIIC) and Salma Yasmeen would take the lead on using the information in MG's report to inform and further develop the strategic objective of reducing inequalities. It was agreed that ST would raise this with Salma.

Action: Subha Thiyagesh

KQ will share the work of MHAC with the EIIC and identify areas of overlap.

Action: Kate Quail

KQ suggested measuring the quality priorities to consider the whole pathway and how we meet the needs of people when they are admitted or detained to our services. Darryl Thompson (DT) raised that we do not yet have a lot of data on the views of patients and carers from BAME backgrounds which is important before we agree a mandate for improvement. KQ indicated that the roll-out of discovery interviews had started in the Trust, and also that the Yorkshire and Humber Forensic Involvement Network are also using them and engaging with ethnic minority service users and carers.

Carol Harris (CH) raised that it was helpful to see the presentation and indicated that as well as people from BAME communities being more likely to be detained, we also know that they are more likely to be detained in a secure environment. CH queried if we had any data on whether there is a difference in medication or pro re nata (PRN) use depending on ethnic background and suggested that it would be good to include that level of detail to ensure that people challenge their own thinking as part of the cultural training.

KQ indicated that we need to enable people to understand their mental health and wellbeing and access sources of support. This will require our engagement with and education of services, communities and primary care to support people to know how to recognise symptoms, access services earlier and be less likely to present in crisis. KQ indicated that any cultural awareness training for staff needs to add value and be fit for purpose.

KQ referred to measurements in the Integrated Performance Report (IPR) that goes to Board and specifically the percentage of IAPT service users that have moved to recovery, which has a 50% target. KQ suggested that this could be broken down into the number of White and BAME service users to highlight any inequalities in relation to recovery outcomes.

KQ thanked MG for the presentation and indicated that their work was supporting the aspiration for more positive outcomes for people from ethnic minority backgrounds.

MHAC/22/17 Legal updates (agenda item 3)

MHAC/22/17a Monitoring the MHA 2020/21 CQC annual report (agenda item 3.1)

Julie Carr (JC) advised that the annual report gives an indication of the areas that the CQC are likely to focus on during service visits over the next year. JC advised that there are 10 focus areas with 45 specific contingencies.

Next steps:

- An initial gap analysis based on the issues identified by the CQC annual report has been scoped.
- Send the initial gap analysis to the Chief Operating Officer and the Deputy Directors for review.
- Priorities for action will be determined by clinical services and inform their work streams for the coming year.

KQ raised that the national report would be used to benchmark against and to help with discussions with staff.

ST indicated that it would be helpful to bring an update on where the gaps were, what we have done and what we might need to do. Chris Lennox (CL) advised that the deputy directors had just received the report today and would be reviewing it.

KQ raised that MHAC can take assurance that SWYPFT is complying with the CQC areas of focus, highlighting any gaps and identifying actions.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/22/17b MCA/LPS code of practice and regulations consultation (agenda item 3.2)
JC reported that on 17 March 2022, the Department of Health and Social Care published the draft code of practice to support the Mental Capacity Act (MCA) and Liberty Protection Safeguards (LPS) along with 6 associated regulations and a number of other documents. JC advised that the consultation was limited to specific questions with a restricted word count and no free text space.

JC referred to plans to engage with service users and carers and also to involve Hospital Managers in responding to the consultation. The submission date is 7 July 2022 and the deadline for internal responses will be the end of June to allow time for review and collation.

JC advised that legal services are working with the Performance and Information (P&I) team to ensure that SystmOne meets the Trust's needs in relation to reporting and recording regulations.

KQ raised that this was an example of excellent consultation work with a widespread audience and acknowledged the huge amount of work that had gone into it.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/22/18 Updates from partners (agenda item 4)
MHAC/22/18a Local Authorities (agenda item 4.1)
The following update was noted:

April Ramsden (AR) – Kirklees Local Authority

- Staff levels are dire and there are regular breaches of statutory duty. There are issues with covering Emergency Duty Service hours and agency staff are being utilised. Emails are going out to partners when there is likely to be a breach.
- There is added pressure due to delays in Yorkshire Ambulance Service (YAS) conveyance and in one case it took 5 days to coordinate a warrant.
- Bed searches are also taking several days or longer and AR gave an example of a bed being located today in Norfolk.

KQ noted the significant pressures and CH queried where the person who waited 5 days for conveyance had been managed. AR advised that they were at home and explained the difficulties that had occurred in that particular case. EM raised that YAS would usually view something like that as a serious incident and queried if there was any update on the long term provision that had been previously mentioned.

AR advised that the response time as per protocol should be within an hour although the reality is around a 4 hour response that regularly extends to 7 or 8 hours. EM suggested that there should be further discussions outside of this meeting with specific issues raised with YAS and the risk included on an appropriate Risk Register. It was noted that there is CCG money available for private ambulances although it is not clear how they are sourced and what their remit is. AR added that the AMHPs also still have to go through YAS first as they are commissioned to provide the service.
DT raised that the CQC had been in the local area in the last few weeks and there had been a lot of interest in acute and liaison services and a focus on keeping people out of ambulances and out of emergency departments.

ST agreed that further organisational level discussions should be held and raised that it was concerning that somebody had had to wait for 5 days. ST acknowledged that this not only impacted on the service user but also the AMHPs and teams involved.

CL indicated that the CCG hold the responsibility as they commission YAS to convey people to a mental health bed. AR raised that as well as timing difficulties, the situation is exacerbated by staff and other pressures including finding a suitable bed. AR referred to an out of area placement in London before Christmas and the individual was still there in March as it had proved difficult to repatriate them even when a bed became available, due to the distance involved.

It was agreed that there was no action for MHAC but that it would be helpful to get an update on the pressures at the next meeting.

MHAC/22/18b Acute Trusts (agenda item 4.2)
The following update was noted:

Alison Edwards (AE) – CHNFT

- Really grateful for the supportive relationship between CHNFT and SWYPFT, particularly in relation to people detained under the Mental Health Act (MHA).
- There are significant staffing and other pressures.
- There is a vacancy for a named safeguarding lead for adults to help support with the MHA and patients with mental health issues.
- A nurse consultant for mental health had been appointed.
- There was a bit of a gap in receipt and scrutiny training and CHNFT are working closely with the MHA office at SWYPFT to bridge that gap.

It was noted that Carly Thimm (CT) is working with Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) to develop a receipt and scrutiny e-learning package which will be rolled out across the region. In the meantime, CT along with Kelly Reittie (KR) and Gemma Williamson (GW) are planning to record a training session.

DT referred to the nurse consultant for mental health appointment and highlighted the links with SWYPFT. DT had sat on the interview panel and noted that this was a very positive appointment.

MHAC/22/18c Independent Hospital Managers feedback and Forum notes 12 April 2022 (agenda item 4.3)
The Committee received the notes of the Mental Health Act Managers' Forum meeting from 12 April 2022 which were taken as read.

KQ referred to the very sad news of the sudden and untimely death of Santokh Khangura, one of the Hospital Managers. Santokh had been highly respected and liked by his colleagues and was deeply committed to service users and staff. Hospital Manager and MHA office colleagues had attended Santokh's funeral and SWYPFT's Chief Executive, Mark Brooks had sent a card and Covid medal to his family. Nancy Cartwright (NC) reported that Santokh's funeral had been well attended and added that he will be missed by those who worked alongside him.

NC did not have any particular issues or concerns to raise with MHAC and added that any problems are dealt with quickly by the MHA office admin staff. It was noted that there are a lot of hearings taking place at the moment and losing Santokh had resulted in an increase for the other Hospital Managers.

MHAC/22/19 Minutes/Actions (agenda item 5)

MHAC/22/19a Minutes of previous meeting held on the 8 March 2022 (agenda item 5.1)

It was RESOLVED to APPROVE the notes of the meeting held on 8 March 2022 as a true and accurate record of the meeting.

MHAC/22/19b Action points (agenda item 5.2)

The action points were noted and the following item raised:

- MHAC/21/02a Service User Experience Discovery Interviews – ST reported that there had been helpful feedback from the interviews to understand the perspective of service users who access our mental health services. ST advised that there is a plan to share and discuss the full findings of the report with service managers and build any actions into the service quality improvement action plans.

  ST also advised that an animation had been created, based on feedback in a 'you said, we did' approach to demonstrate who we are and what we do.

  More work will be done to embed the outcomes of the interviews and Yvonne French (YF) will be liaising with Alexis Ritchie to roll out the project wider.

  It was noted that the Yorkshire and Humber Forensic Involvement Team have been commissioned to undertake a 'Your Voice Counts' initiative and it is hoped that this will complement the work being undertaken in SWYPFT and help to plug any gaps. CH advised that this is the regional network that NHS England used prior to the establishment of the Provider Collaborative to lead on engagement work and our teams are very much involved. KQ added that it would be good to add to our own body of evidence.

  YF advised that the Easy Read documents had been reviewed and would be updated on the intranet.

MHAC/22/20 Risk Registers (agenda item 6)

MHAC/22/20a Consideration of items from the organisational risk register relevant to MHA Committee (agenda item 6.1)

KQ reported that there were no risks assigned to MHAC by Trust Board and the ones that were pertinent to this Committee had oversight by CGCSC.

YF advised that the Organisational Risk Register (ORR) had last been to Board on 26 April 2022. The following risks had previously been identified as having a potential impact on the application of the Mental Health Act:

- 905 – wards not adequately staffed, as there are certain duties that only qualified staff can do such as attending a Mental Health Tribunal.

- 1151 – unable to recruit qualified staff which is a similar principle to 905. This refers to all qualified staff and not just nurses. Graded at Amber.
- 1368 – demand and capacity in West Yorkshire and nationally for beds for 16 and 17 year olds. The difficulties with accessing Tier 4 beds mean that older children are coming into our place of safety suites which impacts on the working age adult pathway and puts more pressure on availability of the suites. Graded at Amber.

- 1624 – service pressures mean that we are not always able to consistently accept a referral to all three of our 136 suites. This impacts on the quality of service we can offer to someone who may have a mental health need in our local community.
- 1650 – inpatient areas with gardens that have access to single storey buildings present an increased risk of absconding and/or falling resulting in physical injury.

EM raised that the staffing risk (905) had now been graded as Red on the ORR. EM queried whether this should be elevated to a strategic level. CH advised that it had already been escalated to the highest level as the impact had been recognised. It was also referred to in the Board Assurance Framework as a strategic risk. CH added that actions are in place to address this and it is discussed at each Board meeting.

It was RESOLVED to RECEIVE the update and to NOTE the current Trustwide corporate/organisational level risks relevant to this Committee.

MHAC/22/20b Mental Health Act Committee risk register (agenda item 6.2)
Committee noted that there were currently no MHAC risks.

It was RESOLVED to RECEIVE and NOTE the update.

MHAC/22/21 Statistical information use of the Mental Health Act (MHA) 1983 and Mental Capacity Act (MCA) 2005 (agenda item 7)
MHAC/22/21a Performance report – Monitoring information Trust wide January-March 2022 (agenda item 7.1)
The report was considered and CL highlighted the following:

- SWYPFT remains in line with the national picture in relation to admission rates despite there being a small increase in admissions.
- There was one admission of a patient under the age of 18.
- There had been a total of 317 uses of Section 2 and Section 3 in Quarter 4 which represents a decrease of 32 uses.
- 42% of all new admissions in Quarter 4 were under the Mental Health Act which was an increase of 1% on the same quarter last year.
- The highest rate of admissions was in Calderdale, with Wakefield having the lowest rate.
- The average length of detention for Section 2 was 21.5 days and for Section 3, 154.1 days. This was a decrease for Section 3 of 58.1 days which may be due to some discharges.
- The Forensic service had seen 13 new uses of the Mental Health Act, 4 of which were prison transfers.
- Trustwide internal transfer activity totalled 47 with Calderdale being the highest source of transfer. The main reason for internal transfer is a return to home area.
- There had been an increase in appeals to Hospital Managers, with a total of 23 appeals in Quarter 4. There was one discharge by Hospital Managers.
- There was a total of 84 Tribunal hearings resulting in 9 discharges. This was noted to be an increase and possibly attributed to the Trust's improvement work around patient rights and promoting advocacy services.
- Section 49 activity had decreased, with only 6 new requests being received. Out of these, 1 was declined and none were repudiated.
- A total of 135 assessments took place in the 136 suites in Quarter 4. 52% of these resulted in admission to hospital.

- There were 6 exception reports for Section 136. Four of these were due to the Barnsley suite being unavailable and 2 were as a result of the suites being occupied whilst an appropriate bed was being sourced. CL reported that there was significant funding available from the CCG to create a bespoke staffing model with an independent team linked to the Intensive Home Based Treatment Team (IHBTT), which should help to relieve some of the pressures.
- Work is ongoing to address the disproportionate use of the Mental Health Act in some BAME populations, as discussed at today's meeting.
- At the close of Quarter 4, 54 patients were subject to a conditional discharge and there was one recall.
- One CTO had been applied and 7 patients were discharged from a CTO.
- All SOAD requests were still being dealt with virtually.
- There had been 4 Deprivation of Liberty applications from the stroke/neuro rehab wards, one from learning disability services and one from rehab services.
- Sadly there were 4 CQC notifiable deaths in Quarter 4. It was noted that these were older people with physical health challenges.
- In relation to Section 17 leave, there were 227 episodes of leave cancelled in Forensic and Specialist Services. This represented an increase of 24 from Quarter 3 and ward managers continue to collect data on cancelled leave. CH raised that staffing levels already identified as a major pressure were contributing to cancelled leave.
- There had been 2 Hospital Manager concerns raised around inaccurate recording of a patient's date of birth and dates of incidents. There was also one compliment in relation to excellent evidence provided by the professionals who attended the hearing. The positive feedback was shared with the clinical team, their line managers and referred to Customer Services to record the compliment.
- Independent Mental Health Advocacy (IMHA) Monitoring had been added as a new section in the report. YF reported the improvements in working with advocacy services and raised that it would be useful to understand how many people are eligible for advocacy services and then compare that number to the referrals. YF added that Forensic services have a more static population and the effectiveness would need to be measured differently.
- The MHA office have a new process in relation to the reading of patient rights which should help to improve the compliance rate of 83% at the end of Quarter 4.
- MCA/DoLS training compliance is 90.27% and MHA training compliance is 89.04%. These were both noted to be an increase on the previous quarter.

DT was pleased to see the number of appeals and hearings going up, which could be attributed to the positive quality improvement work. KQ agreed that this was a positive upturn.

KQ queried how cancelled Section 17 leave was defined, whether it was planned leave or requests unable to be supported at short notice. CL confirmed that the figures included episodes that had already been authorised but could not be honoured on the day. KQ suggested that this be included in the alert /triple A report for Board.

KQ noted the new section for IMHA monitoring and queried if there was support to do the additional work that YF had suggested. YF plans to liaise with CT and agree how the data could be enhanced then report back to MHAC.

Action: Yvonne French

KQ took the opportunity to further highlight the excellent work around patient rights and increase in Tribunal and Hospital Manager appeals, both indicating the positive impact of quality improvement work. KQ also noted the positive improvement in MHA and MCA/DoLS mandatory training.

It was RESOLVED to RECEIVE and NOTE the monitoring report.

MHAC/22/22 CQC compliance actions (agenda item 8)

MHAC/22/22a MHA/MCA Code of Practice oversight group feedback (agenda item 8.1)

YF gave an update to Committee from the MHA/MCA Code of Practice oversight group:

- There are 5 MHA policies due for review. An Equality Impact Assessment (EIA) is needed for each of them as they are in the new format. YF had requested a 3 month extension to allow for that. YF gave assurance to MHAC that there were no major changes to any of the policies and therefore no risk with a delay in having them signed off.
- A monthly review of the current restrictions had been undertaken and no issues noted.
- The Trust had sought clarification from each of the advocacy service providers that the advocacy provision commissioned by the local authorities is an ageless service. This had been confirmed by all services.
- JC had presented on transfer and remission of prisoners. It was noted that the draft guidance specifically refers to psychiatric intensive care units and this had been shared with inpatient services.
- JC had also given a presentation on Liberty Protection Safeguards and the group will support the response to the consultation and provide oversight to the workstreams going forward, with regular reports to MHAC.

It was noted that the update provided assurance to Committee that the Trust is compliant with the required development of policy, procedures and standard operating procedures relating to the Mental Health Act.

It was RESOLVED to RECEIVE and NOTE the activity.

MHAC/22/23 Audit and Compliance Reports (agenda item 9)

MHAC/22/23a Recording of capacity to consent to treatment record (agenda item 9.1)

YF referred to this item which had been deferred from the March meeting. YF advised that there had been a piece of work undertaken on consent to treatment, second opinions and capacity assessments, however when the data was reviewed, YF had highlighted a need to work with medical staff to agree an initial benchmark to compare the data to. YF will give an update in November and the final report will come to the March 2023 meeting. SM will update the work programme.

Action: Sarah Millar

It was RESOLVED to NOTE the update.

MHAC/22/24 Care Quality Commission visits (agenda item 10)

MHAC/22/24a Visits and summary reports Quarter 4 including BDU actions from previous visits (agenda item 10.1)

JC reported that there had been no CQC Mental Health Act visits in Quarter 4 although visits in Quarter 1 had already started.

It was noted that there were 2 actions in Forensic services that were 18 months overdue although it was expected that these would be completed by the end of the next quarter. These related to Integrated Clinical Environment (ICE) access and recruitment/staffing levels.

Calderdale and Kirklees had 6 active actions during Quarter 4. These included out of date risk assessments, care planning issues, access to psychology and staffing pressures impacting on patient care.

KQ noted the excellent progress and that the 2 overdue actions should be closed by the next meeting. KQ also noted that there were no overdue or outstanding actions in Barnsley or Wakefield.

It was RESOLVED to RECEIVE the update and NOTE the progress of the actions following CQC visits.

MHAC/22/25 Key Messages to Trust Board and other Committees (agenda item 11)
The key issues to report to Trust Board were initially agreed as below. ST and KQ would review finally before reporting to Board.

Alert

- Mental Health Units of force – oversight and assurance.

Advise

- The Act in Practice presentation on BAME groups and inequalities related to accessing SWYPFT mental health services.
- The government consultation on the proposed changes to the Mental Capacity Act including the new Liberty Protection Safeguards.
- Addition of IMHA data to the performance report.

Assure

- Actions in place to address the cancellation of Section 17 leave (and noting the increase)
- Assurance from the Code of Practice group on a range of work including oversight of the Liberty Protection Safeguards implementation.
- Monitoring the MHA 2020/21 CQC annual report.
- Discussion and review of the Organisational Risk Register.
- No CQC visits this quarter. Reviewed open and overdue actions. Assurance that most of these will be closed by the next quarter.
- The positive impact of quality improvement work on patient rights.
- Improvement in mandatory training figures for MHA and MCA/DoLS training.
- Involvement & experience of our service users who are detained under MHA.

There was discussion about where to include ‘An increase in cancellation of Section 17 leave‘. CH referred to cancelled Section 17 leave and advised that there had been discussion at Trust Board on the impact of what we are reporting. CH went on to say that there is a clear impact on service users and we cannot say it is all down to staffing issues although that does contribute significantly. CH raised that if there is acuity in a service which means staff cannot be released to facilitate leave, this also has a knock on effect. CH reported that the Forensic service is now taking a Business Delivery Unit (BDU) wide approach where all the wards liaise with each other across the low and medium units and try to ensure people get their leave wherever possible. CH also indicated that it is not clear if

cancelled leave is also linked to outbreaks and we need to understand more about the reasons.

DT suggested including an alert to Board about the CQC actions outstanding from 2019 and linking those to the two outstanding actions from the CQC well-led review in the same year around care planning and risk assessment. CL agreed that it would be helpful to draw the different strands together and then escalate if necessary. KQ indicated that whilst linking the two would be helpful, there was no action for MHAC and it was not for this triple A update to Board.

MHAC/22/26 Work programme (agenda item 12)

It was noted that the work programme would be updated to reflect the deferred report at item 9.1.

MHAC/22/27 Date and time of next meeting

The next Committee meeting will be held on 16 August 2022, 2.00pm to 4.30 pm via Microsoft Teams.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Members' Council meeting held at 09.30 on 10 May 2022

Meeting Held Virtually by Microsoft Teams

Present:	Marie Burnham (MBu)	Chair
	Bill Barkworth (BB)	Public – Barnsley (Deputy Lead Governor)
	Bob Clayden (BC)	Public – Wakefield
	Claire Den Burger-Green (CDBG)	Public - Kirklees
	Dylan Degman (DDe)	Public – Wakefield
	Darren Dooler (DDo)	Public - Wakefield
	Gary Ellis (GE)	Appointed – Mid Yorkshire Hospital NHS Trust
	Laura Habib (LH)	Staff – Nursing support
	Nik Vlissides (NV)	Staff – Psychological therapies
	Anthony Jackson (AJ)	Staff – Non-clinical support
	Adam Jhugroo (AJh)	Public - Calderdale
	Joanne Gander (JG)	Public – Rest of Yorkshire and Humber
	John Laville (JL)	Public – Kirklees (Lead Governor)
	Tony Wilkinson (TW)	Public – Calderdale
	Tony Wright (TWr)	Appointed – Staff Side organisations
	Phil Shire (PS)	Public – Calderdale
	Keith Stuart - Clarke (KSC)	Public – Barnsley
	Helen Morgan (HM)	Staff – Allied Health Professionals
In attendance:		
	Lindsay Jensen (LJ)	Assistant Director of Human Resources & Organisational Development
	Salma Yasmeen (SY)	Director of Strategy and change, Deputy Chief Executive
	Carol Harris (CH)	Chief Operating Officer
	Natalie McMillan (NMc)	Non-Executive Director
	Greg Moores (GM)	Chief People Officer
	Mike Ford (MF)	Non-Executive Director
	Erfana Mahmood (EM)	Non- Executive Director
	James Sabin (JS)	Interim Director of Finance and Resources
	Kate Quail (KQ)	Non-Executive Director
	Darryl Thompson (DTh)	Director of Nursing, Quality and Professions
	James Sabin (JS)	Interim Director of Finance and Resources
	Julie Williams (JW)	Assistant Director of Corporate Governance, Performance and Risk
	Grace Coggill (CG)	Secretary to the Chair, Non-Executive Directors and Members' Council
	Andy Lister (AL)	Head of Corporate Governance (Company Secretary)
	Asma Sacha (AS)	Corporate Governance Manager (author)

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Apologies:		
	Mark Brooks (MB)	Chief Executive
	Beverley Powell (BP)	Public – Wakefield
	Mandy Griffin (MG)	Deputy Chair
	Andrea McCourt (AMc)	Appointed – Calderdale and Huddersfield NHS
	Brenda Eastwood (BE)	Appointed – Barnsley Council
	David Webster (DW)	Non-executive Director
	Sheena McDonnell	Appointed – Barnsley Hospital

MC22/28 Welcome, introductions and apologies (agenda item 1)
The Chair, Marie Burnham (MBu) formally welcomed everyone to the meeting, apologies were noted as above. The meeting was quorate and could proceed.

MBu welcomed new governors, Joanne Gander (JG), public governor for rest of Yorkshire and Humber and Laura Habib (LG) staff governor, nursing support and they made introductions.

AL informed the Members' Council the following governors have been reappointed and they were congratulated on their appointments:

- Keith Stuart – Clarke, Public - Barnsley
- Adam Jhugroo, Public – Calderdale
- Phil Shire, Public - Calderdale
- John Laville, Public - Kirklees
- Bob Clayden, Public – Wakefield

The following are no longer governors:

- Carol Irving – she has decided not to continue and has stood down.
- Debs Teale – she has been replaced by Laura Habib as staff governor for nursing support through election.

JL thanked the governors who have stood down or have come to the end of their office, which includes Debs Teale, Jeremy Smith, Lisa Ward and Carol Irving. He thanked them for their contribution to the council.

The meeting is recorded to support minute taking. The recording will be destroyed once the minutes have been approved (it was noted that attendees of the meeting should not record the meeting unless they had been granted authority by the Trust prior to the meeting taking place). Attendees were requested to remain on mute, unless speaking.

It was RESOLVED to RECEIVE the welcome, introductions and apologies as described above.

MC22/29 Declarations of Interests (agenda item 2)
AL informed the Members' Council that AJh has notified one change to his declaration of interest, the register and been updated and this has gone "live" on the Trust website.

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It was RESOLVED to NOTE the individual declarations from governors and to CONFIRM the changes to the Register of Interests.

MC22/30 Minutes of the previous Members' Council meeting held on 8 February 2022 and 19 April 2022 (agenda item 3)

BC said he doesn't feel the last paragraph reflects what had happened at the meeting (Ref MC22/08f). BC said he believes that once it was decided who was going to be a voting member of the Board, that will remain until they leave the Board. He asked whether this was correct.

AL said this was in reference to the voting executive directors. AL explained the change in the constitution stipulates that now the Chief Executive will be a voting executive, the Medical Director will be a voting executive as well as the Director of Nursing, Quality and Professions and the Chief Operating Officer. The chair and chief executive can also pick two additional members which they have chosen. There will always be one more voting non executive director than executive director for transparency. AL said we will re-word this.

AL said BC was concerned that the voting rights could change per meeting but this is not the case and once they are put in place, they are substantive until notified of a change formally.

DT said on page 13, MC22/20 Integrated Performance Report (agenda item 9.1) the word "deficit" is a typo.

DT said in the extraordinary Members' Council meeting on the 19 April 2022, he has declined the meeting request and has not been noted as an apology. AL said this was an extraordinary meeting and was for members only to appoint the non-executive.

Action: Asma Sacha and Andy Lister

It was RESOLVED to AGREE the minutes of the Members' Council meeting held on 8 February 2022 and the 19 April 2022 as a true and accurate record with the noted amendments.

MC22/31 Matters arising from the previous meeting held on 8 February 2022 and action log (agenda item 4)

AL said there was an outstanding action, MC22/21. AL informed the members' council that he has an appointment with Dawn Pearson this month and he will enquire with her regarding blended meetings. AL said he will provide an update in the August members' council meeting.

It was RESOLVED to NOTE the Action log of the Members' Council.

MC22/32 Chair's report and feedback from Trust Board (agenda item 5)

MBu informed the Council that she will be providing a verbal update today but in future she will be more specific about her feedback. MBu said she will amend her report and

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circulate this for the next meeting. MBu said the Trust excellence award was a great evening and the comments from staff were very overwhelming.

MBu commented that the Trust have issued covid medals to staff and there have been fantastic comments.

MBu said they have appointed a new Director of Finance and Resources and this now completes the Trust Board. It is a strong and exciting Board moving forward. MBu commented she will be writing out to the non executive directors for their objectives for the coming year.

MF introduced himself to the new governors. He stated as non executive directors they do not list every activity they have been involved in throughout the year and some things have been missed off the list. MF commented that the Audit committee checks the effectiveness of all the other committees and they receive assurance from all the committee chairs that they have met their terms of reference and objectives for the year. MF said they received good assurance from all the sub-committees of the Board that they are meeting their objectives.

JL said the chairs report states that the governors should receive the brief every month and he has not received this. JL said they use to receive the brief and asked whether the corporate governance team could circulate this to all governors on a regular basis. AL apologised and informed the governors they will resolve this.

Action: Corporate Governance admin support to circulate the Trust brief to the governors

BC asked about the charitable funds committee and commented that the minutes of the committee was private and there doesn't appear to be any public scrutiny of the charitable funds committee. AL stated the charitable funds committee use to report into Trust Board and all Board Committees submit their minutes in public to the Trust Board once approved and the charitable funds use to do the same. The corporate trustee however is the place that the charitable funds committee reports into this and the meeting is held in private. Discussed how we need to find a way into getting charitable funds committee into public and he will speak to Erfana Mahmood and look at the governance arrangements.

EM said they do the annual report and they have a separate internet page with access to this information. EM said they also register with the charity commission so the council can also view this information online from the charitable commission. They also get audited regularly. EM said she will discuss this further with AL and report back.

Action: AL to liaise with non executive director, Erfana Mahmood to look at the governance arrangements for the charitable funds committee.

KSC enquired whether the committee control what is spent by the Ey Up Charity. EM said they have an operational group which is made up of different staff members including staff from the finance team and they oversee the bids and details of those bids then comes to the charitable funds committee. Every application is then reviewed and there is rigour around that and they review whether it meets the needs of service users and carers. EM asked AL to circulate the annual report to governors to gain an oversight of what they have spent.

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Action: AL to circulate the annual report for the charitable funds.

SY explained the charity receives funding from the Trust to run the charities including the link charities and they have a performance and delivery framework for our link charities and agreed business plans for the charity which go to the trustees to formally approve this and also to make a commitment back to the Trust to deliver this. The link charities help deliver the strategic objective number 5 of the Trust charity.

GE asked whether the charity was consolidated in the Trusts accounts or kept separate. SY said they have separate accounts for the charity, and they have done work on this to make sure they are also counting in and making visible the support and non-financial support in terms of resources that the charity takes up. The charity and link charity have grown substantially and the audit will be significant.

It was RESOLVED to NOTE the Chair's report.

MC/22/33 Chief Executive comments on the operating context (questions to be submitted in advance) (agenda item 6)

SY introduced herself and provided a verbal update. She explained she was will provide an update on behalf of MB who gave his apologies. She explained even though it is challenging, what remains constant is our connective commitment with our mission to enable people to live well within their communities and to achieve their potential. She reiterated how MBu shared news about the excellence awards and the covid awards which is a way of recognising the efforts our staff and our volunteers have continued to deliver.

SY said the Health and Care Bill will provide the policy framework and also the legislative framework for the changes we will see in the near future and the coming period, this has gone through the parliamentary process and that will mean that from the 1 July 2022 we will see Integrated Care Systems (ICS) South and West Yorkshire) they will become formal statutory bodies in their own right.

She explained that as a Trust, we have been part of this journey in two ICS's and four places where we provide services over the last 5 years so it should be continuous work that we have been doing. In recent months we have worked with partners in each places to formalise the decision making forums and governance arrangements in each of them places so we can make shared collaborative decisions as to what the population and people in communities need so we can form services to address health inequalities and improve health outcomes, this work will continue beyond July 2022.

SY explained although covid is with us, the restrictions have been removed for the public but within the Trust we ensure we keep a focus on keeping our staff, service users, carers and visitors safe. There are national policy changes which we will continue to consider and revise and we will continue to do that, making sure that we reinforce safety at every level.

SY explained at the recent Trust Board, we agreed the priorities for the coming year and to build on the work we have been doing over the last year and we will continue to work on key areas to improve health, improve services and making sure we are driving value

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with the use of our resources and working on a number of initiatives to ensure we are making the Trust a great place to work.

SY said we continue to meet annual requirements as well as focusing on day-to-day operations. We see an increasing demand for mental health services especially children and young people and responding to waiting lists in key areas.

Our financial performance is held up over the last year and this will change in the months to come, and we need to consider how to best use our resources and drive value through that. A big focus has been on well being of all our staff. SY said our physical activity instructor is working on staff wellbeing with exercise programmes and this is part of our drive to ensure staff well being is at the forefront.

PS asked about virtual meetings and whether we can get back to having face to face meetings. MBu explained we are driven by national guidance to be more vigilant and what is safe locally. DT and the team are working on a plan for face-to-face meetings. We are also working on a flexible, hybrid ways of working for staff. NM said she has spoken to MB and DT and they are supportive of face to face visits to the ward to talk to our staff which includes quality monitoring visits. MBu said there is a new board developmental session and this will be face to face, although the Trust recognise there are vulnerable groups and people with accessibility issues.

TWr said there is excellent work going on in the Trust on the social responsibility and sustainability strategy. He stated he has forwarded the draft sustainability strategy to AL to circulate to the members' council for an opportunity to comment.

Action: AL to circulate the sustainability strategy to the members' council for comment.

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

MC/22/34 7.1 Annual report unannounced / planned visits (agenda item 7)

DT provided an update on the unannounced Care Quality Commission (CQC) visits and confirmed there have been no announcements within this reporting period. He explained we have maintained our quality oversight through our quality visit structure. There is reference to our self accreditation scheme, which was a pilot on one of our Wakefield inpatient wards to get a baseline expectation of quality for all inpatient areas to benchmark against. Covid has had a significant impact on this, including staffing and acuity. It has been agreed to pause this until 2023/34 and this will be discussed in committee. We have Mental Health Act CQC visits and we get feedback on those and there is suggestion to align them with our Quality Monitoring Visits (QMV) to ensure that learning is embedded.

BC said the report states there was no issues for escalation, he explained he has been on 3 QMV's and there were issues for escalation and the report seems to be more optimistic than he found from the visits he had undertaken. DT said the word immediate is key and there were escalations with regards to mandatory training compliance and also with regards to clarity about our NEWS2 denominator, our national early warning score for physical health deterioration is mentioned in the report. DT said he acknowledges that how we have worded this may be unhelpful. NM said she chairs the clinical governance and clinical safety committee and we may need to clarify the terminology and so everyone knows what everyone means by escalation through the clinical governance and clinical safety committee and through to the Board. NM said they do scrutinise and challenge

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areas of concern and how we learn from other areas who are working very well but it is a balanced report.

NM said all areas are discussed in clinical governance and clinical safety committee and under achieving areas are also discussed. She explained we also use triangulation of data, in Finance and also Workforce Committee, she explained there is robust challenge. DT acknowledged it was a good point and we can capture the variants in more detail for future reporting.

MF said the governors are important part of this quality visit and we may be able to work this through the members' council quality group and if there could be a joint paper where governors views are reflected on the executive summary.

KQ said they get frequent CQC visits to the wards looking at Mental Health Act and two things that come up are care planning and risk assessments and we look at it in clinical governance and clinical safety committee, but we also look at this in the mental health committee and we also share information and look at CQC actions and our compliance. This should give the members' council more assurance. The Mental Health Act committee also report to Trust Board and they have a alert system.

JW said through governor development we can look at the process and how issues are escalated and how assurances are given and received. There is something around how we write the report in a certain way to help the governor to get assurance on a day-to-day basis and she will work on the quality group as to how the report structure looks like and how often they want to receive this. PS said this would be helpful and to look at this in the August quality group meeting.

Action: Members Council Quality Group to consider report structure and what governors require from the executive management team.

LH spoke about how we need to look at streamlining assessments and audits, for example the primary nursing audit and the time taken to complete the paperwork. She said the users should also be involved in this and she can provide feedback on her own experiences.

It was RESOLVED to RECEIVE the update on the annual report/unannounced visit.

MC/22/35 7.2 Care Quality Commission (CQC) action plan (agenda item 7)

DT explained this was also a summary of the new inspection process and new model around the CQC. This explains the four themes and the likelihood of inspection in different areas. Each core services have a section on the intranet which is a useful information resource for each service. We continue to work on clinical record keeping and there are challenges on waiting lists which is impacted on covid. There are also pressures on staffing.

CDBG explained in the pre governor meeting and the quality group meeting that she raised her concerns about the narrative being about being inspection ready. She explained that she welcomes DTs comments about it being fundamental standards of care continuously and not just about being inspection ready.

KSC said many years ago he did the 15 steps and he felt it was important for staff to know that governors were supporting them. BC asked about the acronyms in the report and asked whether we can explain them. Agreed not to use acronyms in any future reporting.

JL asked if staff were doing unannounced visits across the Trust. DT said matrons have a lead on quality oversight. JL suggested for example, a member of staff from Ward 18 to go to the Dales unit unannounced and inform them they are doing an inspection. DT said we don't have peer reviews at the moment and our matrons work closely together on reviewing quality on the ward.

JL enquired about the service user stories at Trust Board and whether the Members' Council can feature an improvement story. MBu said they can discuss this outside of this meeting but it can be uncomfortable for unannounced peer reviews.

AJh said he has done quality monitoring visits and it would be helpful to do unannounced visits but it is the process to follow to get a snapshot of care planning and staffing on the wards. We can also pull the care planning audits from SystmOne.

It was RESOLVED to RECEIVE the update on the CQC action plan.

MC/22/36 8.1 Governor feedback and appointment to Members Council Groups (agenda item 8)

JL said they are continuing with the virtual governor meetings and the Q&A sessions are continuing with the executive team. There are pressures on the system in relation to recruitment and retention. JL said yesterday he had a conversation with GM about GM joining the staff governor meetings. JL said there was a joint, Kirklees, Barnsley and Wakefield governors meeting and he is aware it is mental health awareness week and there hasn't been any literature from the Trust which would indicate that.

JL said Fieldhead is 50 years old in July 2022 and asked if we are celebrating this event in anyway.

JL explained there are specific issues from Kirklees about poor quality of written communication from the Trust which has been discussed in the quality group and actions are forthcoming.

JL said there was an action from the Kirklees mental health forum, where one of our members asked if they could work on a procedure where carers were consulted about changes in treatment but acknowledged this was difficult due to confidentiality. There is feedback about last minute appointment cancellation. Some carers have also asked if video consultation will continue.

LH said there are a lot of new student nurses doing apprenticeships and due to covid and because of additional support being limited on the ward from qualified nurses, a lot of students have left the Trust. LH said a lot of nursing support do not feel valued.

Action: GM will liaise with LH outside of this meeting.

CDBG said in the quality group, it was agreed they would form a group in relation to Trust communication (letters sent to service users) and work on improving this. JL said the Members' Council need to make reference to the discharge letter and the work we did on improving this and we can also work on improving other Trust letters. CDBG asked DT when they will hear about the working group. DT confirmed Carmain Gibson Holmes, Assistant Director of Nursing will contact the governors directly.

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KSC asked about service users understanding about the care plan and how often this is reviewed. LH said this depends on capacity and how well they are, there are continuous reviews during the multi-disciplinary team meetings. Every care plan and individual is different and consent can change and this is reviewed on an ongoing basis. CH said the Trust don't do well on whether the service user has received a copy of their care plan. A piece of work has been done on how we measure and record this to provide better assurance.

JL asked on behalf of DD on where we are with serenity integrated mentoring. JL said it was discussed around the time Rob Webster was CEO and he asked DT whether he can look into this and speak to DD outside of the meeting.

Action: DT to liaise directly with DD.

It was RESOLVED to RECEIVE the governor engagement feedback.

MC/22/37 8.2 Review of Chair and Non-Executive Directors' remuneration (agenda item 8)

LJ explained that in 2019 the Nominations Committee felt that the current rate for Non-Executive Directors was broadly in line with the NHS Improvement and NHS England rate. They recommended the rate of £13,584 per annum for Non-Executive Directors was frozen and not uplifted until such time as the NHS Improvement and NHS England rate exceeded it. The Nominations Committee proposed all new appointments, and any re-appointments continue to be appointed on the frozen rate of £13,584 per annum.

There are two current Non-Executive Director roles which attract an additional supplement of £2,000 per annum and these are Deputy Chair/ and Chair of the Audit Committee. The recommendation of the Nominations Committee is that on either re-appointment or a new appointment, the supplement should continue to be £2,000 per annum to align with NHS Improvement and NHS England's recommendation.

The Chair's current remuneration is £47,100 per annum which is the second point on the Trust's incremental scale. Progression up the scale is determined by the Members Council based on the annual appraisal. The recommended rates and guidance from NHS England and Improvement has not changed since 2019 as their guidance gave a trajectory of pay rates up to April 2022. The current remuneration for the Chair and Non-Executive Directors remains aligned to the recommendations.

It is proposed by the Nominations Committee that the remuneration levels remain as previously agreed and is reviewed again in April 2023.

The Chair's remuneration and progression up the scale will be determined by the Members Council based on her annual appraisal.

Should there be any changes to NHSEI recommendation remuneration levels prior to this time this would be reviewed in accordance with any new recommendations.

JL asked members' council whether they supported this decision.

TW asked whether pro rata is clarified when figures are put in reports. JL said this has been noted. The governors agreed with the plan.

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It was RESOLVED to APPROVE the review of the Chair and Non Executive Directors remuneration.

MC/22/38 8.3 Assurance from Members' Council groups and Nominations Committee including:

8.3.1 Members' Council Co-ordination Group annual report 2021/22 including update to the Terms of Reference
8.3.2 Members' Council Quality Group annual report 2021/22 including update to the Terms of Reference
8.3.3 Nominations Committee annual report 2021/22 update to the Terms of Reference
(agenda item 8)

MBu asked whether any governors had to raise any issues regarding this section.

MF said we have split the role of the Deputy Chair and Senior Independent Director. MF said MG is attending members' council coordination group, he asked whether that role should be Senior Independent Director attending the members council coordination group. Agreed to discuss this.

Action: AL said he will arrange a meeting to discuss this.

BC said in the nominations committee terms of reference, he believes the Associate Non Executive Directors will be under the care of the nominations committee, he said in the terms of reference there is no mention of this. He said in section b and section f there should be reference to this. AL said we can make this amendment.

Action: AL to review the amends to the nominations committee terms of reference

It was RESOLVED to RECEIVE and APPROVE the annual report including terms of reference from the Members' Council Co-ordination Group, Members' Council Quality Group and Nominations' Committee.

MC/22/39 8.4 Review of Audit Committee terms of reference (agenda item 8)
MF provided an update on the terms of reference for the audit committee, he explained there is one change on page 5 of the paper, which is an inclusion of health and safety and emergency response and business continuity. MF said he provides assurance that the terms of reference are reviewed at Audit Committee and at present there are both external and internal audit and they give approval that we have terms of reference that are best practice with good governance standards.

It was RESOLVED to NOTE the updates to the Terms of Reference for the Audit Committee.

MC/22/40 8.5. Members' council elections (agenda item 8)

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AL said on the first page there is a typing error, executive summary, public Barnsley, two nominations received, this was a typing error, there was one nomination received, and there is one vacancy in Barnsley.

are a number of vacancies (8 in total) and they have spoken to JL about this. AL said in the voting results, the numbers of votes cast against how many eligible voters and the numbers are very low. He explained there will be some engagement work with Dawn Pearson and Julie Williams to the broader membership and this has been paused during covid but we are keen to reengage with the membership to have better return on the votes.

MBu asked whether we can look at how we can be a public governor and a member of staff, and if we can review our constitution. We will also look at how often we advertise for governors. MBu said we will also look at how we promote this.

BC enquired about elected governors being members of staff, he said they wouldn't be able to vote for themselves. MBu said we will look at the constitution. AL said we need to consider what changes the ICS system will bring when localities move into place based systems and the election rules are strict.

LH spoke about her own experiences in applying as a staff governor. She said she has been speaking to her colleagues about recruiting for governors, such as filling the nursing governor vacancy.

It was RESOLVED to receive an update to the Members' Council elections.

MC/22/41 Workforce and workforce planning (agenda item 9)

Presentation by LJ and GM.

GM introduced himself as Chief People Officer. Key highlights (see power point presentation)

A great place to work – Feeling Safe Recruit more staff
A great place to work – Keep fit and well – retention
A great place to work – supportive teams
A great place to work – developing my potential
A great place to work – your voice counts
A great place to work – ongoing challenges31

KSC explained that in his constituency of Barnsley people are not favourable towards SWYPFT because there are services closing down such as Mount Vernon and Broadway respite centre. MBu said we understand there is history and services working in Barnsley are doing well and recruitment in Barnsley is good.

BC asked about the careers website, LJ said we will send them a link once this is done.

GE thanked LJ and GM for the presentation as they demonstrated there is a lot of good work going on. GE asked what the opportunities and threats in relation to ICS. LJ said we are working through this and is evolving; the Trust is connected into our places and from a workforce perspective.

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JL asked about the work leadership programme, what level were the managers, JL said we are looking at 8a and above and we may broaden this to other managers, we are looking at 111 managers and then broaden this out to other leaders at all levels. We will be working through a phased approach. JL said this is welcoming and retention is about good management. JL asked about ensuring appraisal is done and also ensuring exit interviews are done rather than leaving it to an electronic system. GM said we are allowing more time for conversation with appraisals and it is about the quality of the appraisals rather than lots of paperwork.

AJh said there are issues in relation to bank staff and are not necessarily working on the ward they pick to work the shift. He said some staff may not book shifts if they fear they will be moved to work on a different ward. AJhSerneity asked whether governors could see what was said on the exit questionnaire.

Action: LJ to share information from the exit questionnaire with governors.

It was RESOLVED to RECEIVE the presentation for workforce and workforce planning.

MC/22/42 9.1 Integrated performance report (information only) (agenda item 9)

MBu explained to the governors that this IPR will be presented at the next members' council meeting.

TW shared with the governors that he has attended the governor IPR course and it was very helpful.

It was RESOLVED to RECEIVE the integrated performance report.

MC/22/43 Any other Business (agenda item 10)

MBu said as a future agenda item we can look at presentations by staff members and longer time period for discussion and level of assurance as she felt the non executive contribution has been excellent today.

MBu said she is happy to speak to governors on a one to one basis which can be arranged by contacting her PA, Gemma Lockwood.

It was RESOLVED to NOTE any other business.

MC/22/44 Closing remarks, work programme and future meetings (agenda item 11)

AL said the work programme has been to the coordination group and due to the amount of time on discussion items this meant a reduction on time on other items, such as the IPR. The IPR has been scheduled for a full presentation at the next members' council meeting.

Action: AL asked for feedback on the work programme

JL this has been a good meeting and we have had good conversations. JL commended AL on the work programme.

Date of next Members' Council meeting is:
16 August 2022, 9.00 – 12.00

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Members' Council meetings 2022/23:
15 November 2022 (including the annual Joint Trust Board and Member's Council meeting)
14 February 2023

It was RESOLVED to RECEIVE the work programme for 2022/23

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South West Yorkshire Partnership NHS Foundation Trust

Minutes of Workforce and Remuneration Committee
5th July 2022
12.30-2.30pm
Virtual Teams Meeting

Present	
Mandy Griffin (MG)	Non-Executive Director (Chair)
Natalie McMillan (NM)	Non-Executive Director
Mark Brooks (MB)	Chief Executive

In attendance	
Greg Moores (GM)	Chief People Officer
Lindsay Jensen (LJ)	Deputy Chief People Officer
Carol Harris (CH)	Chief Operating Officer
Sindhur Nagendra (SN)	Speciality Doctor (agenda item 5)
Norman Khan (NK)	Speciality Doctor (agenda item 5)
Zarina Asidi (ZA)	Staff Nurse (for agenda item 5)
Ashely Hambling	HR Business Manager (for agenda item 8)
Estelle Myers	Ambassador for Cultural Change FTSU Guardian
Chloe Hoyland (CLH)	PA to Chief People Officer (Author)

Apologies	
Marie Burnham (MB)	Chair of the Trust
Richard Butterfield	Head of Workforce Planning

WRC/22/77 Welcome, Introductions and Apologies (agenda item 1)

MG welcomed everyone to the meeting including introductions. Apologies were received from Marie Burnham, Chair of the Trust and Richard Butterfield, Head of Workforce Planning.

It was noted that the meeting was quorate and could proceed.

WRC/22/78 Declaration of Interests (verbal item) (agenda item 2)

There were no declarations over and above those made in the annual return to Trust Board in March 2022.

WRC/22/79 Minutes of the meeting held on:

- 09 May 2022 (attached)

MG thanked NM for chairing the last meeting in her absence.

The Committee RESOLVED to APPROVE the above minutes of the meeting held on 9th May 2022.

WRC/22/80 Matters arising (agenda item 4)

(a) ***WRC/22/64 and WRC/22/65: Retention measures for the workforce IPR***

GM and MG had earlier discussions about the IPR and agreed this is still work in progress and more work will be undertaken with the People Leadership Team and other colleagues. GM confirmed there had been some small changes in this current version of the IPR for consideration by the committee today, and there will be further refinements at the next Committee in September. It was agreed that since the work is currently being undertaken around the IPR the committee agreed to close these actions and if needed new action(s) will be identified in September.

(b) ***WRC/22/66: Onboarding / careers website***

MG confirmed she had discussed this previously with GM and this will be deferred to September.

(c) ***WRC/22/67: Integrated Workforce Performance Report***

MG confirmed that a meeting was held between herself and GM on the 1st of July. Priorities were discussed and deep dives were yet to be determined, but this is work in progress. It was agreed to close this item**.**

(d) ***WRC/22/68: Staff Survey Results Recruitment Plans***

Staff survey is on the agenda**.**

(e) ***WRC/22/52: Committee Annual Report 2021/2022***

MG confirmed this is now complete.

(f) ***WRC/22/09: Freedom to Speak Up Annual Report and Action Plan***

FTSU annual report is on the agenda

The Committee NOTED the actions from the previous meeting.

WRC/22/81 Staff Stories (agenda item 5)

MG welcomed SN, NK and ZA to share their stories with the committee. LJ confirmed the committee is keen to hear from staff about their experiences working in the Trust and these are colleagues who have joined the Trust as part of our international recruitment programmes and we were keen to hear their experience both positive and any challenges.

SN confirmed she was one of the 1st international fellows (Doctor) employed in the Trust and moved to us in the middle of the pandemic, SN confirmed SWYPFT has been incredibly supportive, and patient and thanked Amanda and Lucy specifically from the medical staffing team. SN

confirmed the team helped her find accommodation and gave her a letter of support to open a bank account, the Trust covered all her travel and shipping costs including a welcome pack which helped hugely as it had all the essentials in. SWYPFT also covered part of SN rent for the first six months. SN highlighted the NHS is a very different system from her home country and all the induction courses were very helpful in understanding the system. SN highlighted how thankful she is to the team; the NHS and the whole experience so far has been helpful both professionally and personally. The Trust and all staff have been extremely warm and welcoming.

NK thanked the Committee for the opportunity to speak at the Committee and expressed his experience so far. He is also a doctor and is on the fellowship programme. KN feels SWYPFT has provided him the opportunity to work in one of the best healthcare systems in the world. NK highlighted how smooth the recruitment process was, NK mentioned how helpful Amanda and Lucy were throughout the process, they provided NK with full guidance throughout the moving process including preparing him in advance with useful booklets on moving to the UK and what he may expect. Despite general nerves in settling into living in the UK the Trust has continued to be helpful. Being new to the UK and the Trust SWYPFT has provided NK with training programmes that has helped, including shadowing which has been fantastic. NK confirmed he still has on-going fantastic support. NS highlighted he has a good work life balance and is enjoying the role. NK said he would highly recommend people joining via international recruitment.

ZA confirmed the Trust has been very supportive, the reception upon arrival was very warm, the welcome package was amazing. She has joined the Trust as part of the International Nurse programme. The training was very eye opening as it is very different to ZA's home country Kenya. The training gave a good head start and what to expect. ZA highlighted how fantastic Beechdale (the ward she works on) is and how all the staff made her feel extremely welcome and comfortable. ZA confirmed how fantastic the team was in ensuring she felt confident in her role by shadowing. The support has been there throughout and feels the Trust is a fantastic place to work and would highly recommend anyone thinking about joining this journey to join the Trust.

MB thanked all the staff for sharing their journey and feels we do great planning, MB asked if there was anything we could have done better and learn from their experiences.

NK highlighted there was a lot of training sent to him although he was very grateful for this, he was unsure which to prioritise. NK explained it would be useful for future candidates to be given the training in an order of importance.

NM thanked all the staff for coming and sharing their experiences with Committee. NM asked if they had been given previous opportunity to give feedback on their experience at all stages.

SN confirmed she has had regular supervision with the consultants which has given her good opportunity to give feedback to her line manager and consultants.

GM thanked all staff for sharing their experience. GM also asked why they specifically chose SWYPFT given how in demand their services are.

NK confirmed he did have other offers however SWYPFT offered a longer visa meaning he can build a life for himself in the UK as opposed to having to go back home after two years. The feedback that NK had received from other colleagues who have been through this process was very positive.

SN had also spoken to a friend who works in the Trust who gave her excellent feedback and highlighted that the recruitment process was seamless, and everyone was friendly and welcoming and that SWYPFT seemed to be better over other opportunities.

CH asked the staff if there is anything they can do to help us encourage others on this journey.

ZA confirmed she would be more than happy to help in any way she can with telling her story and helping others understand the process.

SN has already recommended the programme to many previous colleagues in India. If any opportunities come up she said to email her and she will be more than happy to share these with her previous colleagues, many of whom are already looking into the programme.

NK confirmed he often posts on social media highlighting the benefits of the programme and will continue to do so.

MG thanked all staff for their time and sharing their stories.

The Committee NOTED and COMMENTED on the update from the International Fellowship Doctors and International nurse.

WRC/22/82 Covid – 19 update and Workforce Report (agenda item 6)

MG confirmed we are here to receive the Workforce IPR. GM shared the report on screen highlighting figures. Establishment ledger and level of employed staff we currently have in the Trust (4135.45). GM confirmed we all know our vacancy rate has been a real pressure for the Trust, however, there has been a slight growth in our overall staff in post figure. Our employed FTE and headcount have been increasing slightly. GM confirmed what we have talked about in both Board and the Workforce and Remuneration Committee (WRC) is that there has been a lot of investment in mental health that creates both opportunities and vacancy pressures, particularly in in-patient areas. If we look at the internal movement of our staff we can see people are going from in-patient areas through to other areas which is creating pressure.

GM confirmed the overall vacancy percentage is 16.4%, our establishment ledger is 4910 FTE, our staff in post is 4106 FTE. GM highlighted our overall turnover is 15.80%, however, there is a lot of variation across our BDUs and services with some services operating at a higher level. GM highlighted this is YTD extrapolation from the figures in April and May, turnover tends to be higher in those two months so it maybe that the overall annual figure works out lower. Sickness rate is almost on track at 4.58% against a target of 4.4%. GM confirmed around a third of staff sickness is due to stress, anxiety, depression although we have a lot of positive things happening in the Trust regarding staff health and wellbeing. We need to challenge ourselves in terms of thinking are we doing enough. LJ confirmed we now have extra resource in the Occupational Health department, and we are getting the team to think about how things have changed since the pandemic and what do we now need to do differently. LJ confirmed we are working with CH and other colleagues looking at work life balance and more flexibility for staff. GM highlighted the great progress in in-patient sickness reducing from 7.2% to 5.1%. Estates currently at 8.04% the team are having conversations on how this can be improved. GM said appraisal figures are currently being looked at to determine what is the right appraisal measure for us to report in the Workforce IPR.

LJ highlighted that there is a lot of support and guidance being offered to use and embed our electronic appraisal system WorkPal as there had been a request to re-introduce some paper-based appraisals. CH highlighted concerns from an operational perspective, some staff are struggling with using computers which is making the appraisal process take a lot longer. Discussions are being held around if paper-based appraisals are still a possibility for a small number in the interim whilst people are more familiar/confident with the system.

GM highlighted we had more leavers than starters in April. GM discussed some feedback that has been received regarding exit questionnaires and the main reason being career progression followed by learning and development and the third most common was flexible working.

The Committee NOTED and DISCUSSED the key points of the Covid – 19 update and Workforce Report.

WRC/22/83: Workforce Strategy Actions and Organisational Development Plan/People Directorate Update (agenda item 7)

GM verbally updated the Committee confirming he has had conversations with MB, MG and NM in terms of the Organisational Development (OD) Strategy/Plan. GM has a time-out planned with his People Leadership Team (PLT) on the 19th July and will bring back an update to the September meeting. In the interim whilst discussions are taking place GM informed the committee that his team is still focusing on delivering our priorities. GM added that we have submitted our people priority programmes to be included in the overall trust priorities for 22/23 and they include diversity, recruitment and retention and the work that is undergoing around the people directorate structure.

The Committee NOTED the Workforce Strategy actions and Organisational Development Plan/People Directorate update.

WRC/22/84: Staff Survey (agenda item 8)

MG said we are here to note and support actions from the staff survey results.

AH confirmed five out of the nine NHS staff surveys key themes that were better than average against our peer group, two areas that were below average are learning and teamwork. Flexible working is showing an average score and is an area we want to improve as part of our work on staff retention. A lot of work has been undertaken in analysing the results for different staff groups, services/areas including the different demographic and diverse groups in the Trust. A report on the results from an equality and diversity view was shared and discussed at the last Equality, Inclusion and Involvement Committee. We are also keen to look at it from a staff group perspective. Also included is a high-level summary of the work and outputs from what we have been doing in services on the results. The hotspots are the mental health in-patient units and the forensic services where their results came out lowest. CAHMS, support services and Wakefield mental health all have positive results. Where we can we are linking this work to existing work streams.

AH will provide a further update on how items above are progressing in September.

NM asked how we are going to hold to account on progress and whether the actions that have been raised are being evaluated.

MG also raised how do we measure this and by when.

CH confirmed we used to do action plans following the staff survey and said we moved away from these a few years ago. We may have moved too far away from this and need to find something in the middle that does not turn this into a highly managed process. CH asked AH to attend the OMG to discuss how we can move forward on middle ground with this.

The Committee NOTED and SUPPORTED the Staff Survey update.

WRC/22/85 Appointment of Executive Primary Care Advisor (agenda item 9)

MB gave a verbal update. MB confirmed initially it was hoped that this role could be a secondment from the Barnsley practice, however, since receiving external independent legal advice on our options this has not been possible due to financial considerations. We have, therefore, undertaken a high-level recruitment process outlined in the paper which closes today.

MB confirmed that in terms of hours and salary level this will be based on a clear set of objectives and achievement of those objectives.

The Committee NOTED and SUPPORTED the appointment of Executive Primary Care Advisor

WRC/22/86 Freedom to Speak Up (agenda item 10)

EM gave verbal update on FTSU, the work that is being undertaken and the audit that was carried out in 2021 including an update on the action plan.

EM confirmed all audit actions identified have been completed and are now closed.

More recently the concerns that have been coming to the FTSUG are from people not knowing where to go so have needed signposting. This has resulted in some of the cases taking longer to close as this depends on responses from others and not in the remit of speaking up.

EM confirmed training figures are good for Speak Up training, however, Listen up and follow up training figures are low which is a reflection of Speak up being mandatory and Listen up and follow up being as required. EM asked if we could encourage managers to undertake Listen up and can band 8A's and above complete follow up.

MB confirmed the Committee can support the above request, however, realistically there are issues managers need to address internally in terms of undertaking the training. MB is keen to effectively communicate the roles of FTSU, Equity Guardians etc by sharing the new logo.

MB confirmed to the Committee that everything is being done in terms of raising awareness and wondered what the future plan is in place to promote FTSU. EM commented she will continue to attend all welcome events. EM confirmed she attends Forensics on a regular basis and is in touch with other inpatient ward matrons and managers.

NM commented how important it is to link FTSU to other key areas, NM also highlighted how important it is that FTSU is for both staff who line manage and who don't. NM highlighted the number of cases that have been reported 21 – 22 (pg7 of report) related to worker safety is 26 however the previous year was zero is this correct? EM commented that a new category of worker safety has been introduced which was not on her radar.

LJ shared that a new poster has been developed which explains the different support offers from the different roles we have i.e. FTSU, equity guardians, civility and respect champions, trade unions to help staff know where and how to go for different issues/support and this will be shared with the Committee.

Action: CHoy

EM also shared that the bullying and harassment work has re-started, there is a new FTSU screen saver added to staff's laptop as well as linking with the Great Place To Work and that she is a member of the RACE forward group.

MG wanted to clarify the action plan which was part of the audit, there are some actions on-going should there be a completion date around the on-going actions? There are some actions that are for later dates so we will still expect that to come back to the Committee and be signed off.

EM acknowledged the above and will bring a further update in six months' time to the Committee.

Action: EM

The Committee NOTED and COMMENTED on the Freedom to Speak Up update.

WRC/22/87 Recruitment Plan (agenda item 11)

It was discussed and agreed by MG and GM prior to the meeting that this item will move to September's meeting.

Action: GM

The Committee NOTED the update.

WRC/22/88 Local Clinical Excellence Awards (agenda item 12)

LJ summarised the paper and informed the Committee that we have been paying local Clinical Excellence Awards (CEA) to consultants for many years as part of the Consultant contract. Four years ago, NHS employers reviewed the process and came up with a new national 3-year CEA process which was adopted in the Trust. We were led to believe that following this 3-year scheme a further national scheme would be developed. However, the national negotiations with the BMA have failed to agree a replacement scheme and therefore the guidance from NHS Employers is that Trusts needs to consult and agree on a local CEA scheme. Given the complexity of this and that the old scheme was not fit for purpose, and it will take some time to develop a new scheme, we proposed to our Joint Local Negotiating Committee (JLNC) for doctors that we adopt the same approach as last year based on a fair shares approach which they agreed. We have started to speak to our colleagues in Leeds, York and Bradford to see if we can work together on this process for next year going forward. LJ is asking the Committee to ratify the approach for this year to divide up the CEA allocation equally between eligible consultants.

NM supported the approach although said she is disappointed that nationally it has been left in this way as it puts us in a difficult position, the reality is Clinical Excellence Awards have been very difficult for years. NM felt we need to make other Non-Executive Directors (NEDs) aware this will not be resolved quickly. NM asked to note she does not agree with Clinical Excellence Awards, that all staff should receive the same recognition and that everyone has been under pressure and has worked hard.

MG formally asked the Committee to ratify the recommendation made by LJ

The Committee RATIFIED the payments of the Clinical Excellence awards in line with agreement between NHS employers and BMA.

WRC/21/90 Horizon Scanning (agenda item 14)

Horizon Scanning update given by GM under any other business.

WRC/22/91 Workforce Risk Register (agenda item 15)

GM informed the Committee there are some changes to risk 1151 being unable to recruit and retain clinical staff due to national shortages, some changes in the description which aligns to what was discussed earlier in the Committee, about national shortages, the growth and additional posts and roles being developed through the MHIS is exacerbating our shortages. GM concluded understanding all those considerations that the risk score has been increased which now makes it a 16 which is the biggest strategic risk for the Trust.

GM informed the Committee risk 1614 increase in scoring to mirror escalating to a 16 and further updates on the report in terms of the risk actions.

MG confirmed she is pleased with the changes and the conversations that have been had today and appreciate it is a high risk with workforce and knows the Trust is doing everything they can to keep wards and areas safe.

NM agreed with the above.

The Committee noted the change of dates given there is more groundwork to be done however MG commented that we need to be cautious not to push items to far down the line.

GM highlighted how impressed he is since moving to SWYPFT on how risk is managed he has monthly meetings with Asma to go through the risks.

MB commented it is good practice to have dates against risks but to remember some of these may go on for longer given the size and impact of the risks when taking everything into consideration.

The Committee DISCUSSED and AGREED the Workforce Risk Register.

WRC/22/92 Terms of Reference (agenda item 16)

The Committee confirmed they are happy with the terms of reference.

The Committee AGREED the terms of reference.

WRC/22/93 Annual Work Programme (agenda item 17)

GM and MG met prior to the meeting and agreed some of the items will be reviewed and an update will be given in the September Committee meeting.

The Committee NOTED the update.

WRC/22/94 Actions from Trust Board (agenda item 18)

MG confirmed there are three actions coming to this Committee from Trust Board:

(1) To consider whether we want to receive a quarterly report from the Guardian of Safe Working (GOSW).

(2) Higher risk level around agency staff (GM/MG confirmed this will be included in the IPR session).

(3) Pace of recruitment processes. MG said there has been a lot of narrative in this meeting about what we are doing regarding the pace of recruitment. GM confirmed there will be an agenda item in September in terms of reducing lead times at the onboarding process.

GM agreed to add Guardian of Safe Working to the work plan.

Action: GM

WRC/22/95 Matters to report to the Trust Board and other Committees (agenda item 19)

The key points to report to Trust Board and other Committees are as follows:

Alert:
To escalate an issue that requires further discussion or action 1. There was an in-depth discussion around recruitment and retention. This included staff leavers feedback, turnover and vacancy rates. The committees' risks have also been reviewed to reflect current position. This will be the focus of the committee over the next few months. **2.** The committee was due to receive a recruitment plan. This was deferred until September. A verbal update was given, and progress is being made in regard to the pace of recruitment and action received from trust board.
Advise:
To highlight an issue that may require further monitoring (by the Committee) over a period 1. Absence numbers were in line with expectation overall, however there are some service areas where absence is of concern, inpatients has seen some improvement but still high, whilst Estates and facilities is high at 8%. There was also some concern regarding current COVID absence on the back of the new wave. 2. Concern around appraisal data as the numbers only shows statistics relating to appraisal window. Committee has requested a rolling 12month position to assure them on overall compliance. 3. An update and action plan from the staff survey results including actions from each service area was presented, the committee did ask that the measures be defined and be more specific with appropriate end dates for completion. 4. The clinical excellence awards were ratified by the committee. The recommendation was to pay on an equal share bases in line with last year and the region. It was agreed that a discussion should take place about future years. 5. An update was received, and support was given for the recruitment of the Primary Care Executive Advisor. 6. The committee agreed to receive the quarterly guardian of safe working hours report. **7.** The committee would like to receive more detail on agency spend.
Assure:
1. The committee received the six monthly update of the FTSUG status and progress against the action plan from the internal audit. Whilst there are still concerns around take-up of civility champions and numbers good progress has been made.
Risk Register: reviewed risks. **1.** The committee reviewed all 4 risks associated with WRC. Two risks scores have been increased, one reduced and one updated. The increase in risk scores for 1151 and 1614 were relating to recruitment and retention and now reflect the trust current position.

WRC/22/96 Any other Business (agenda item 20)

GM wanted to flag there has been a national directive around changes to the Covid-19 terms and conditions going back to standard pre pandemic status.

GM also highlighted we need to keep an eye on the industrial relations climate, the pay award still has not been settled. He said we have budgeted for 3% however this has not been firmly negotiated nationally. The BMA are asking for 30+%. We will do what we can locally. GM wanted the Committee to be made aware.

The Committee NOTED the update.

WRC/22/97 Date and Time of next meeting (agenda item 21)

The next meeting will be held on 13 September 2022 at 10.00am, via Microsoft Teams Meeting.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 September 2022
Agenda item 11.1

Private/Public paper:	**Public**		
Title:	**South Yorkshire Integrated Care System (SY ICS) Update including Mental Health, Learning Disability and Autism Provider Alliance (MHLDA)**		
Paper presented by:	Chief Executive and Director of Strategy & Change/Deputy Chief Executive		
Paper prepared by:	Chief Executive and Director of Strategy & Change/Deputy Chief Executive		
Purpose:	The purpose of this paper is: • To update the Trust Board on key developments in SY ICS and the SY MHLDA Alliance and linked programmes. • To update on partnership developments in Barnsley.		
Strategic objectives:	Improve Care	✓	
	Improve Health	✓	
	Improve Resources		
	Make this a great place to work		
BAF Risk(s):			
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 Alliance.		
Executive summary:	From 1 July 2022, NHS South Yorkshire Integrated Care Board (ICB) took on the commissioning responsibilities of clinical commissioning groups and will lead the integration of health and care services across South Yorkshire. Work continues with our partners in Barnsley to evolve and develop place-based partnership governance arrangements. We have continued to develop the partnership with primary care as part of the recently formed health and care alliance. The Alliance has agreed the branding and communication approach, a business plan is being progressed and work has commenced on the priorities including improving annual health checks for people with learning disabilities and mental health, frailty and aging well and improving early mental health support for people in the community. **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 Alliance develops. New risks may emerge.
Recommendation:	**Trust Board is asked to NOTE the SY ICS update.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27th September 2022

Agenda item – 11.1 South Yorkshire update including South Yorkshire Integrated Care System (SY ICS)

1. Introduction

The purpose of this paper is to update the Trust Board on key developments in the South Yorkshire Integrated Care System (SY ICS) and the South Yorkshire Mental Health, Learning Disability & Autism Provider Alliance (SY MHLDA) and linked programmes and also on partnership developments in Barnsley.

The paper summarises key developments from recent ICB and place-based meetings.

2. South Yorkshire Integrated Care Partnership

South Yorkshire Integrated Care Board

Member	Chief Executive
Items discussed and summary of key points	Update from meeting of 7th September 2022 • Story telling - two separate stories were received by the Board, focused on learning disabilities and autism. The important role of key workers, having patient centred care and the benefits of engaging effectively/employing people with lived experience were perfectly illustrated. • Key topics covered included the cost-of-living crisis, the importance of the role of place, concerns over and preparation for winter, the importance of the flu and covid booster vaccination programme for both staff and communities and focus on population health/addressing inequalities. • Reports from each place were provided and reviewed. There are common themes of challenge in each place and also examples of good practice, for which there is potential for shared learning. Within the Barnsley report, progress of the Barnsley Place Committee was noted. Key achievements for Barnsley place were noted including discharge pathways (including Discharge to Assess) from hospital, urgent community response, work to address the wider determinants of health and care and the establishment of the Mental Health and Learning Disability Alliance. • Integrated performance report - the integrated performance report was received and discussed. This will evolve in coming months and will need to show a balance of both national and local priorities. Key areas of focus currently are urgent & emergency care, priorities for the winter, elective recovery and cancer backlog.

	• Corporate assurance report - all assurance and place committees have met since July 1st. The Risk Management Framework and Board Assurance Framework are due to be consolidated. • Richard Jenkins has been confirmed as the substantive Chief Executive of Rotherham NHS Foundation Trust in addition to his role as the Chief Executive of Barnsley Hospital NHS Foundation Trust. He has been covering the Rotherham role on a temporary basis. Oliver Coppard will chair the South Yorkshire Integrated Care Partnership. Oliver is the Mayor of South Yorkshire. • Commissioning policies - work is taking place to consolidate commissioning policies. • Emergency Preparedness Resilience and Response (EPRR) Framework - the EPRR process and process for agreeing self-certification were agreed. • Strategy development - The Integrated Care Partnership will play a lead role in the update of the South Yorkshire strategy. An accompanying 5-year delivery plan is to be developed and the strategy will articulate how we will make a difference. There will be an emphasis on partnership with a decision-making framework developed to support the agreement of priorities. • South Yorkshire response to Cost-of-Living Crisis - the impacts of rising energy prices and the wider cost of living crisis were discussed. Each place is identifying what solutions can realistically be delivered. As well as the very real impact on communities and staff, it is also having an effect on partner organisations. • People, workforce and culture - a verbal update was provided regarding the people strategy which will be developed on a co-produced and inclusive basis. 'One workforce' will be fundamental to the development of the strategy. • South Yorkshire Integrated Care System Green Plan - this was supported with a recognition we need to strive for ambitious and realistic change. • Population Health and Health Inequalities - the five priorities for ICB wide - action to reduce health inequalities in 22/23 were agreed. There is concern the cost-of-living crisis will exacerbate existing health inequalities.
Date of next meeting	Next meeting scheduled for 2nd November 2022
Further information:	Meetings and papers :: South Yorkshire ICB

3. South Yorkshire Mental Health, Learning Disability and Autism Provider Alliance

Member	Chief Executive
Items discussed	Update from meeting of 14th September

	• South Yorkshire MHLDA Financial position and support - Lee Outhwaite (Finance Director for the South Yorkshire ICB) attended for this item. There was an introductory conversation regarding finance in the collaborative. Key points raised covered:
	  ○ The path for transitioning delegation of some financial responsibilities from the ICB to the provider collaborative - recognition that resources will need to transfer to make this happen.
	  ○ Data analytics to support better population health management.
	  ○ How future investments are prioritised.
	  ○ Capital.
	• ICB Partner Member Feedback.
	• Setting Our Priorities workshop - the partnership session on agreement of collaborative priorities has been deferred until October.
	• Strategic planning timeline and inputs.
	• SY MHLDA Provider Collaborative Chief Executive Leadership Arrangements - planning for upcoming retirements was discussed.
	• The chair of the MHLDA Provider Collaborative rotates and is due to change at the end of October. Sarah Jones (Sheffield Children's) has agreed to stay as chair until March 2023 so there is clarity on Chief Executive (CEO) positions before the next chair of the collaborative is agreed (so as to ensure the chair is from a different Trust to the lead CEO).

Date of next meeting	12th October 2022

4. Barnsley Place

Barnsley Integrated Care Partnership

Member	Chief Executive and Chair
Items discussed	<u>Update from meeting of 25th August 2022</u> Key agenda items included: • Bold & Ambitious – Exploring our Wicked Issues in Barnsley. • Terms of reference for Barnsley Place Partnership Board Sub Groups. • Reflections on how well the meeting's business has been conducted.
Date of next meeting	29th September 2022

Barnsley Place Partnership Delivery Group

Member	Director of Strategy and Change
Items discussed	Update from meeting on 13th September 2022 Agenda items included: • Place design - progress/updates on place-based arrangements, progress/updates on ICB arrangements and risks. • Update on the programme executive. • Health and Care Plan update. • Escalations - pressures on services were discussed. Social care reported a focus on community capacity. Cost-of-living was raised and the impacts of rising energy prices and the wider cost-of-living crisis were discussed. • A presentation was received from the Recovery College, which was well received. • Patient access to medical records online - a best practice example was shared.
Date of next meeting	20th September 2022

Barnsley Community Health and Care Alliance

Member	Chief Executive, Chair and Director of Strategy and Change
Items discussed	The meeting was stood down in August, therefore, the last meeting was 27th July 2022. Update from meeting on 27th July 2022 • Additional Roles Reimbursement Scheme (ARRS) update - an update on progress was provided. The Trust and Barnsley Healthcare Federation have been working closely together to implement new roles. The Alliance is starting to consider roles which have a beneficial impact to the system, rather than focusing solely on Primary Care, with some of the additional roles being new to Barnsley. • Business Plan (initial draft) - the draft Business Plan was presented, which has been produced in collaboration with the ICCP. The Business Plan will play a key role in providing the Alliance Committee with ongoing assurance, alongside the reporting process from the ICCP. • ICCP Update - updates were received on frailty and dementia, health checks for those with a learning disability. • Communications and engagement - it was reported that a new Communications and Engagement Lead is due in post shortly, employed by Barnsley Healthcare Federation to progress this work at pace. • The Alliance branding agreed and approach to joint communications.

Date of next meeting	30th September 2022

Barnsley Health and Wellbeing Board

Invited observer	Director of Strategy and Change
Items discussed	The August meeting was stood down due to a workshop. The last meeting remains the meeting of 9th June 2022 where the following items were discussed: • Message of thanks to Cllr Andrews - Verbal - Nominated Chairperson. • Health Inequalities in Barnsley - Emma Robinson. • Verbal update from the Barnsley 2030 Board - Bob Kirton. • Director of Public Health Annual Report - Julia Burrows. • Mental Health Strategy - Patrick Otway & Adrian England. • Verbal Update from Creativity and Wellbeing Week - Kathy McArdle.
Date of next meeting	The next meeting scheduled for 6th October 2022
Minutes	Papers and draft minutes (when available): https://barnsleymbc.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=143

Recommendation

To receive papers and note updates from SY ICB and Barnsley place.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 September 2022
Agenda item 11.2

Private/Public paper:	**Public**		
Title:	West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update.		
Paper presented by:	Director of Strategy and Change/Deputy Chief Executive and Director of Provider Development.		
Paper prepared by:	Director of Strategy and Change/ Deputy Chief Executive and Director of Provider Development.		
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 that the Trust provides services (Calderdale, Wakefield, Kirklees).		
Strategic objectives:	Improve Care	√	
	Improve Health	√	
	Improve Resources	√	
	Make this a great place to work	√	
BAF Risk(s):			
Any background papers / previously considered by:	Strategic discussions and updates on the West Yorkshire Health & Care Partnership developments and place-based developments have taken place regularly at Trust Board.		
Executive summary:	From 1 July 2022, NHS West Yorkshire Integrated Care Board (ICB) took on the commissioning responsibilities of clinical commissioning groups and will lead the integration of health and care services across West Yorkshire. Work continues in each of the places that make up the partnership 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 in response to the White Paper.		

Recommendation:	**Trust Board is asked to RECEIVE and NOTE the update on the development of Integrated Care Systems and collaborations:** ○ **West Yorkshire Health and Care Partnership;** ○ **Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees.** • **RECEIVE the minutes of relevant partnership boards/committees.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 September 2022

Agenda item 11.2

West Yorkshire Health & Care Partnership (WYHCP) - including the Mental Health, Learning Disability and Autism Collaborative and Place-Based Partnerships Update

1. Introduction

The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire Health and Care Partnership (WYHCP), focusing on developments that are of importance or relevance to the Trust. The paper also includes an update on key developments in the three districts in West Yorkshire that the Trust provides services (Calderdale, Wakefield, Kirklees).

From 1 July 2022, NHS West Yorkshire Integrated Care Board (ICB) took on the commissioning responsibilities of clinical commissioning groups and will lead the integration of health and care services across West Yorkshire.

The partnership continues to develop the governance arrangements, which remain in development after 1 July and will need to be reviewed and adapted as they bed in. Formal reviews will be at 12 and 18 months which have been built into all aspects of the arrangements.

All nomination and appointment processes to the board include a commitment to improve the diversity of the Partnership's leadership and to ensure a spread of representation across places. Work continues in each of the places that make up the partnership 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 in response to the White Paper.

The paper summarises key developments from recent ICB and place-based meetings.

2. West Yorkshire Health and Care Partnership

Key updates from key meetings of the West Yorkshire Health and Care Partnership are summarised below.

West Yorkshire Integrated Care Board

Member	The Trust is not a member but is represented by Sara Munro, Chief Executive of Leeds and York Partnership NHS Foundation Trust, as member for the mental health, learning disability and autism Trusts.
Items discussed	Update from meeting of 20th September 2022 This was the second meeting of the Integrated Care Board. Agenda items included: • Citizen voice- the Board received a proposal from Healthwatch and our Non-Executive for Citizens and Future Generations to consider and agree how citizen voice will be embedded into ICB decision-making. • Chair's report • Chief Executive's report • Board assurance framework • Financial strategy • Integrated performance dashboard • Risk register • Winter planning • Committee reports/workplans • Focus on children and young People
Date of next meeting	Next meeting scheduled for 15th November 2022.
Further information:	NHS West Yorkshire Integrated Care Board meeting - 20 September 2022 :: West Yorkshire Health & Care Partnership (icb.nhs.uk)

West Yorkshire Health & Care Partnership Board

Member	Chief Executive
Items discussed	Update from meeting of 6th September 2022 Key items discussed included: • Update from Partnership's Chief Executive Lead- Covid bed occupancy in West Yorkshire currently is currently c200 (4% of the total). This seems to be plateauing at this number. There are concerns around the sustainability of partner organisations e.g. care homes and voluntary sector organisations during the winter as cost of living pressures mount, and concerns over social care funding. • Partnership Board terms of reference- these were agreed. • Healthwatch Insight report – key points to note included primary care access, access to dentistry, mental health support (access, children and young people, crisis support and community), inequalities and variation in service delivery and cost of living. • Refreshing the Partnership's Five Year Strategy- a refresh of the strategy is underway. A strategy design group is in place, made up of partner representatives.

	• Leeds Health and Social Care Hub. • Tackling health inequalities for Black, Asian and minority ethnic communities and colleagues- an update on progress against the Partnership's action plan in relation to improving safe access to work and ensuring the Partnership's leadership is reflective of communities was received. • Patient and Public Voice. • Role of the Partnership in helping to alleviate the impact of poverty- a powerful presentation was given. Health impacts were highlighted. There is work taking place in all places and a strategic leadership group will be established to develop a shared approach.
Date of next meeting	Next meeting scheduled for 6th December 2022.
Further information:	Further information about the work of the Partnership Board is available at: https://www.wyhpartnership.co.uk/meetings/partnershipboard Meeting papers are available here: https://www.wypartnership.co.uk/meetings/partnershipboard/papers/west-yorkshire-health-and-care-partnership-board-meeting-6-september-2022

West Yorkshire Mental Health, Learning Disability and Autism Partnership Board

Member	Director of Provider Development, Chief Operating Officer, and Medical Director
Items discussed	Update from meeting of 13th September 2022 • Chair's update. • Physical heath checks for people with severe mental illness, and the approach in each 'Place' to Core 20 + 5. • Transforming Care Partnership- reporting frequency was agreed as bi-monthly. There was a particular focus on developing a West Yorkshire framework for Dynamic Support Registers, and ensuring links to the Children and Young People's Keyworker role. • West Yorkshire Hub evaluation- a proposal for the future operating model is expected to be taken through the People Directorate of the ICB. • ICB Strategy refresh- the approach to this was discussed. The Strategy will have a big focus on the cost of living impact, whilst keeping the existing 10 Big Ambitions. Development work on the narrative will take place over the autumn. • Planning and performance – development of the performance dashboard.
Date of next meeting	Next meeting scheduled for 11 October 2022.

Wakefield

The Trust continues to be a pro-active partner in the Wakefield District Health and Care Partnership (DHCP) and associated work, leading in specific areas, for example, the Wakefield Mental Health Alliance.

The Wakefield DHCP met in June, which was the last meeting in shadow form. The first formal meeting as a Committee of the ICB was held in public on 19 July 2022.

Wakefield District Health and Care Partnership Committee

Date	Next meeting scheduled for 20th October 2022.
Member	Chief Executive (deputy - Director of Provider Development)
Items discussed	Items for discussion at upcoming meeting on 22nd September • Public health profiles- an outline of the content of the Public Health Regional Health profiles is due to be given explaining the key areas in the profiles where Wakefield is an outlier e.g. life expectancy, childhood and adult obesity, smoking in pregnancy, adult self-harm and suicide. • Report of the Place Lead. • Re-contracting of the existing Adult Hearing Loss Providers in Wakefield- approval will be sought at the meeting. • Enhanced primary care access- approval will be sought at the meeting. • Core20plus5 investment proposal- approval will be sought at the meeting. • Governance- the Wakefield District Health and Care Partnership Workplan and Wakefield district Health and Care Partnership Risk Register. These are planned to be endorsed in the meeting. • 2022/23 Quarter 1 Quality, safety and experience report. • Wakefield People Plan- approval will be sought at the meeting.

Wakefield Provider Collaborative

Member	General Manager, Wakefield Community Services
Items discussed	The September meeting of the Provider Collaborative was cancelled. <u>Update from meeting on 11th August 2022</u> • New Model of Care – Dementia Support Pathway & Dovecote Lodge Pathway. • Core20Plus5- the West Yorkshire ICB principles for investments in this area and next steps were outlined. • ICB Strategy- the 10 'big ambitions' were outlined and strategies for delivery will be developed. There will be an ICB 5-year delivery plan which will include 'must do's' such as performance targets and workforce development. • Wakefield People Plan was received for approval. • Better Care Fund. • Virtual Wards Update. • Winter and system pressures- Wakefield have applied for additional funding to support winter pressures. There will be a West Yorkshire and Wakefield place winter plan. Further guidance is expected.
Date of next meeting	Next meeting scheduled for 20 October 2022.

Wakefield Mental Health Alliance

Member	Director of Provider Development (Chair), with Trust representative as a member.
Items discussed	<u>Update from meeting on 20th September 2022</u> • Positive Mental Health Network engagement feedback- a meeting is planned to agree how the Alliance can include the voluntary and community sector (VCSE) within the Mental Health Dashboard. • Core20plus5 funding- this will be agreed by the Wakefield District Health and Care Partnership. A template for proposals to meet the 'plus' and '5' elements will be issued following the meeting. • Connexus Perfect Partnerships- a presentation was received which highlighted the approach to collaborative working with the VCSE. There was an offer of support/further discussion with Alliance members. • The updated Partnership Agreement and meeting template were agreed. • Cross system communication detailing mental health support to those affected by the cost of living crisis will be developed was agreed.
Date of next meeting	Next meeting scheduled for 12th October 2022.

Wakefield Health and Wellbeing Board

Member	Chief Executive (deputy - Director of Provider Development)
Items discussed	Update from meeting on 1st September 2022 • Healthy standard living for all- housing and homelessness. There was specific reference to the Groundswell Report. • Giving every child the best start in life- Born and Bred in Wakefield programme. • Health and Wellbeing Board protocols. • Better Care Fund 22/23 plan. • Development of Integrated Care Strategy. • Pharmaceutical needs assessment. • Safeguarding Adults Board report.
Date of next meeting	Next meeting scheduled for 3rd November 2022.
Further information	Papers and draft minutes are available at: http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

Calderdale

SWYPFT is a strong partner in delivering the Calderdale Vision 2024 and Calderdale Cares. We have continued to work with partners to develop a place-based approach and response to the national White Paper.

Calderdale Cares Partnership Board

Member	Chief Executive
Items discussed	Update from meeting on 25th August 2022 • Planning – an updated plan will be developed in line with ICS required timescales. The introduction of a sub-group will be considered to carry out the detailed work. • Feedback was invited on the ICS's proposed financial strategy. • Quality arrangements –an outline of proposed quality arrangements was given. • Primary Care enhanced access proposal– this is mandated nationally and will come back to the public meeting in September for approval.
Date of next meeting	Next meeting scheduled for 29th September 2022.
Further information	Further information and meeting minutes can be found here: Home - Calderdale Cares Partnership

Calderdale Community Collaboration Partnership Board

Member	Deputy Director Strategy and Change
Items discussed	Update from meeting of 8th September 2022 Items discussed included: • Integrated Health and Well-being Support for Adults- a presentation was received. • Older People's Mental Health Transformation- the Trust presented an update of this work which was well received. • Ageing Well (rising risk of Frailty)- a presentation was given of the work within the Primary Care Network (PCN) linked to population health management. Outcomes are good, and the approach is being spread across Calderdale. Links were made with the integrated health and wellbeing support, Active Calderdale and creativity. • PCN Service and Estates Strategy. • Virtual Wards- an update was provided by Calderdale and Huddersfield NHS Foundation Trust. • Update Terms of Reference Review (Calderdale Community Collaboration Partnership Board). • Calderdale Community Collaboration Partnership Board Finance & Performance Subgroup. • Innovation funding is ready to launch.
Date of next meeting	Next meeting is scheduled for 13 October 2022.
Further information	https://future.nhs.uk/CalderdaleCCPBoard/view?objectId=36472912

Calderdale Health and Wellbeing Board

Invited Observer	Director of Nursing & Quality
Items discussed	Update from meeting of 1st September 2022 • Confirmation of membership of the Health and Wellbeing Board and appointment of the Deputy Chair, including changes due to the new West Yorkshire Integrated Care Board- Board Members were advised that the Council meeting held on 27th July 2022 approved the Boards recommendations. • West Yorkshire Integrated Care Board Strategy. • Ageing Well. • Calderdale Cares Carers Strategy- this was signed off. • The Role of Deputy Chair of Calderdale Health and Wellbeing Board will be open soon.
Date of next meeting	Next meeting scheduled for 20th October 2022.
Further information	Papers and draft minutes are available at: https://calderdale.moderngov.co.uk/mgCalendarMonthView.aspx?GL=1&bcr=1

Kirklees

The first meeting of the Kirklees ICB Committee took place on 13th July 2022.

The Kirklees Delivery Collaborative is now meeting on a regular basis and has appointed Project Management support capacity.

The Kirklees Mental Health Alliance continues to meet and progress workstreams. Governance arrangements for the Alliance have been aligned to the new Kirklees place governance arrangements from 1 July 2022.

Kirklees ICB Committee

Member	Chief Executive (deputy – Director of Provider Development)
Items discussed	The meeting was due to be held on 14th September 2022, but has been rescheduled to 28th September 2022. Therefore the last meeting of the Committee was 13th July 2022. <u>Update from meeting 13th July 2022</u> • People Story - Four examples of patient feedback were provided to the meeting. • Terms of reference for Finance and Performance, Quality and Transformation Sub-Committees were approved, with agreement to review after 6 months of operation. • Community Contract - Recommendation to directly award contract for community services to Locala (current provider) for 18 months was approved, in order to carry out some work to determine if there needs to be any changes in pathway/provision. All providers agreed to work together regarding community provision. • Quality Report presented with focus on maternity, special educational needs and child protection. • Finance report presented. The plan has improved from £5m deficit to £1.7m deficit (additional cost of living funding).There will be more focus on establishing the underlying deficit position in coming months. <u>Planned agenda items for the meeting of 28th September include:</u> • Joint Health and Wellbeing Strategy Refresh • Enhanced Access Transition • Kirklees Delivery Collaborative Terms of Reference • Kirklees ICB Committee – Sub-Committee Work Plans. • Accountable Officer's Report • Kirklees Place Quality Report • Finance update • Performance Report against Key Performance Indicators for 2022/23 • High Level Risk Report: Cycle 1 2022/23 (July – September 2022). • Items for the attention of the ICB Board • Committee Work Plan
Date of next meeting	Next meeting scheduled for 9th November 2022.

Further information	Further information and papers are available at: Kirklees ICB Committee papers - NHS Kirklees Clinical Commissioning Group (kirkleeshcp.co.uk)

Kirklees Integrated Health and Care Partnership Forum

Member	Director of Provider Development
Items discussed	Update from meeting of 1st September 2022 • People stories • Current Living in Kirklees Survey • Kirklees Outcomes Framework- an update on the outcomes indicators was received. • Community Diagnostic Centres – the current position, next steps for the business case and impact for Kirklees place was discussed. • Kirklees Integrated Health and Care Systems Leadership – update on 2022 programme and future plans. • Board work plan
Date of next meeting	Next meeting scheduled for 6 October 2022.

Kirklees Health and Wellbeing Board

Invited Observer	Director of Provider Development
Items discussed	Items for discussion at upcoming meeting on 22nd September 2022 Items to be covered: • Health and Wellbeing Board Terms of Reference Update- it was noted the new terms of reference of the Health and Wellbeing Board as approved by Council on the 7th September 2022. • 2022-25 Pharmaceutical Needs Assessment update • Joint Health and Wellbeing Strategy • West Yorkshire Integrated Care Board Strategy- the approach to refresh the Partnership's five-year Strategy was outlined. • SEND update
Date of next meeting	Next meeting scheduled for 24th November 2022.
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

Kirklees Delivery Collaborative

Member	Director of Provider Development
Items discussed	Update from meeting on 5 September 2022 • Kirklees Recovery and 2023/24 Planning Process • Health Inequalities Funding- an overview of the WYHCP Core20Plus5 & "Plus" Inequalities Funding for Kirklees Place was given. The first meeting of the Kirklees Core20Plus5 Steering Group has been held and initial proposals across the 5 clinical outcome areas focused on the most deprived 20% shared with partners at the Steering Group and Delivery Collaborative. • Ageing Well • Social Care Reform • Community Diagnostic Centres
Date of next meeting	Next meeting scheduled for 3rd October 2022.

Kirklees Mental Health Alliance

Member	Director of Provider Development (Co-Chair), with Trust representative as a member.
Items discussed	Update from meeting on 5th September 2022 • Patient Story • Older People's Mental Health Inpatient Transformation • CLiK results • Programme highlight reports by exception • Strategic developments • Forward plan
Date of next meeting	Next meeting scheduled for 17 October 2022.

Recommendations:

Trust Board is asked to:

- **Receive and note the update on the development of Integrated Care Systems and collaborations:**
    - **West Yorkshire Health and Care Partnership;**
    - **Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees.**

- **Receive the minutes of relevant partnership boards/committees.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27th September 2022
Agenda item 11.3

Private/Public paper:	**Public**		
Title:	**Specialised NHS-Led Provider Collaboratives and Alliances - Update**		
Paper presented by:	Director of Strategy and Change/ Deputy Chief Executive and Director of Provider Development		
Paper prepared by:	Director of Strategy and Change/ Deputy Chief Executive and Director of Provider Development		
Purpose:	The purpose of this paper is to provide the Trust Board with: 1. An update on key developments within the West Yorkshire and South Yorkshire and Bassetlaw Specialised NHS-Led Provider Collaboratives and key priorities that are of relevance to the Trust. 2. An update on the Phase 2 Provider Collaboratives.		
Strategic objectives:	Improve Care	✓	
	Improve Health	✓	
	Improve Resources	✓	
	Make this a great place to work		
BAF Risk(s):			
Any background papers / previously considered by:	Strategic discussions and updates on Provider Collaboratives and developments have taken place regularly at Trust Board.		
Executive summary:	**West Yorkshire Specialised NHS-Led Provider Collaboratives** In West Yorkshire, the Trust is Lead Provider of the Adult Secure Provider Collaborative, and a partner in the Children and Young People Mental Health (CYPMH) inpatient services (Tier 4) and Adult Eating Disorder Provider Collaboratives, led by Leeds and York Partnership NHS Foundation Trust (LYPFT). All West Yorkshire Provider Collaboratives continue to operate in line with their financial plans, and to progress collaborative ambitions. All continue to experience staffing challenges, and this issue has been a focus, with connections made to ICS workstreams to support. The Adult Secure Provider Collaborative Board has continued to meet and progressed among a range of items: • Development and prioritisation of patient pathways in West Yorkshire.		

	• Repatriation plans for patients placed out of area (West Yorkshire) and outside of natural clinical flow. • Quality and performance oversight framework and processes of the Collaborative. • Spend against the Investment Fund to fund non-recurrent actions to progress strategic objectives utilising the financial surplus generated in 2021/22. • Development of a proposal for the Learning Disability and Autism Pathway Fund. • Continued collaborative working, with a 'Systems Thinking Event' planned for September 2022 to bring together clinical, operational and commissioning colleagues in person. • Involvement in national work to revise the secure service specifications, for implementation in April 2023. • Support for the improvement plan at Cygnet Bierley. **South Yorkshire and Bassetlaw Provider Collaboratives** In South Yorkshire and Bassetlaw, the Trust is Lead Provider of the Adult Secure Provider Collaborative. The Provider Collaborative Oversight Group for the collaborative is in place, ensuring oversight of the Trust's commissioning responsibilities which reports into the Trust's Collaborative Committee. The draft Lead Provider contract has now been shared with the Trust by NHS England/Improvement. This will be subject to full review and Board-level agreement prior to signature. **Phase 2 Provider Collaboratives** Discussions continue regarding phase 2 provider collaboratives, specifically Forensic CAMHS and Perinatal Mental Health Services across Yorkshire and Humber. There is support from colleagues across the region in the Trust taking on the 'coordinating provider' role for FCAMHS, and work has progressed to develop an implementation plan for the collaborative. **Risk Appetite** The development and delivery of Provider Collaboratives is in line with the Trust's risk appetite.
Recommendation:	**Trust Board is asked to RECEIVE and NOTE the Specialised NHS-Led Provider Collaboratives Update.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 September 2022

Agenda item 11.3

Specialised NHS-Led Provider Collaboratives and Alliances - Update

1. Introduction

The purpose of this paper is to provide an update to the Trust Board on the Specialised NHS-Led Provider Collaboratives, focusing on developments that are of importance or relevance to the Trust. The paper includes updates on the West Yorkshire and South Yorkshire & Bassetlaw Provider Collaboratives where the Trust is a Lead Provider or partner, and a brief update on the national Phase 2 Provider Collaboratives.

2. Phase 1 Provider Collaboratives

In **West Yorkshire**, Provider Collaboratives have been established for national Phase 1 services:

- Adult Low and Medium Secure Services - led by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT).
- Children and Young People Mental Health (CYPMH) inpatient services (Tier 4) - led by Leeds and York Partnership NHS Foundation Trust (LYPFT).
- Adult Eating Disorder Services - led by LYPFT.

In addition to being Lead Provider for Adult Secure, the Trust is a partner in both the Adult Eating Disorder and CYPMH Provider Collaboratives.

The Adult Eating Disorder Collaborative went live on 1st October 2020, and the CAMHS and Adult Secure Collaboratives 1st October 2021 (with transitional support from NHSE/I until 31st March 2022).

In **South Yorkshire and Bassetlaw**, Provider Collaboratives have also been established for all national Phase 1 Services:

- Children and Young People Mental Health (CYPMH) inpatient services (Tier 4) - led by Sheffield Children's Hospital.
- Adult Eating Disorder Services - led by Rotherham Doncaster and South Humber NHS Foundation Trust.
- Adult Secure Services - led by SWYPFT.

The Adult Eating Disorder and CYPMH Provider Collaboratives went live on 1st October 2022, and the Adult Secure Provider Collaborative on 1st May 2022.

Although the South Yorkshire Integrated Care System does not now include the Bassetlaw population, for the purpose of the Phase 1 services the Provider Collaboratives continue to include the Bassetlaw population. Hence Bassetlaw is still included in the title.

3. Phase 1 Provider Collaboratives - West Yorkshire

Recent developments for all West Yorkshire Provider Collaboratives include:

- Development of a Commissioning Hub Quality Assurance Framework/Standard Operating Procedure.
- Transfer of Serious Incident Management (StEIS) from NHSE/I to the West Yorkshire Commissioning Hub.
- Update of the clinical escalation process, and agreement by all partners.
- Review of Provider Collaborative Business cases, and Partnership Agreements.

All Provider Collaboratives continue to experience staffing challenges, and this issue has been a focus, with connections made to West Yorkshire integrated care system (ICS) recruitment and retention workstreams to support.

3.1 West Yorkshire Adult Secure Provider Collaborative

The Adult Secure Provider Collaborative Board has continued to meet and progressed among a range of items:

- Development and prioritisation of patient pathways in West Yorkshire.
- Repatriation plans for patients placed out of area (West Yorkshire) and outside of natural clinical flow.
- Quality and performance oversight framework and processes of the Collaborative.
- Spend against the Investment Fund to fund non-recurrent actions to progress strategic objectives utilising the financial surplus generated in 2021/22.
- Development of a proposal for the Learning Disability and Autism Pathway Fund.
- Continued collaborative working, with a 'Systems Thinking Event' planned for September 2022 to bring together clinical, operational and commissioning colleagues in person.
- Involvement in national work to revise the secure service specifications, for implementation in April 2023.
- Support for the improvement plan at Cygnet Bierley.

Commissioning intentions for 2022/23 for the Provider Collaborative were supported by the Adult Secure Provider Collaborative Board, and approved at the August meeting of the Collaborative Committee.

The Collaborative continues to perform in line with financial plan.

A Collaborative clinical lead post has been recruited and Steven Dilks commenced in post on 1st August 2022.

The second meeting of the Collaborative Committee of the Trust Board took place on 4th August 2022. The Terms of Reference have been agreed by Board.

3.2 West Yorkshire Adult Eating Disorders Provider Collaborative

There have been ongoing challenges regarding the physical health monitoring for Adult Eating Disorder patients under the care of the Provider Collaborative (CONNECT). Short and medium-term options to address this are being developed.

3.3 West Yorkshire Children and Young People's Mental Health (Inpatient) Provider Collaborative

Red Kite View is operating in line with its overall occupancy plan.

Demand for PICU beds, continues to be monitored and partners updated via the Provider Collaborative Board.

A Family Ambassador Post is being recruited to on a 12-month basis, which will be funded through NHSE non-recurrent allocation.

4. Phase 1 Provider Collaboratives - South Yorkshire

4.1 South Yorkshire Adult Secure Provider Collaborative

The Collaborative went 'live' on 1st May 2022, with the Trust as 'Lead Provider'.

Key areas of focus have included the following:

- Governance structures are in place, with co-ordinated attendance from SWYPFT as Lead Provider. The Commissioning Hub is fully established.
- The Provider Collaborative Oversight Group for the collaborative provides oversight of the Trust's commissioning responsibilities. This will report into the Trust's Collaborative Committee going forward.
- The Trust has engaged legal advice to prepare a 'Letter of intent' to our provider collaborative partners whilst a Partnership Agreement between all providers is progressed. Risk share discussions continue between providers.
- The draft Lead Provider contract has now been shared with the Trust by NHS England/Improvement. This has been reviewed by the Commissioning Hub and discussions with NHSE/I ongoing. Board-level agreement will be sought prior to signature.

Discussions have commenced between SWYPFT, as Lead Provider, and the Commissioning Hub regarding future commissioning intentions for the collaborative with specific focus on plans to expand community forensic provision. A full business case will be worked through with partners over the coming months.

5. Phase 2 Provider Collaboratives

The following services were intended to be part of Phase 2 of the Provider Collaboratives Programme:

- Adult Secure: Adult Low and Medium Secure Acquired Brain Injury and Deaf Services, Women's Enhanced Medium Secure Services, High Secure Services.
- CYPMHS: Children's (Under 13s), CYPMHS Medium Secure and CYPMHS Medium Secure LD Services, Deaf CYPMHS, Forensic CYPMHS.
- Specialist Services: Obsessive Compulsive Disorder and Body Dysmorphic Disorder Services, Tier 4 Personality Disorder Services, Non-secure (Acute) Deaf Services.
- Perinatal: Specialist inpatient services and associated teams (e.g. outreach).

NHSE undertook consultation for phase 2 Adult Secure and CYPMH services. Following consultation, Adult Low and Medium Secure Acquired Brain Injury and Deaf Services, Women's Enhanced Medium Secure Services will continue to be commissioned directly by NHS England and Improvement (NHSE/I) with a national ring-fenced budget. NHSE/I remains

accountable and is responsible for the commissioning of these services but delegates specific functions to placing or host Lead Providers.

Work is underway to consider how the services reviews for Medium Secure CYP and U13s can be aligned to developing a PC approach.

The National Specialised Commissioning Team have determined that Obsessive Compulsive Disorder and Body Dysmorphic Disorder Services, Tier 4 Personality Disorder Services, Non-secure (Acute) Deaf Services are not appropriate for a PC approach at this time.

In West Yorkshire, the Trusts who comprise the WY MHLDA collaborative have agreed a set of principles to determine which Trust is our preferred option to be the coordinating provider ('lead provider' in NHS England terminology) for particular services that might have commissioning responsibility delegated from NHS England or the WY Integrated Care Board, which has guided discussions.

5.1 Forensic CAMHS

The National Specialised Commissioning Team engaged CYPMH Lead Providers and regional colleagues to discuss recommendations for Forensic CAMHS (FCAMHS).

The national direction is that Forensic CAMHS services should be commissioned through CYPMH provider collaboratives. However, the Trust and our regional Specialised Commissioning Team have advocated nationally that the existing Yorkshire and Humber regional FCAMHS service works well as it is and that there is effectively a lead provider model already in place, with SWYPFT as coordinating provider.

An options analysis was considered at the May meeting of the West Yorkshire Specialised Mental Health Learning Disability and Autism Programme Board and support gained for SWYPFT to be 'co-ordinating provider' for FCAMHS across Yorkshire and Humber due to the fact SWYPFT currently provides the full pathway of care and across the appropriate geography.

This planned approach was outlined to wider partners across Yorkshire and Humber in a letter from Keir Shillaker and Sarah Sams on behalf of the WY Mental Health, Learning Disability and Autism (MHLDA) Collaborative in August 2022. Support for this approach has been confirmed, subject to a Board with equal membership of all key partners being established to oversee the quality assurance, service delivery, planning, finance, and positive impact of the Forensic CAMHS service across the region. It is envisaged this will build on the existing FCAMHS Board.

The Head of Mental Health North East and Yorkshire Region, NEY Specialised Commissioning Team (NHSE/I) has confirmed that the Community FCAMHS recommendation was approved at the National Provider Collaborative Oversight Group and National Specialised Mental Health and Learning Disability Programme of Care Board, and work will commence to implement FCAMHS Provider Collaboratives.

NHSE/I have confirmed that the expectation is that the approach for sign off prior to go live of FCAMHS Provider Collaboratives will be 'light touch', but there will be a process to go through with Regional Specialised Commissioning.

NHSE/I are in the process of developing a standard operating procedure (SOP) to support with operationalising the FCAMHS recommendations, coproduced with experts by profession and experience, and is anticipated this will not be available before October 2022.

A draft implementation plan, has been prepared by the Trust for further discussion with NHSE/I and partners. This plan is effectively a 'due diligence' process, and aims for a Trust Board approval of a 'go live' recommendation at the December 2022 Board meeting, subject to guidance being received by NHSE/I as planned.

5.2 Perinatal Mental Health

At national level, it has been approved that the NHS-Led Provider Collaborative model is implemented for Specialised Perinatal Mental Health services (Mother and Baby Units and Community) through joined up commissioning. The preferred approach being suggested is that NHS-Led Provider Collaboratives for Perinatal are delegated the full commissioning budget, both from regional Specialised commissioning teams and ICSs.

To support this the next step NHSE/I is working with Regional Mental Health Teams (both specialised commissioning and non-specialised commissioning colleagues) and have asked them to:

- Identify the perinatal provider collaborative footprint – we understand this will be Yorkshire and Humber. To note each of the Provider collaboratives needs to have a mother and baby unit in the patch.
- Establish appetite for aligned commissioning of the whole pathway.
- Identify implementation timescale (January 2023 or April 2023).
- Discuss appetite to be coordinating provider.

Within West Yorkshire, Leeds and York Partnerships NHS Foundation Trust (LYPFT) has been identified as coordinating provider for Perinatal Mental Health services (using the agreed set of principles), because LYPFT currently provides the full pathway of care and across the appropriate geography.

This planned approach was outlined to wider partners across Yorkshire and Humber in a letter from Keir Shillaker and Sarah Sams on behalf of the WY Mental Health, Learning Disability and Autism (MHLDA) Collaborative in August 2022. There are collective concerns across the region regarding process/expectation, availability of data and the importance of retaining local responsibility for community perinatal provision. Therefore, further conversations are planned with partners.

Recommendation:

Trust Board is asked to:

Receive and note the Specialised NHS-Led Provider Collaboratives Update.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 September 2022
Agenda item 12.1

Private/Public paper:	**Public**		
Title:	**Quality Account 2021/22 publication**		
Paper presented by:	Chief Nurse/Director of Quality and Professions		
Paper prepared by:	Interim Associate Director of Nursing, Quality and Professions		
Purpose:	The quality account is an annual report that focuses on how we perform against a set of quality priorities that we set for ourselves and a range of mandated items as identified by NHS Improvement and England and the Department of Health and Social Care. The aim is to identify how we provide safe and effective services, reflect areas that we need to improve upon and celebrate our successes.		
Strategic objectives:	Improve Care	✓	
	Improve Health	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Not aligned to any specific BAF risks.		
Any background papers / previously considered by:	Previous quality account update papers to Clinical Governance Clinical Safety Committee and Trust Board.		
Executive summary:	**Quality Account requirements 2021/22** Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts. The processes for producing Quality Accounts remain the same as previous years, with the following exceptions to NHS providers: • **NHS foundation trusts are no longer required to produce a Quality Report** as part of their Annual Report. This is confirmed in the FT Annual Reporting Manual for 2021-22. • NHS foundation trusts will continue to produce a separate Quality Account for 2021-22. • **There is no national requirement for NHS trusts or NHS foundation trusts to obtain external auditor assurance** on the quality account or quality report. For quality accounts approval from within the Trust's own governance procedures is sufficient. There is no requirement for interim audit of mandated items Q1-Q3. • **Integrated Care Boards (ICBs) will assume Clinical Commissioning Group (CCG) responsibilities** for the review and scrutiny of Quality Accounts (subject to the Health and Care Bill receiving Royal Assent). Where this function has not transferred from		

CCGs to ICBs, CCGs must continue to undertake it for the 2021-22 reporting cycle.

Publishing requirements for 2021/22

- We were required to publish the Quality Account for the 2021-22 financial year by 30 June 2022. This was achieved and the Account is accessible via this link.
- The NHS.uk website no longer allows NHS organisations to upload reports, therefore, the Quality Account will be uploaded onto the organisation's website, with clear visible access to the public. We forwarded the link to the webpage as required to quality-accounts@nhs.net.

Detailed requirements for report

We have reviewed detailed requirements guidance and in line with this guidance have included the following in the report:

Part 1: Statement on quality from the chief executive and the Trust

Part 2: Priorities for improvement and statements of assurance from the board

2.1 Priorities for improvement

- Quality Priorities - summary of performance 2021/22
- Our approach to quality improvement
- Our approach to quality governance
- Quality Priorities for 2022/23

2.2: Statements of assurance from the board

- Review of services
- Participation in clinical audit
- National clinical audit programme 2021/22
- National confidential inquiry 2021/22
- Local clinical audit
- Participation in clinical research
- Commissioning for Quality and Innovation Payment Framework
- Care Quality Commission
- NHS number and general medical practitioner code validity
- Data security and protection toolkit (formally Information governance toolkit attainment)
- Clinical coding accuracy
- Quality of data
- Learning from healthcare Deaths

	2.3: Reporting against core indicators • Patients on Care programme Approach who were followed up in 7 days • Percentage of admissions to acute wards for which crisis resolution home treatment teams acted as gatekeeper • Readmission rates • Patient experience of community mental health services • The number and percentage of such patient incidents that resulted in severe harm or death • Guardian of Safe Working Hours • Performance against indicators set out in the Single Oversight Framework (NHSI 2021/22) **Part 3: Our performance against quality initiatives 2021/22** • Our performance in 2021/2022 Quality Priorities • Quality Improvement and innovation in South West Yorkshire Partnership NHS Foundation Trust 2021/22 Annex 1: Glossary Annex 2: Statements from our stakeholders **Progress against timetable for production of Quality Account** • The 2021/22 Quality Account is now published • We have maintained the internal governance process for report sign off, i.e. sharing with the members council sub-group, review within CGCSC, EMT & Trust Board • The report was approved at EMT on 21 April 2022 and presented to Clinical Governance Clinical Safety Committee on 17th May 2022. The Committee received and approved the Account and were assured it met the detailed legal requirements • The report was reviewed and approved prior to publication at Private Trust Board on 28 June 2022 • We have included feedback from our stakeholder partners in the report **Risk appetite** The Trust continues to have a good governance system for monitoring and reporting against the actions that are required to support the quality account process.
Recommendation:	**Trust Board is asked to RECEIVE and NOTE the Quality Account 2021/22.**

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Quality Report

2021/2022

Contents	
Part 1: Statement on quality from the chief executive and the Trust	
Chief Executive and Chair's welcome	i
Statement of assurance	ii
Part 2: Priorities for improvement and statements of assurance from the board	
2.1 Priorities for improvement	5
Quality Priorities- summary of performance 2021/22	5
Our approach to quality improvement	13
Our approach to quality governance	16
Quality Priorities for 2022/23	16
2.2: Statements of assurance from the board	19
Review of services	19
Participation in clinical audit	19
National clinical audit programme 2021/22	19
National confidential inquiry 2021/22	19
Local clinical audit	22
Participation in clinical research	22
Commissioning for Quality and Innovation Payment Framework	22
Care Quality Commission	23
NHS number and general medical practitioner code validity	22
Data security and protection toolkit (formally Information governance toolkit attainment)	24
Clinical coding accuracy	24
Quality of data	24
Learning from healthcare Deaths	25
2.3: Reporting against core indicators	29
Patients on Care programme Approach who were followed up in 7 days	29
Percentage of admissions to acute wards for which crisis resolution home treatment teams acted as gatekeeper	29
Readmission rates	31
Patient experience of community mental health services	32
The number and percentage of such patient incidents that resulted in severe harm or death	34
Guardian of Safe Working Hours	35
Performance against indicators set out in the Single Oversight Framework (NHSI 2021/22)	36
Part 3: Our performance against quality initiatives 2021/22	37
Our performance in 2021/2022 Quality Priorities	37
Quality Priority: SAFE	38
Quality Priority: EFFECTIVE	45
Quality Priority: CARING	47
Quality Priority: RESPONSIVE	59
Quality Priority: WELL LED	67
Quality Improvement and innovation in South West Yorkshire Partnership Foundation Trust 2021/22	71
SAFE	71
EFFECTIVE	74
POSITIVE EXPERIENCE	76
SUSTAINABLY RESOURCED	76
WELL-LED	78
Annex 1: Glossary	79
Annex 2: Statements from our stakeholders	81

Part 1:
Chief Executive and Chair's Welcome

Welcome to our 2021/22 quality account. We are delighted to introduce this reflection of our services outlining our performance and priorities for improvement. In what has been another challenging year for the NHS as a whole, we have seen many examples of innovation changing care for the better and opportunities to learn in order to become outstanding

Our Trust has four clear priority areas which motivate and drive everything we do – to improve care, improve health, improve our use of resources and to make the Trust a great place to work. All of these carry a thread of quality and a desire to constantly better our services for the people who use them and the staff who provide them.

Much has changed for our Trust over the last year. As we have continued to learn throughout the COVID-19 pandemic this has brought about different ways of working, innovation in delivering services, and transitions to situations that were once unusual becoming standard practice for us. What hasn't changed is our clear and unwavering focus on maintaining the quality of everything we do.

Throughout the year we have seen many notable successes locally, regionally and nationally. The Trust won a national award in the Healthcare People Management Association (HPMA) Awards in the Social Partnership Forum category, which celebrates partnership working between employers and trade unions. Our Barnsley tissue viability service was a winner at an international award ceremony celebrating the world's leading tissue viability and wound care professionals, while our Live Well Wakefield team won an award in the Social Prescribing Awards 2021. Yorkshire Smokefree achieved the top 5 best quit rates in the region for people who have quit within 4 weeks, with Barnsley, Wakefield, Doncaster, Calderdale and Sheffield being the top achieving services across Yorkshire and the Humber.

We launched our adult 'Choose well for mental health' guide, the first of its kind in the country, helping people to get the right support for their mental health and wellbeing at the right time. Our creative teams also continued to provide support through art, culture and physical health initiatives.

We achieved these things while facing increased acuity and demand. The pressures of the COVID-19 pandemic remain with us and it is thanks to our staff that we have been able to maintain, and in many cases improve, the quality of our services.

Quality is what matters most to people who use our services. Our service users, their families, friends and carers rightly want to be assured that the service they receive will be safe, effective, caring, well-led and responsive. We describe this as a "quality counts, safety first" approach, and it is something that is evident in many of our services.

Much of this work is recognised and commended by external bodies. The Trust's serious incident review process was accredited by the Royal College of Psychiatrists. Kirklees memory service received a Sustainable Mental Health Service Commendation from the Royal College of Psychiatrists for their commitment to enabling patients to manage their conditions and reducing waste. Health Education England wrote to the Trust to congratulate us on the success of our medical and non-medical student placements.

We deeply value feedback from the people who use our services. Suggestions for improvement from people who have first-hand experience of the care we provide is invaluable to us progressing as an organisation. One way we do this is through the Friends and Family Test – a tool to help NHS services understand whether patients are happy with the service provided. All services are required to collect Friends and Family Test feedback, as it helps us identify what is working well and what can be improved.

All feedback is shared with team managers automatically each month by email. Managers then share feedback with their team, celebrate their success and take actions where necessary. It is hugely important for service users, carers and their families to see that we are acting upon feedback and know what we have done to improve their experience.

In our annual NHS staff survey, which was sent out between October – December 2020, many of our staff spoke highly of the Trust. 69% would recommend the Trust as a place to work - an increase from 61.5% last year and higher than the national average of 67.7%. 71.8% would recommend the Trust to family and friends as a place to receive care and treatment. This is up from 65.6% last year and above the national average of 70.4%.

Our quarterly Great Place to Work survey yielded similar results. 68% would recommend the Trust as a place to work, 83% feel that care of service users and patients is the Trust's top priority, and 61% felt that can make service improvements happen in their team. Our #allofusimprove initiative, which encourages people to take action if they see something that can be changed for the better, will continue to support this. We will also continue working with our teams to develop action plans which address the local findings of the NHS staff survey, linked to our workforce plan and the feedback from our staff insight sessions.

The roll out of Electronic Prescribing and Administration of Medications (EPMA) also continued throughout the year. EPMA is a key development for the Trust; designed to improve patient safety, efficiency in service delivery, improve quality of data and deliver financial benefits for the organisation by replacing the current paper medication chart with an electronic medication chart within our patient records system.

We know that how we do our work is as important as what we do. In response to valued feedback from our members' council, we introduced new discharge letter templates to our patient records system. The new letters better reflect our Trust values and our compassionate approach. One of the letter templates is also in Easy Read, promoting accessibility and inclusivity.

It's our ability to recognise when and where we can make improvements to our services and acknowledge that there are always opportunities to do better that makes us a successful organisation. We are continuously learning from each other, our partner organisation colleagues, the people we care for and their families, friends and loved ones to better understand where our strengths and weaknesses lie. By consistently self-evaluating, we are able to maintain quality throughout all the services we provide and offer outstanding care to support the lives of people in our communities

Statement of assurance

This Quality Account has been prepared in line with the requirements of the NHS Act 2009, regulations of the Health and Social Care Bill 2012 and NHS Improvement, the independent regulator of foundation trusts. The Board of Directors has reviewed the Quality Account and to the best of our knowledge, we confirm that the information contained in this report is an accurate account of our performance and represents a balanced view of the quality of services provided by the Trust.

Chief Executive: Mark Brookes

Chair: Marie Burnham

Part 2:
Priorities for improvement and statements of assurance by the board

Part 2.1 – Priorities for improvement

In part two of our Quality Report, we outline our planned improvement priorities for 2022/23. We give an overview of our approach to quality improvement and our approach to quality governance.

Quality Priorities 2021/22

In 2020/21, due to the impact of the pandemic on capacity and planned work programmes, the Trust agreed to roll forward its thirteen Quality Priorities into 2021/22. In December 2021, following an option appraisal, the Executive Management Team revisited and re-prioritised the Priorities, taking into account the ongoing impact of the Pandemic and with the intention of identifying a smaller number that would be given greater prominence in 2022/23.

A summary of our position against last year's quality priorities can be found below. Further detail on our progress can be found in Part 3.

SAFE: delivered in a way that minimises things going wrong and maximises things going right; continuously reduces risk, empowers and enables people to make safe choices and protects people from harm, neglect, abuse and breaches of their human rights; and ensures improvements are made when problems occur.

Quality improvement	What we planned to do	What outcomes we identified	What we did	What next?
Staffing initiatives Staffing establishments in mental health community teams to be reviewed and improved.	Focus on maintaining safe staffing on inpatient units Roll out safer staffing initiatives into community services Embed initiatives to improve staffing Develop new career pathways and	Inpatient staffing levels Roll-out of safer staffing and e-Rostering initiatives against plan Implementation of staffing initiatives and new career pathways and professional roles	Introduced 7/7 senior leadership presence to oversee and address staffing pressures on our mental health in patient wards. Ongoing recruitment initiatives and recruitment of registered international nurses. Established a New Roles Group to explore how teams might be staffed differently whilst maintaining quality and safety standards. Introduced financial enhancements at times	Roll-out of e-Rostering to Mental Health Community by December 2022. Embed the MHOST within our inpatient wide establishment review plan (April 2022). Continue with the roll out of SafeCare with the Forensic and Barnsley BDU next (Aug 2022). Community safer staffing group to: - Offer support where staffing shortages have been identified

	professional roles Trust-wide with focused work on inpatient services and Mental Health teams		of increased challenge or acuity. Established Community Mental Health Safer Staffing Group Continuing roll-out of Allocate's eRostering and SafeCare solutions and the Mental Health Optimal Staffing Tool (MHOST) into service development and operational management.	- Recruit bank specialists to support the services. - Support the AHP locum requirement. Use the Mental Health Optimal Staffing Tool (MHOST) throughout all 31 inpatient areas starting in July 2022 with a full report due by September 2022.
Patient safety strategy Reduced frequency and severity of harm resulting from patient safety incidents Reduced costs, both personal and financial associated with patient safety incidents	Implement safe wards and reduce restrictive interventions in Mental health and learning disability inpatient services Reduce the total number of prone restraints across our services Expand programme of safety huddles over the next 12 months	Reduction in restrictive interventions and prone restraints Safety huddles targeting key risks are established in all services	Adapted to COVID-19 pandemic to monitor and manage risks to patient safety. Continuing implementation of Patient Safety Strategy Implementation plan Achieved accreditation from Royal College of Psychiatrists for our Serious Incident investigation processes Received significant assurance from an internal audit on incidents/serious incident processes Continuing involvement with the national Patient Safety Collaborative on reducing restrictive practice Adapted safety huddle methodology for use in COVID-19 pandemic environment	Improving learning from incidents has been identified as a Quality Priority for 202/23. Additional Patient Safety work includes: Further develop the Patient Safety Specialist role and the supporting framework. Continue to adapt and progress Patient safety implementation plan, with a focus on quality improvement. Work closely with NHS England on a range of national patient safety developments. Promote patient safety training for all staff including Board and senior managers.

Suicide prevention	Implement actions from Suicide Prevention Strategy Trust-wide	Progress against planned objectives monitored by the suicide prevention group	Embedded and evaluated use of Formulation Informed Risk Management. Strengthened staff knowledge and awareness for increased risk and specific interventions risk in services where risks are known to be higher for certain groups. Involved service users, families and carers in developing care plans and connecting people to wider community resources linked to the wider risk factors. Addressed risks in the physical environment via oversight by the Clinical Environment Safety Group Further development on the Suicide Prevention Champions network. Advancing learning from incidents involving suicide or attempted suicide	Completion of the 2022-2025 Trust Suicide Prevention Strategy including implementation plan. Testing alternative seclusion exit strategies to support a reduction in prone restraint. Working with pharmacy to explore alternative intramuscular injection sites.
Improve safety in medication practice	Improve performance of missed doses of medication Trust inpatient acute and older adult services	Quality improvement programme milestones	Implemented the safety cross in 11 wards reducing the proportion of missed doses in the majority	Teams continue make adaptations to embed the medication safety cross processes. Work has commenced on a quality improvement project to ensure opening dates are recorded for short shelf-life medication.

EFFECTIVE: informed by consistent and up to date high quality training, guidelines and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing wider determinants of health; delivered in a way that enables continuous improvements based on research, evidence, benchmarking and clinical audit.

Quality improvement	What we planned to do	What outcomes we identified	What we did	What next?
Outcome measures	Identification of outcome measures for use at both local and Trust wide level Development of systems and processes to support implementation Trust-wide services	Improvements in reporting against CQUIN indicators for routine mental health outcome measurement.	Selection of Health of the Nation Outcome Scales (HoNOS) as a clinician reported outcome measure. Development of a digital solution to collect Patient Reported Outcome Measures and commissioning of a provider to provide a solution to support use within our inter-operability portal.	Solution to be implemented by June 2022 and roll out in early implementor teams in Phase 1. Embedding clinical outcome measures into clinical practice in mental health services. PROMs data collection and reporting system development work will continue with a potential to roll out to community services Monitoring PROM data against the 2022/23 CQUIN target of 40% of services users with paired outcomes
Clinical record keeping	Improve quality of clinical record keeping, i.e. service user voice, care plans and risk assessments. Review standards for care plans and risk assessments. Monitor adherence to standards through audit and quality monitoring.	95% compliance with clinical record keeping standards relating to service user voice, assessments, care planning and risk assessments. Monitored by clinical governance group.	Introduced ward manager and matron checklists for record keeping. Introduced new care plan and risk assessment tools on SystmOne. Launched revised care planning and risk assessment training. Launched revised Clinical Risk Assessment, Management and Training Policy. Introduced lead roles across the Trust for risk assessment and care planning.	This is a Quality Priority for 2022/23.

	Improving co-production capturing demographic data. All staff in clinical areas.		Revised and piloted clinical record keeping audit. Creation and launch of a 'good practice in care planning guide' for staff	

CARING: Caring is part of delivering a positive experience:

- Responsive and personalised – shaped by what matters to people, their preferences and strengths; empowers people to make informed decisions and design their own care; coordinated; inclusive and equitable.
- Caring – delivered with compassion, dignity and mutual respect.

Quality improvement	What planned to do	What outcomes we identified	What we did	What next?
Staff experience & well being	Monitor and implement actions of staff health and well-being plan Improving staff satisfaction and wellbeing Trust-wide services	Staff Feedback Improved scores in key areas on national staff survey and local well-being survey Internal wellbeing survey 80% of staff recommend the Trust as a place for care and treatment	Adapted the plan to COVID-19 pandemic including enhancing the wellbeing offer to staff and undertaking a risk assessment for BAME staff. Implemented a range of improvements set out in the plan	Mapping and the improving the communication of our health and wellbeing offer review in employment policies to ensure they supports workplace wellbeing. Continued focus on psychological and physical health, and the prevention of illness. Further roll out of Schwartz rounds. Recruitment of a staff dietitian. Continued work on creativity/arts and physical activity for staff.

				Further embed the Wellbeing champion role.
Patient experience	Implementation of new FFT model. Implementation of patient experience toolkit. Use feedback from student placements to enhance patient experience. Trust-wide inpatient services	Percentage of people who are extremely likely/ likely to recommend the service to their friends and family. Actions taken in response to service user experience feedback	Continued to support services in improving uptake of the FFT and using FFT data Started a pilot of a new text message to improve the quality of response in CAMHS Expanded use of text messaging in Community services	Development of Patient Experience representatives across the Trust to support the Patient Experience agenda. Expanding the text messaging service across Community Health Continue to work with teams to develop a practical way to collate actions being taken across the Trust to demonstrate the changes that are being made because of feedback. Work with other support services to triangulate insight to inform quality improvement. Ensuring that feedback methods are accessible to service users, carers, and families.
Equality, Involvement, Communication and Membership Strategy	Implement actions from the Equality, Engagement, Communication and Membership Strategy	Trust-wide services	Implementation of Equality elements of the strategy will be monitored through the Equality& Inclusion committee	Key milestone of the strategy implementation plan will be achieved within timescale

RESPONSIVE: Responding to people's needs in a timely way is part of delivering care that is both Effective and Caring.

Quality improvement	What we planned	What outcomes we identified	What we did	What next?
Improve waiting times	Reduce waiting times in services for people with Learning Disabilities	Numbers waiting for assessment and treatment Time spent waiting	Teams and services have adapted to the impact of COVID-19 pandemic on service users and their families and on staff, and changes in the profile of need. A range of initiatives have been delivered to ensure services are safe and to adapt to changes. Governance processes in this area have been strengthened.	Continuing partnership working and local place-based service development. Continuing focus on developing a sustainable workforce. Continuing focus on transition from Children's services to adults for young people. Embedding risk assessment Revising the CPA process Developing and establishing new roles.
	Reduce waiting times in CAMHS services	Numbers waiting for assessment and treatment Time spent waiting	Services and pathways have adapted to COVID-19 pandemic and changes in need and demand. Appointments have continued face-to-face and by telephone and video-link. A CAMHS Bronze-level control group has continued to meet weekly, as part of the emergency command structures. Ongoing review of business continuity plans and agreement of a re-set position.	Optimising recurrent investment (within developing Integrated Care Systems (ICS) Development of business cases for neurodevelopmental pathways and to address the needs of children in Crisis and those with eating disorders.

Reducing placement in Out of Area (OOA) Beds	Improvements in patient flow, management of demand and capacity and ongoing development of home-based treatment and integrated Community Services.	OOA Bed Days Acute and PICU Bed Days	Adapted impacts of COVID-19 pandemic on demand, capacity and the wider system e.g. availability of additional bed capacity Reset goal to achieve zero OOA bed days by September 2022	Active action to move people in a timely way Coordination and input into care of people currently in OOA beds Ensuring effective role of home-based treatment and community services in timely flow Agreeing continuity of care principles Inpatient programme priorities to support effective ward management.
Complaint closure and resolution times	Continuously improve complaint response times in line with national guidelines and our internal standards.	Response times by category of response. Formal complaints closed within 40 days (internal standard). Concerns are acknowledged within 48 hours.	Internal standards for categories of complaint have been affected by capacity of staff to respond.	Improvement awareness of and skills in using the complaint process. Investigate experience of the complaint process with service users and partners to inform further improvement. Improve learning from complaint investigations.

Our approach to quality improvement

The Trust is committed to the triple aim[1] of improving population health whilst simultaneously delivering excellence in care and reducing cost.

Our Trust-wide improvement approach is described in our Quality Strategy. In 2022 we will be refreshing our Quality Strategy, taking into account the views of people who use our services, carers, colleagues, and other stakeholders and thinking particularly about how we need to adapt to the impact of the pandemic over the last two years.

What does Quality mean for us?

Quality is about how well our services and activities support people to achieve the best possible outcomes and have the best possible experience. Our approach to quality is informed by the National Quality Board's shared single view of Quality:

This means that we aspire to the following in our services and the support we deliver:

Safe: delivered in a way that minimises things going wrong and maximises things going right; continuously reduces risk, empowers and enables people to make safe choices and protects people from harm, neglect, abuse and breaches of their human rights; and ensures improvements are made when problems occur.

Effective: informed by consistent and up to date high quality training, guidelines and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing wider determinants of health; delivered in a way that enables continuous improvements based on research, evidence, benchmarking and clinical audit.

Positive experience:

- Responsive and personalised – shaped by what matters to people, their preferences and strengths; empowers people to make informed decisions and design their own care; coordinated; inclusive and equitable.

[1] The IHI Triple Aim | IHI - Institute for Healthcare Improvement [Accessed online 22/03/22]

- Caring – delivered with compassion, dignity and mutual respect.

Well-led: driven by collective and compassionate leadership, which champions a shared vision, values and learning; delivered by accountable organisations and systems with proportionate governance; driven by continual promotion of a just and inclusive culture, allowing organisations to learn rather than blame.

Sustainably resourced: focused on delivering optimum outcomes within financial envelopes, reduces impact on public health and the environment.

Quality care is also equitable: everybody should have access to high-quality care and outcomes, and those working in systems must be committed to understanding and reducing variation and inequalities.

Our teams are working hard to maintain and improve quality in all our services. We now need to understand and address new and additional needs, waits and delays, inequality in care delivery and outcomes and successfully embed innovation that has emerged during the pandemic. We must also understand the impact of the pressures of the last two years on our staff and ensure we help them to adjust and recover.

We aim to coproduce the changes we need to make with service users, carers, communities and wider stakeholders. We have a great deal of experience of innovating in this area. We will support teams to do this work using our approach to Quality Improvement.

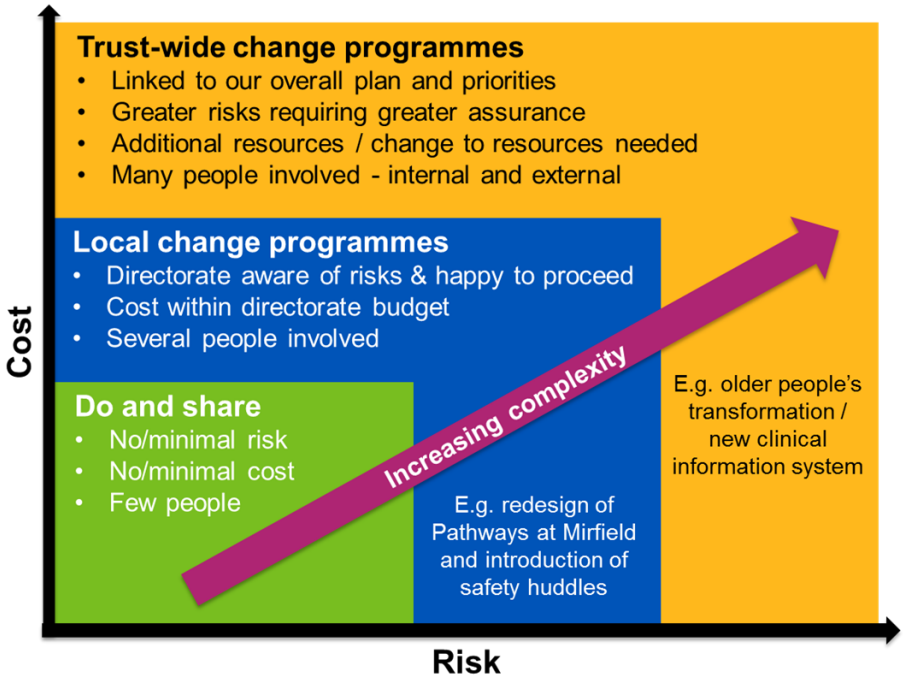
Our approach to Quality Improvement

Our Trust-wide approach to quality improvement is described in our Quality Strategy, which starts with our mission and values, including our ambition to 'improve and be outstanding'. Our priority programme, #allofusimprove, is underpinned by the NHS Change Model, ensuring that quality improvement happens as near to people who use our services as possible. Our approach is based on an accessible improvement framework (the Model for Improvement, Associates in Process Improvement[2]) with a strong focus on engagement and involvement and a culture of compassion and learning.

Our strategic priorities set out the main programmes of work designed to help us make progress towards our vision - to provide outstanding physical, mental and social care in a modern health and care system - and mission - to help people reach their potential and live well in their community. As part of setting our organisational priorities, we take stock of how we are doing on the quality of care across our services and identify a selection of priorities for the year ahead.

Improvement work is governed by our integrated change framework which ensures increased levels of oversight linked to the complexity of the improvement work we are doing. It helps to ensure that change is managed proportionately and supports our staff and teams to lead continuous improvement.

[2] API - Associates in Process Improvement - Home (apiweb.org, accessed 21/03/22)



Our chosen improvement methodology is the Model for Improvement, shown below.

We support staff and teams to improve by providing:

- Access to improvement training which helps individuals work towards becoming Improvement Facilitators
- Coaching and support from Improvement Experts
- Standard methods and tools for improvement work
- Access to an Improvement Network and a hub (the i-hub) which allows people to connect, share and collaborate.

Our approach to quality governance

Our Executive lead for quality improvement and quality governance is the Director of Nursing, Quality and Professions.

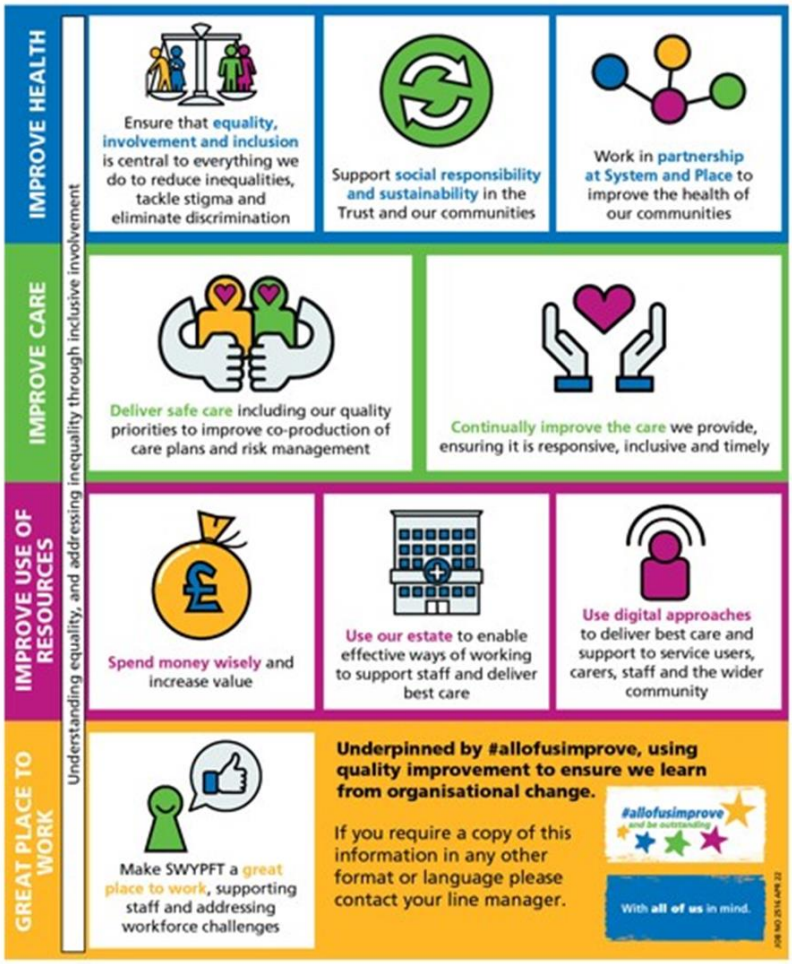
Central to our approach to governance of quality and improvement is the Clinical Governance and Clinical Safety Committee (CGCSC) which is a sub-committee of the Trust Board. Reporting in to the CGCSC is the Trust's Clinical Governance Group which is responsible for assuring quality based on horizon and risk scanning; interpretation and reporting of national/local quality and safety directives; critical consideration of organisational quality and safety improvements; information sharing; planning and monitoring implementation. A Members' Council Quality Group also supports and oversees the Trust in its approach to quality governance.

Governance and quality assurance play a key role in managing quality. At Trust, divisional and service-level, our trio model of clinical, operational and governance roles provides leadership for quality.
We routinely track quality indicators in our integrated performance report (IPR), which can be viewed by team, service, Trust-wide and externally on the Trust's website. Quality indicators include the NHS Friends and Family Test (FFT), infection prevention and control performance, serious incidents, safer staffing, pressure ulcers, CQUIN performance (not in scope for 2021/22 due to COVID-19 pandemic), restrictive interventions and complaints. Each of these has specific 'stretch' targets that reflects our ambitions to continuously improve. The report is considered at the Executive Management Team (EMT), Trust Board and its committees.

We learn through a clinical audit programme and participate in research and development with links to universities and the Academic Health Sciences Network (AHSN). We also contribute to and learn from external benchmarking and reporting initiatives, including the National Confidential Inquiry into Suicide and Homicide (NCISH), mental health benchmarking and workforce capacity and demand.
To maintain an operational focus on quality, an enhanced clinical risk performance report is presented to the Operational Management Group (OMG) and a rolling programme of Quality Monitoring Visits to our operational areas provides significant learning and quality assurance.

Quality Priorities 2022/23

Annually, we undertake a process to set the strategic priorities for the Trust. The process includes review of, and consultation on, a detailed analysis of our current position, both internally and externally using a SWOT and PESTLE framework, a review of recent progress including feedback from regulators and stakeholders, staff and service user experience, a review of serious incident intelligence and a consideration of key strategic documents including a recent review of quality improvement at the Trust and the Business Organisation and Risk Register. A refreshed set of priorities is shown below.



Following this analysis for 2022/23, there has been a developing consensus on key quality issues:

- Keeping services and service users safe given the pressures on the workforce and the increased acuity and demand
- Supporting staff health and well being
- Tackling health inequalities, including within the management of waiting lists

In December 2021, a focused review and option appraisal of the Trust's current Quality Priorities was undertaken. This was based on an assessment of progress on improvements on the 2021/22 Quality Priorities, the Trust's strategic priorities, risk, performance and CQC key lines of enquiry (KLOEs). As a result, a prioritised group of Quality Priorities was identified. They align safety, staffing/staff wellbeing and inequality with the Trust strategic priority areas and the CQC key lines of enquiry (KLOEs) (below):

Quality Priority 2022/23	Suggested Quality programmes	Trust Strategic Priority Areas	CQC KLOE
1. Safe and responsive care	Deliver quality improvements to support clinical safety and reduce risk: • Clinical risk assessment & risk management • Co-produced care planning • Clinical record keeping • Learning from incidents	Improve care	SAFE CARING EFFECTIVE RESPONSIVE

	• Reducing waiting times and supporting people while they wait • Safe and effective alternatives to face to face care • Improving the Inpatient environment and care		
2. Equality, inclusion & equity	Ensure that equality, inclusion and equity is central to everything we do through providing person-centred care which promotes inclusive, culturally and gender sensitive services	Improve health	RESPONSIVE EFFECTIVE CARING
3. Health, wellbeing, and experience of staff	Deliver wellbeing offer and implement initiatives to support the wellbeing of staff Understand, recruit, and retain staff, develop new roles. Identify innovative and supportive ways to retain effective levels of staffing in services	Make this a great place to work	WELL LED SAFE CARING

The Quality Priorities are seen as those which will have the greatest and most direct impact on improving the quality of care for service users and describe areas of focus for our clinical, front-line services. Quality improvement programmes within each priority will be defined at a business delivery level to ensure that meaningful and Place-based programmes are developed, led by front line colleagues. We will explore these areas with teams across the organisation to help staff identify specific areas of good practice to share and areas for improvement to address using Quality Improvement approaches.

Measures relating to improvement on the Quality Priorities 2022/23 (above) will be reported and monitored in the following ways throughout the year:

- Driven by and overseen within Business Development Unit Governance Groups
- Reporting into Clinical Governance Group (CGG) for central oversight
- Reporting into the Clinical Governance and Clinical Safety Committee

Part 2.2 – Statements of assurance from the board

This section is a series of statements from the Board for which the format and information required is set out in regulations and therefore it is set out verbatim.

1	During 2021/22 South West Yorkshire Partnership NHS Foundation Trust provided and/or subcontracted 83 relevant health services.

1.1	South West Yorkshire Partnership NHS Foundation has reviewed all the data available to us on the quality of care in 83 of these services.

1.2	The income generated by the relevant health services reviewed in 2021/22 represents 100 per cent of the total income generated from the provision of relevant health services by the South West Yorkshire Partnership NHS Foundation Trust for 2021/22.

Participation in clinical audits and national confidential enquiries

2	During 2021/22 thirteen (13) national clinical audits and one (1) national confidential enquiry covered relevant services that South West Yorkshire Partnership NHS Trust provides.

2.1	During that period South West Yorkshire Partnership NHS Foundation Trust participated in 13/13 (100%) national clinical audits and 1/1 (100%) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in

2.2	The national clinical audits and national confidential enquiries that South West Yorkshire Partnership NHS Foundation Trust was eligible to participate in during 2021/22 are as follows: 1. National Audit for Cardiac Rehabilitation (NAT05) 2. National Asthma and COPD Audit Programme (NACAP) (NAT06) 3. National Audit of Care at the End of Life – Round 3 (NAT02) 4. Sentinel Stroke National Audit Programme (SSNAP) (NAT08) 5. POMH Topic 14c Alcohol Detoxification (NAT03) 6. National Audit of Psychosis spotlight audit (NAT09) 7. POMH Topic 19b Prescribing for depression in adult mental health services (NAT04) 8. POMH Topic 1h and 3e Prescribing high-dose and combined antipsychotics on adult psychiatric wards (NAT07) 9. LeDeR - Learning Disabilities Mortality Review (NAT10) 10. National Audit of Dementia (NAD) - spotlight audit in memory services (NAT12) 11. National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) (NAT 13) 12. National Clinical Audit of Psychosis (EIP Audit) (Year five) (NAT16) 13. Learning Disabilities Improvement Standards (NAT17)
2.3	The national clinical audits and national confidential enquiries that South West Yorkshire Partnership NHS Foundation Trust was eligible to participate in during 2021/22 are as follows:

National Confidential Inquiry into Suicide and Homicide by people with mental illness

The national confidential inquiries that South West Yorkshire Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2021/22, are listed below alongside the number of cases submitted to each inquiry as a percentage of the number of registered cases required by the terms of that inquiry.

Title	Number of cases submitted	Number of cases completed	Commentary
National Confidential Inquiry into Suicide and Homicide by people with mental illness	6	4 (80%)	2 questionnaires continue to be processed

2.4 The national clinical audits and national confidential enquiries that South West Yorkshire Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2021/22, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The percentage of registered cases required by the terms of the audit is not specified. This is because the Prescribing Observatory for Mental Health (POMH) audits does not specify a minimum number in their sampling framework criteria.

National Clinical Audits 2021/22		Cases submitted *(If applicable)*
1	National Audit for Cardiac Rehabilitation (NAT05)	Continuous clinical audit. Data collection commenced March 2020. (In total 939 cases submitted/partially submitted based on eligible criteria).
2	National Asthma and COPD Audit Programme (NACAP) (NAT06)	Continuous clinical audit, data collection commenced March 2020. 38 cases submitted 2021/22.
3	National Audit of Care at the End of Life – Round 3 (NAT02)	NACEL round three – participated in Trust/HB Overview Hospital site collection
4	Sentinel Stroke National Audit Programme (SSNAP) (NAT08)	Continuous clinical audit National Annual Report 20/21 now publicly available

5	Prescribing Observatory for Mental Health (POMH) Topic 14c Alcohol Detoxification (NAT03)	33 cases submitted to POMH based on eligible patients. Report published November 2021
6	National Audit of Psychosis spotlight audit (NAT09)	National and local reporting published December 2021. 98 cases submitted based on eligible criteria Contextual data submitted for each team
7	POMH Topic 19b Prescribing for depression in adult mental health services (NAT04)	83 cases submitted to POMH based on eligible patients National and local reporting due to be published April 2022
8	POMH Topic 1h and 3e Prescribing high-dose and combined antipsychotics on adult psychiatric wards (NAT07)	Audit due to commence February 2022
9	LeDeR - Learning Disabilities Mortality Review (NAT10)	Continuous data collection model
10	National Audit of Dementia (NAD) - spotlight audit in memory services (NAT12)	162 cases submitted based on the eligible criteria Contextual data submitted for each team National and local reporting due to be published in August 2022
11	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) (NAT 13)	Continuous data collection model
12	National Clinical Audit of Psychosis (EIP Audit) (Year five) (NAT16)	342 cases submitted based on eligible criteria Report due to be published summer 2022
13	Learning Disabilities Improvement Standards (NAT17)	Data collection deadline 18th February 2022 Report due to be published summer 2022

2.5/ 2.6

National Clinical Audit

The reports of seven (7) national clinical audits were reviewed by the provider in 2021/22 and South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve the quality of health care provided.

- Each clinical audit has a project lead that is responsible for presenting the audit results to their business delivery unit (BDU). Areas of concern or high risk are escalated to the deputy district director for immediate action.
- The members of the governance group or another lead will action the plan against the audit recommendations.

	• Implementation of the action plan is monitored by the BDU as part of their governance systems

2.7/ 2.8	**Local Clinical Audit** The reports of 10 local clinical audits were reviewed by the provider in 2021/22 and South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. • Each clinical audit has a project lead that is responsible for presenting the audit results to their business delivery unit. Areas of concern or high risk are escalated to the deputy district director for immediate action. • The members of the governance group or another lead will action the plan against the audit recommendations. • Implementation of the action plan is monitored by the BDU as part of their governance systems

3.0	**Participation in clinical research** The number of patients receiving relevant health services provided or sub-contracted by South West Yorkshire Partnership NHS Foundation Trust in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee is 185. This figure is reflective of the ongoing challenges presented by COVID-19 pandemic during this period and the national pause of many studies. The focus of the Research and Development Department (and the Trust) during this exceptional period has been to support the regional activity in delivering Urgent Public Health Studies and Vaccine studies (where recruitment is attributed to the region rather than a single partner organisation). The Trust has actively contributed towards the set up and management of the PROVENT study (Monoclonal Antibody study), where Wakefield was the first site to recruit to this international study. The trust has also supported the NOVAX study (Leeds) and Falcon Study (which established the use of the lateral flow tests). Alongside these high-profile studies, the trust has also contributed to the Clinical Characterisation Protocol of severe emerging diseases (CCP) study which is part of the national data set in monitoring COVID-19 pandemic. Due to the easing of COVID-19 pandemic restrictions and the successful research restart program, the R&D team has continued to support the setup and delivery of key studies across the Trust including the following studies that have contributed to the 185 figure: the GLAD study (Genetic Links to Anxiety & Depression), PIPP2 Study (the prevalence of pathogenic antibodies in psychosis), Hearing Nasty voices, Experience of mental health care in Perinatal services, prevalence of memory problems in patients with a psychiatric disorder or neurodevelopmental diagnosis, Health and wellbeing of patients with serious mental illness, Experience of Housing support officer role and service users perception of spirituality -spiritual competent practice.

4.0	**Commissioning for Quality and Innovation Payment framework** South West Yorkshire Partnership NHS Foundation Trust income in 2021/22 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and

	Innovation payment framework because of the COVID-19 pandemic. All CQUIN payments were suspended throughout the year with all main contracts paid on a set block basis.

5.0/ 5.1	**Care Quality Commission** South West Yorkshire Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is that it is registered in respect of the following regulated activities: • Assessment or medical treatment for persons detained under the Mental Health Act 1983 • Diagnostic and Screening Procedures • Treatment of disease, disorder or injury There are no conditions attached to the registration other than the specified locations from which the regulated activities may be carried on at or from. South West Yorkshire Partnership NHS Foundation Trust's conditions of registration state that the three regulated activities listed above can only be carried out at the following locations: • Fieldhead Hospital (Wakefield) • The Dales (Calderdale Royal Hospital) • Kendray Hospital (Barnsley) • The Priestley Unit (Dewsbury District Hospital) • Lyndhurst (Halifax) • Enfield Down (Huddersfield) • The Poplars (Hemsworth) The Care Quality Commission has not taken enforcement action against South West Yorkshire Partnership NHS Foundation Trust during 2021/22.

7.0	South West Yorkshire Partnership NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

8.0	**NHS Number and General Medical Practice Code Validity** South West Yorkshire Partnership NHS Foundation Trust submitted records during 2021/22 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was: • 99.8% for admitted patient care • 100% for outpatient care The percentage of records in the published data which included the patient's valid General Medical Practice Code was: • 100% for admitted patient care

	• 100% for outpatient care

9.0	**Data security toolkit Data security and protection toolkit** South West Yorkshire Partnership NHS Foundation Trust achieved a status of 'Standards Exceeded' for the 2021/ 22 toolkit assessment.

10	**Clinical coding accuracy** South West Yorkshire Partnership NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2021-22 by the Audit Commission.

11 Quality of Data

Improving data quality remains one of South West Yorkshire Partnership NHS Foundation Trust's key strategic priorities. There was continued focus in 2021-22 on improving the quality of clinical record keeping. With a number of areas routinely reported and monitored to the Trust's Improving Clinical Information Group. This underpins the delivery of safe effective care and assures the Executive Management Team (EMT) and the Trust Board that data taken from the clinical record and used for activity and performance monitoring and improvement is robust.

South West Yorkshire Partnership NHS Foundation Trust will be taking the following actions to improve data quality

Data Quality	Actions
Bringing Clarity to Quality	• Continue to improve the training, guidance and support available to help staff and services to understand and improve data quality
Measuring Quality	• Continue to develop a wide range of team, service line, BDU and Trust level operational and performance reports and monitor these reports in appropriate forums. • Service line reporting and electronic dashboards will include key performance indicators and will enable users to look at performance at team, service line, BDU and Trust levels. • Team dashboards are available via the Trust intranet and will continue to be developed and further rolled out across all services areas. • Internal and external benchmarking will be incorporated on dashboards. The Trust has established a benchmarking group to review benchmarking data and identify areas for opportunity to further increase quality and effectiveness and make comparisons with peers.

Publishing Quality	• Continue to publish its data to the Secondary Uses Service, NHS England Improvement, the CQC, the Department of Health, Commissioners and Partners and to the Members Council.
Partnership for Quality	• Continue to work with partner organisations to ensure that all our respective quality and performance requirements are met and that duplication of data collection and inputting is minimised.
Leadership for Quality	• The improving clinical information group will oversee the development and delivery of the data quality improvement programme and will provide a quarterly progress update to EMT. • BDUs will ensure the development, monitoring and delivery of the individual BDU level improvement plans.
Innovation for Quality	• Following the Trust's implementation of SystmOne for Mental Health, the Trust continues to work to ensure innovation for quality is embedded within this as part of the continued development of the system • The Trust continues to exploit new technology to make these systems easy to access and use. Particular use of digital solutions for non-face-to-face activity was implemented during the COVID-19 pandemic which allowed continued service delivery in a challenging environment, and this is being evaluated as part of the Trust's restoration and recovery programme alongside new ways of working.
Safeguarding Quality	• The Trust's Executive Management Team will ensure essential standards of safety and quality are maintained and monitored and will take action where data quality issues arise.

Learning from Deaths

27.1 **The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.**

During 2021/22, 3473 of South West Yorkshire Partnership NHS Foundation Trust patients died (at 12 April 2022). This figure relates to deaths of people who had any form of contact with the Trust within 180 days (approx. 6 months) prior to death, identified from our clinical systems. This includes services such as end of life, district nursing and care home liaison services. For a large number, the Trust was not the main provider of care at the time of death. The following number of deaths occurred in each quarter of that reporting period:

Quarter	Deaths
One	800
Two	921
Three	943
Four	809

27.2	**The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure**

By 6 April 2022, 173 case record reviews (team level case note review or structured judgement review) and 31 investigations have been carried out in relation to 204 of the deaths included in item 27.1.
In 31 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Quarter	Deaths reviewed/ investigated
One	42
Two	53
Three	47
Four	62

27.3	**An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.**

0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

Quarter	Deaths reviewed/ investigated found to be due to problems in care
One	0 (0%)
Two	0 (0%)
Three	0 (0%)
Four	0 (0%)

Of the 204 case note reviews or investigations in the reporting period, 165 have been completed and no problem in care has been identified which resulted in death. 39 cases remain under review at the time of reporting.

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths. Working with eight other mental health trusts in the North of England Alliance, we have jointly developed a policy and use a common reporting dashboard that brings together important information. The Alliance are unable to report on what are described in general hospital services as “avoidable deaths” in inpatient services. This is because there is currently no research base on this for mental health services, no satisfactory definition of ‘avoidable’ and no consistent accepted basis for calculating this data. We also consider that an approach that is restricted to inpatient services would give a misleading picture of a service that is predominately community focused. As an Alliance, we continue to review this decision and develop our data and general understanding of the issues.

	These numbers have been estimated using the methodology below: Our Structured Judgement Reviews are conducted by trained reviewers from a clinical background (e.g. medicine, nursing, physio) who work outside the clinical area. The reviewer scrutinises the clinical records to review the care and treatment the individual received leading up to their death. They record their findings in a template under specific phases of care. Each phase of care is rated with supporting narrative. The reviewer also makes a judgement about if the death was due to problems in care that resulted in harm. All completed reviews are discussed at Business Delivery Unit governance groups to agree next steps, which may include areas for improvement or further investigation. Our investigations range from local level investigations to serious incident investigations. Investigators will review the care and treatment of the individual who died to identify any care and service delivery issues in the care received over a period of time. The focus is on human factors, systems and processes. They will also examine if any issue led to the death occurring. Most care and service delivery issues identified are not contributory to the death occurring.

27.4	**A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.** Not applicable

27.5	***A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).*** Not applicable

27.6	**An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.** Not applicable

27.7	**The number of case record reviews or investigations finished in the reporting period (2020/21) which related to deaths during the previous reporting period (2020/21) but <u>were not included in item 27.2 in the relevant document for that previous reporting period</u>.** 20 case record reviews and 13 investigations were completed during 2021/22 which related to deaths which were reported in the previous reporting period (2020/21).

27.8	**An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.** 0 representing 0.00% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Trust mortality review processes described above in 27.3. There remains one case which has been investigated internally, where this has not yet been concluded, pending the outcome of external enquires.

27.9	**A revised estimate of the number of deaths during the previous reporting period (19/20) stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.** 0 representing 0.00% of the patient deaths during 2020/21 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Part 2.3 – Reporting against core indicators

South West Yorkshire Partnership Foundation Trust is required to report performance against a core set of indicators using data made available to the trust by NHS digital. For each indicator, South West Yorkshire Partnership NHS Foundation Trust must also make assurance statements for which the format and information required is set out in regulations and therefore it is set out verbatim.

13 **Percentage of Patients on Care Programme Approach who were followed up within seven days**

Indicator	NHS Outcomes Framework Domain	South West Yorkshire Partnership Foundation Trust NHS Digital data Goal = 95%					
			Q1	Q2	Q3	Q4	TOTAL
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period. **Performance indicator is 95%**	1: Preventing people from dying prematurely 2: Enhancing quality of life for people with long-term conditions	2021/22	97.9%	99.4%	98.0%	97.4%	98.0%
		2020/21	99.3%	99.3%	99.7%	98.6%	99.2%
		2019/20	97.7%	97.2%	97.6%	96.4% *(local data)*	97.2% *(Local data)*
		2018/19	97.7%	96.2%	97.3%	99.6%*	97.5%
		2017/18	97.7%	95.5%	96.9%	97.2%	
		2016/17	96.9%	97.8%	97.4%	97.5%	
		2015/16	98.66%	97.98%	95.64%	97.44%	

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

- This information is taken from the electronic clinical record system
- Clinical staff are given training and guidance to input data onto the system. No staff member can use the system until they have received this training

- Data is clinically validated before it is submitted to NHS Digital
- Performance data is reviewed monthly by the Executive Management Team and the Trust Board

The South West Yorkshire Partnership NHS Foundation Trust has taken the following actions to improve this percentage and therefore the quality of its services:

- The Trust has an established Improving Clinical Information Group sponsored and chaired by the Director of Nursing, Quality and Professions, that meets quarterly to focus on the quality of clinical data.
- Each Business Delivery Unit has developed a robust process to improve the quality of their clinical data.
- Each Business Delivery Unit is provided with performance and quality reports monthly. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent deterioration in quality

17 **Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper**

Indicator	NHS Outcomes Framework Domain	NHS Digital South West Yorkshire Partnership NHS Foundation Trust performance data					
			Q1	Q2	Q3	Q4	TOTAL
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period **Performance target is 95%**	2: Enhancing quality of life for people with long-term conditions	2021/22	99.7%	99.4%	98.3%	97.8%	98.8%
		2020/21	100%	96.1%	98.7%	99.4%	98.9%
		2019/20	99.7%	100%	99.7%	97.9% *(local data)*	98.4% *(local data)*
		2018/19	97.6%	97.9%	98.9%	96.5%*	97.7%
		2017/18	98.4%	96.9%	96.9%	99.6%	98%
		2016/17	96.9%	99.3%	99.3%	99.3%	
		2015/16	95.81%	97.29%	96.04%	98.32%	

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

- This information is taken from the electronic clinical record system
- Clinical staff are given training and guidance to input data onto the system. No staff member can use the system until they have received this training

- We have two specific gatekeeping activity codes that are used for all gate kept admissions - this information can be extracted directly from the electronic record system
- Data is clinically validated before it is submitted to NHS Digital
- Performance data is reviewed monthly by the Executive Management team and the Trust Board

The South West Yorkshire Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and therefore the quality of its services:

- The Trust has an established Improving Clinical Information Group, sponsored and chaired by the Director of Nursing, Quality and Professions, which meets quarterly to ensure a focus on the quality of clinical data. Each Business Delivery Unit has developed a robust process to improve the quality of their clinical data
- We undertake a weekly audit of our gate kept admissions to validate the gate keeping function
- Each Business Delivery Unit is provided with performance and quality reports on a monthly basis. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality

19 **Readmission rates**

The data made available to the National Health Service trust or NHS foundation trust by NHS Digital with regard to the percentage of patients aged— (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

Indicator Readmission rates by age	NHS Outcomes Framework Domain	South West Yorkshire Partnership Foundation Trust Data								
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2020/21	2021/22
0-15	3: Helping people to recover from episodes of ill health or following injury	0	0	0	0	0	0	0	0	0
!6 and over		6.86%	7.02%	8.7%	9.7%	9.8%	9.8%	9.1%	5.2%	4.5%

South West Yorkshire Partnership NHS Foundation Trust had no readmissions for patients aged 0-15 during this period. All data applies to people aged 16 or over.

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

- 95.5% of people were not readmitted in 2021/2022 from April to December 2021

- This information is taken from the electronic clinical record system
- Clinical staff are given training and guidance to input data onto the system No staff member can use the system until they have received this training
- Data is clinically validated before it is submitted to NHS Digital

The South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- An Improving Clinical Information Group sponsored and chaired by the Director of Nursing, Quality and Professions, that meets quarterly to ensure a focus on the quality of clinical data. Each Business Delivery Unit has developed a robust process to improve the quality of their clinical data.
- Each business delivery unit is provided with performance and quality reports on a monthly basis. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

- 95.5% of people were not readmitted in 2021/2022 from April to December 2021
- This information is taken from the electronic clinical record system
- Clinical staff are given training and guidance to input data onto the system No staff member can use the system until they have received this training
- Data is clinically validated before it is submitted to NHS Digital

The South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- An Improving Clinical Information Group sponsored and chaired by the Director of Nursing, Quality and Professions, that meets quarterly to ensure a focus on the quality of clinical data. Each Business Delivery Unit has developed a robust process to improve the quality of their clinical data.
- Each business delivery unit is provided with performance and quality reports on a monthly basis. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

22 **Patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period. The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:**

Indicator	NHS Outcomes Framework Domain	South West Yorkshire Partnership NHS Foundation Trust score	National score
		2020 score	National 2020 score National comparison

		The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.	2: Enhancing quality of life for people with long-term conditions 4: Ensuring that people have a positive experience of care	7.0	About the same as other trusts nationally (CQC website)	
				2019 Score	National 2019 score	
					National comparison	
				7.0	About the same as other trusts nationally (CQC website)	
				2018 Score	National 2018 score	
					National comparison	
				6.7	About the same as other trusts nationally (CQC website)	
				2017 Score	National 2017 score	
					National comparison	
				7.9	About the same as other trusts nationally (CQC website)	
				2016 score	National 2016 score	
					Highest trust score	Lowest trust score
				7.5	8.5	6.8
				2015 score	National 2015 score	
					Highest trust score	Lowest trust score
				8.00	8.2	6.8
				2014 score	National 2014 score	
					Highest trust score	Lowest trust score
				7.9	8.4	7.3
				2013 score	National 2013 score	
					Highest trust score	Lowest trust score
				8.6	9.0	8.0

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

- This information was taken from the national CQC community patient survey, which uses approved survey contractors, external to the organisation and using anonymous information

The South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve this percentage and therefore the quality of its services:

- This information will be triangulated with other sources of patient and staff experience feedback in order that we can successfully focus our improvement action

25

The number and percentage of such patient safety incidents that resulted in severe harm or death

The number and, where available, rate of patient safety incidents reported within the trust during the reporting period (2021/22), and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Period	Number of patient safety incidents uploaded (by incident date) (at 21/04/22)	Severe harm	% severe	Death	% death
2021/22	6097	19	0.31	34	0.55

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

- Patient Safety Incidents are uploaded to the National Reporting and Learning System (NRLS) when they have been through the internal management review and governance processes. This ensures accuracy of data.
- Incidents are exported to NRLS when these reviews have been completed, which results in a natural delay in uploading patient safety incidents to the NRLS. This data has been prepared on 21/04/2022, this is a much earlier point in time than in previous years.

In 2021/22 the Trust uploaded a total of 6097 patient safety incidents to the NRLS, compared with 6252 reported in 2020/21 Quality Accounts. 96% of the 6097 incidents resulted in no harm or low harm. Nationally, it is believed that organisations that report more incidents usually have a better and more effective safety culture, with which we agree. If we understand what our incidents are, we can learn and improve our services. Each of our BDUs have a systematic way for reviewing learning from their incidents.

The Trust reported a total of 53 severe harm and patient safety related death incidents in 2021/22, compared to 57 incidents in 2020/21 (as at 21/04/22). These numbers indicate that severe harm and patient safety-related death incidents remain at similar levels (the percentage of severe harm incidents has decreased to 0.31% when compared with 0.45% in 2020/21. The percentage number of patient safety related deaths (uploaded to NRLS) has increased to 0.55% compared with 0.46% in 2020/21). However, not all incidents reported up to 31 March 2022 will

have been reviewed and uploaded to the NRLS at the date of the report and the Trust will revisit the data when it is complete.

The South West Yorkshire Partnership NHS Foundation Trust continues to develop its approach to learning from incidents as part of our Patient Safety Strategy and implementation plan. This includes supporting the development of a compassionate and just culture, developing our system of learning in line with Patient Safety guidance, and using evidence-based methods to review and learn from incidents resulting in harm and patient safety-related death.

Guardian of Safe Working Hours

The 2016 junior doctors' contract introduced stronger safeguards to prevent junior doctors from having to work excessive hours. The safety of patients is a paramount concern for the NHS and significant staff fatigue is a hazard both to patients and to the staff themselves. The new contract introduced the role of Guardian of Safe Working Hours who is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The Guardian ensures that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and provides assurance to the Trust Board or equivalent body that doctors' working hours are safe.

The introduction of a new contract for Doctors in Training impacted on the Trust in February 2017 with new employees moving onto the contract at that point. The Trust appointed a senior medical representative as the Guardian of Safe Working and his 2020/21 Annual Report and subsequent quarterly reports, highlighted the following:

- The number of exception reports has remained low during this period which is in line with the majority of Trusts providing mental health care (Table below). The two most common issues are (a) pressure of work on in-patient areas, especially during colleagues' absence, and (b) higher trainees acting-down to cover gaps on the 1st on-call rota. Previous exception reports relating to the workload associated with out of hours Seclusion Reviews led to a change in policy (with consultants and members of the team that knows the patient completing more of the reviews) and a subsequent audit has demonstrated a reduction in the number of reviews that on-call trainees are having to complete, releasing time to respond to other emergencies more promptly.

Exception Reports by Area				
Area/BDU	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Barnsley	0	0	0	0
Calderdale	0	1	1	0
Kirklees	0	1*	1	0
Wakefield	0	6	6	0
Forensic	0	1	1	0
Total	**0**	**9**	**9**	**0**

- The pandemic clearly created significant challenges, not least with the cover of rotas where a number of staff were shielding, self-isolating or off-sick (nearly 70% increase in gaps and nearly 50% increase in hours to be covered / costs overall with 553 or 22% of first tier shifts vacant. However, this fell back to just 9% in April-June 2021 and 7% in July-September 2021). There were 10 shifts where it was not possible to obtain junior doctor cover, a small reduction on the previous year. Where there is a rota gap, the rota co-ordinators will seek to find someone to cover via the Medical Bank resource. If this is not possible, senior doctors act down to cover.

- Rota coordinators managing the Trust Medical Bank, with the support of the trainees have done fantastic work to maintain the service despite these challenges.
- Improved recruitment to core training in Psychiatry has led to a significant reduction in vacancies across the Trust. With the reduced effect of the pandemic over the last 6 months there were fewer gaps on the rotas, but it remains to be seen how Omicron will affect the level of absences and resultant gaps.
- The Guardian of Safe Working Hours continues to have sessions with all new trainees at induction to offer support and encourage trainees to raise any concerns that they may have. After concerns from trainees that they could not find login details, the postgraduate administrative team have put in additional measures to ensure that trainees always have access to the Allocate system to complete exception reports as and when they need to do so. The Guardian of Safe Working Hours also meets trainees at the quarterly Junior Doctors' Forum.

Performance against indicators set out in Single Oversight framework

The table below shows our performance against the indicators which are monitored by NHS Improvement, as required for our regulation process and set out in the Single Oversight Framework (SOF)

Indicator		South West Yorkshire Partnership NHS Foundation Trust data	South West Yorkshire Partnership NHS Foundation Trust data
	Target	2020/21	2021/22
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	60%	89.5%	89.0%
Improving access to psychological therapies (IAPT): a) proportion of people completing treatment who move to recovery (from IAPT dataset)	50%	52.2%	53.5%
b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral	75%	94.0%	94.0%
ii. within 18 weeks of referral	95%	99.4%	99.8%
Admissions to adult facilities of patients under 16 years old	0	1	1
Inappropriate out-of-area placements for adult mental health services	494	1691 bed days	3216 bed days

Part 3: Our performance in 2021/22 Quality Priorities

This section of the Quality Account will be used to present an overview of the Quality of care offered by South West Partnership NHS Foundation Trust in 2021/22. This will include our performance against the Quality Priorities for 2021/22 including where the pandemic has had an impact and how we plan to make further progress.

The initiatives we undertake against our quality priorities change from year to year, which means we are not always able to make a direct comparison of our performance against each priority each year. Where we can make comparisons across the years we have done so. We make these changes to continually strive to improve the quality of our care.

Our Trust provides a wide range of services across several communities. These services are commissioned by separate commissioning groups, which are:

- Barnsley CCG
- Calderdale CCG
- Kirklees CCG
- Wakefield CCG

The CCGs in Calderdale, Kirklees and Wakefield work in partnership to commission services. Some of the Trust's specialist services such as the Forensic Mental Health services are commissioned by NHS England. The improvement goals in each area can differ however the Trust ensures that a consistent approach to quality is applied across all our services.

South West Yorkshire Partnership NHS Foundation Trust is a compassionate and innovative organisation with equality, co-production, recovery and creativity at its heart. We aim to help people reach their potential and live well in their community, we aim to provide outstanding physical mental and social care in a modern health care system.

This section will also showcase examples of quality improvement from across the organisation that have been initiated within individual services or areas of the Trust. Whilst the pandemic had an impact on service delivery and progress on some quality initiatives, many services responded positively to the challenge of staying engaged with patients and service users and were able to innovate and improve to meet need. Our annual Excellence awards showcase the achievements of both individuals and teams who have continued to innovate and improve the quality of services during these challenging times. They also demonstrate how as a Trust we have learned from the COVID-19 pandemic and improved services with hybrid working that meets the changing needs of the population it serves going forwards.

Our performance in 2021/22 Quality Priorities

In this section we will report on the progress that was made in 2021/22. In 2021/22 we used the 5 Care Quality Commission domains as a framework to organise our quality improvement priorities:

- SAFE
- EFFECTIVE
- CARING
- RESPONSIVE
- WELL-LED

Throughout 2021/22 we tracked our priorities. Our focus on the pandemic response means that progress has been affected and is not always what we would have hoped to report. The following provides a detailed summary of progress for each priority.

Quality Priority - SAFE

Safe means services delivered in a way that minimises things going wrong and maximises things going right; continuously reducing risk, empowering and enabling people to make safe choices and protecting people from harm, neglect, abuse and breaches of their human rights; and ensuring improvements are made when problems occur.

SAFE quality initiatives in 2021/22

The quality initiatives prioritised for action in 2021/22 as part of the quality account process were as follows:

- Staffing initiatives
- Patient Safety
- Suicide prevention
- Medication Safety

SAFE Quality Initiative – Staffing Initiatives
What we Prioritised We said that we would: - Focus on maintaining safe staffing on inpatient units - Roll out safer staffing initiatives into community services - Embed initiatives to improve staffing - Develop new career pathways and professional roles
What we did Safe staffing during the pandemic and safe staffing initiatives roll-out • We now have senior leadership present seven days a week to specifically oversee and address staffing pressures on our mental health in patient wards. • Active efforts to recruit have continued, together with recruitment of registered international nurses. • A New Roles Group has been established, chaired by the Director of Nursing, Quality and Professions, to explore how teams might be staffed differently whilst maintaining quality and safety standards. • Financial enhancements have been paid to colleagues at times of increased challenge or acuity. • As a Trust we have used several tools to support the Safer Staffing agenda: ➢ A strategic tool - we continue to utilise the Mental Health Optimal Staffing Tool (MHOST), to provide advice and direction when assessing staffing templates during an establishment review and transformation work. We will be establishing a rolling programme for our inpatient services to ensure we continue to have the most relevant staffing templates and resources available using the tool in a more consistent manner. ➢ A local tool – implementation of SafeCare solutions on some of our inpatient wards in 2021/22, which is a staffing resource and acuity tool allows us to move away from the

traditional view of having a set “number” of staff on inpatient areas and utilise the acuity and demand to flex the staffing resources appropriately.

  - A local tool - continued implementation of Allocate’s eRostering During 2021, a major engagement exercise took place to introduce the eRostering system to the managers and budget holders of all Community Mental Health teams. Information was also collated to describe each team’s type of shift/hours worked, structure and times of operation. This provides the foundation to tailor implementation to each team and support their integration into the system, alongside training for all managerial and administrative staff who will be involved in using it.

- The Inpatient Safer Staffing meeting has continued to meet monthly to assure safe and effective clinical staffing across the trust. The group has continued to review and adapt the relevant information to ensure that an accurate overview and narrative is provided within the safer staffing agenda. This allows the Trust to focus their resources appropriately and safely. Monthly exception reports continue to highlight areas where staffing levels fall below 90% overall and below 80% for Registered-qualified staff. This in turn has allowed the continued refinement of local escalation plans to support inpatient areas.

We relaunched the safer staffing in the community program in October 2021. Despite pressures on staffing and the ongoing COVID and Business Continuity Plan pressure on community teams, we have met several times and have looked to finalise the membership and terms of reference. We will be looking to do testing of several tools as pilots within several teams over the summer of 2022.

What next ?

- Roll-out of e-Rostering to Mental Health Community teams will be completed by December 2022.
- Embed the MHOST within our inpatient wide establishment review plan (April 2022).
- Continue with the roll out of the acuity staffing management tool, SafeCare, across the Trust moving into the Forensic and Barnsley Business Development Unit next. (Aug 2022).
- The Community safer staffing group will continue to:
  - Offer support where staffing shortages have been identified
  - Recruit bank specialists to support the services.
  - Support the Allied Health Professional locum requirement.
- We have utilised the tool within staffing reviews, which has proven to be effective in demonstrating the correlation between demand and capacity. Utilising the Mental Health Optimal Staffing Tool (MHOST) for a regular and planned staffing review throughout all inpatient areas will begin in July 2022 with a full report due by September 2022. This will include all 31 inpatient areas.

SAFE Quality Initiative – Patient Safety

What we Prioritised

The selected initiatives featured in the previous quality account were

- Reducing restrictive physical interventions
- Continuously developing our patient safety strategy and action plan, adjusting for national priorities and guidance
- Implementing safety huddles

Between 2019 and 2021, one of the aims of the Patient Safety Strategy was focused on reducing the frequency and severity of harm from patient safety incidents. Overall numbers of incidents and levels of severity and harm are monitored at Board and BDU level through various reports. The Trust continues

to work to increase overall incident and near miss reporting as part of safety culture work. In 2021/22, 97% of all incidents reported resulted in no or low harm. The number of incidents resulting in moderate or severe harm or patient safety related death are small and we use individual reviews of these cases to help us learn from them.

Throughout 2021/22, we have continued to make good progress with our patient safety-related quality improvement work, despite the constraints of the pandemic. We have adapted improvement methodologies to support our teams, such as using safety huddle methodology to aid communication and support safe care.

The Trust's Patient Safety Strategy is supported by an implementation plan and is monitored through the quarterly Patient Safety Strategy Implementation Group. each Business Delivery Unit (BDU) has developed their own patient safety priority plans, which they share in the Strategy group. This enables cross sharing of information that aids services to learn from each other and improve together. Each BDU has continued to show progress with their plans despite the pandemic.

The Strategy builds on the two foundations of patient safety culture and a patient safety system, and strengthening our use of insight, involvement of patients, staff and partners, and delivering improvement.

The following progress has been made during the last 12 months:

Culture

- Monitoring NHS staff survey data to understand our safety culture.
- Delivered Restorative Just and Learning Culture training.
- Delivered Freedom to Speak Up Guardians campaign to raise awareness of the role, with further guardians appointed and mandatory training made available.
- Introduced an anonymous Incident report form to enable staff to report in confidence.
- Undertaken quality improvement work to review improve the ease of incident reporting on Datix.
- Reviewed our data quality processes for incident data to ensure accuracy. Work to strengthen this work continues.

Insight

- Continued to work with the national patient safety team to learn about new developments in patient safety. Reviewed our existing processes against the draft Patient Safety Incident Response Framework (PSIRF) documentation
- Held learning events following each Serious Incident investigation with the staff involved.
- Held a Trust-wide learning event in November 2021 where BDUs and Specialists advisors shared learning with each other which was well received, with plans to host further themed events
- Developed processes for sharing information from (a) serious incidents action themes and (b) equality data from incidents. This has been established following PDSA cycles, and now a data resource has been established for both datasets, that policy leads can interrogate for relevant data to influence policy change.
- Shared learning through the year (Bluelight alerts and Learning library summaries)
- Developed new methods of sharing learning to enhance team communication
- Made further improvements to Datix reporting and corresponding dashboards
- Delivered further training on completing Mortality structured judgement reviews
- Reviewed our Patient Safety Alert processes to maintain compliance

Improvement

- Worked on our Covid 19 recovery and restoration plans
- Worked with the Patient Safety Collaborative on Reducing Restrictive Practice

- Continued to develop our work to improve sexual safety including recording on Datix.
- Continued to progress with our Suicide prevention plans
- Achieved accreditation from Royal College of Psychiatrists for our Serious Incident investigation processes
- Received significant assurance from an internal audit on incidents/serious incident processes
- NEWS2 implemented (early warning system for deteriorating patients in place)
- Self-care wound pathway implemented - reducing the burden of wounds through workforce optimisation
- Continued to promote falls prevention, with promotion of falls assessments and post fall protocol
- Worked on improving the recording and language associated with pressure ulcers to improve understanding
- Implementation of e-prescribing system to aid medication safety

Involvement

- Identified our dedicated Patient Safety Specialists who will lead on patient safety across the Trust. This role came into effect on 1 April 2021. As part of this role, we have been working on priority areas from the NHS England patient safety plan, although timescales have changed nationally due to the pandemic.
- Updated our Being Open policy to incorporate CQC guidance changes on Duty of Candour and held Q&A session.
- Developed leaflets for staff to share with bereaved families; poster developed with prompts for staff when speaking with bereaved families; bereavement support champions network continues
- Raised awareness of new Patient safety training for all staff at the Education Governance Group.

What next?

- Further developing our Patient Safety Specialist role and supporting framework.
- Continuing to adapt and progress our Patient safety implementation plan, with a focus on quality improvement
- Working closely with NHS England on a range of national patient safety developments
- Promoting patient safety training for all staff including Board and senior managers

SAFE Quality Initiative – Suicide Prevention

What we Prioritised

Our focus for suicide prevention in 2021/22 was anchored in a programme of regional and Trust-level work built from the Suicide Prevention Strategy launched in 2017 and in support of our Patient Safety Strategy. We are currently in the process of refreshing the Trust strategy and plan for 2022-2025.

What we did

Our vision for suicide prevention in the Trust has been translated into themes as follows:

Culture

- Continued development of our open, learning-based approach to understanding how and why people may die through suicide in our care.
- Used the data we collected to inform our organisational understanding on the loss of life to suicide and identified areas of improvement.
- Expanded the organisational workstreams for engagement of carers, family and significant others with the aim to further address of the known issues reported through our organisational learning, friends and family feedback and customer services insights.

- Strengthened our governance and accountability systems and process trust wide to enhance the incident investigations and monitoring processes.
- Continued our partnership working and collaboration including regionally, with Local Authorities, primary care and the Community and Voluntary Sector.

Effective clinical management of people at risk of suicide

- Continued to embed current evidence-based interventions and pathways, and identifying and managing risk factors and depression, medication-related harm or addiction, following care pathways for self-harm and trauma.
- Shared learning Trust-wide on learning from incidents, areas of good practice and areas of improvement through the learning library, blue light alerts, green light alerts and use of the Situation, Background, Assessment, Recommendations (SBAR) model for communication.
- Embedded the use of Formulation-Informed Risk Management (FIRM) Trust wide across all care groups, providing ongoing support in the understanding of the tool, sharing examples on effective formulation and management of risk.
- Actively engaged in meetings that seek to break down the barriers to information sharing in electronic care records to improve sharing of information with key professionals externally such as GPs and other service providers.
- Expanded and enhanced the Quality and Governance process within the inpatient units, developed a working guide for Matrons enhancing data and information relating to for example Care plans, Risk Assessments, observations and admission and discharge processes.
- Updated and reflected changes in operational policies, strengthening internal monitoring of policies and procedures and associated updates, including plans for additional actions.
- Devised a safer discharge project following themes arising out of discharges to community-based services with an aim to map themes and make improvements.
- Reviewed the Apparent suicide report, alongside the national confidential inquiry report, identifying areas of ongoing challenge, improvements and future thinking in line with Covid-19 pandemic impacts on mental health and potential impacts on suicides.
- Embedded the Trauma Informed Pathways across the Trust, promoted and shared insights on risks to vulnerable individuals through the development and sharing of the Therapeutic Risk Guidance.

Family and carer involvement and collaborative care.

- Further advance in the work following the launch of the carer's charter and supporting families and carers.
- Share Trust wide insights from local, regional and national learning on improving information sharing to enhance families/carers insights in to supporting people with suicide risk and how they can help to help break down further the barriers to information sharing.
- Use our organisational intelligence to further advance insights and ensure this fits with regional community transformation workstreams.
- We consulted with and were guided by the Trust's Carer Support Network, with regards to family involvement and clarity about communicating with family members when we updated the Clinical Risk Assessment, Management and Training Policy

A focus on equality and reducing inequalities

- Based on evidence through regional and national intelligence, a review of the current data collected organisationally was undertaken to help inform our understanding of the needs of individuals and populations of people considered marginalised and how we captured information on populations such as minority ethnic and individuals who identify as LGBTQ+ people, with the aim to use insights and plan improvements.

- Rigorous attention to recording of data that can also be extracted from our reports that help to shape more individual understanding on those people who die by suicide and who are in receipt of care or recently discharged.

Training

- Ensured the Trust has a comprehensive, ongoing understanding of training needs and a training offer that is tailored to different roles and settings through the completion of a Trust wide, service wide training needs analysis.
- A masters-level CPD-funded course in Clinical Risk Management in Mental Health and Learning Disability was commissioned from the University of Huddersfield and was due to run from September 2021. At that time, it was not possible to recruit the minimum number of participants however the Trust remains committed to supporting staff to access the course during 2022.

Staff support and workforce wellbeing

- Promoted the Trust offer of support for staff following critical incidents and staff involvement.
- Supported a regional wide investment in training for a critical debriefing offer across the region.
- Explored in partnership with Front Line services an additional offer to develop a suicide-specific supervision model and access to support.
- Continued to champion the regional partnership work for the staff 'check in' campaign.
- Updated Trust intranet information sites to expand on accessible support for all staff across the organisation, ensuring a focus on recognition of the vulnerability of all people to suicide including staff working in health and social care settings.

Impact of covid-19

Implementation of the wider improvement plan had been affected by COVID during 2021/22, workstreams remained in place while the organisation faced excessive challenge in the delivery of business as usual. The continued delivery of the Suicide Prevention Champions Network meetings enabled the gathering of soft intelligence to inform future focus and enhance information sharing in respect to Suicide Prevention and the organisational aims and ambitions.

Progress has continued to be made across the following areas:

- Embedding and monitoring the impact of Formulation Informed Risk Management including qualitative analysis to assess the changes in detail and staff understanding on risk.
- Strengthening staff knowledge and awareness for increased risk and specific interventions risk in services where risks are known to be higher for certain groups
- Involving service users, families and carers in developing care plans and connecting people to wider community resources linked to the wider factors contributing to their risk.
- Systematically and continuously addressing risks in the physical environment via oversight by the Clinical Environment Safety Group
- Further development on the Suicide Prevention Champions network and strengthening connections with the Regional ambitions.
- Advancing learning from incidents involving suicide or attempted suicide (might we say how?)

Reducing Restrictive Physical Interventions (RRPI)

The Trust's Reducing Restrictive Physical Interventions (RRPI) team use a range of approaches to reduce the use of restrictive physical interventions.

In 2021/22 this has included:

- Accreditation of RRPI training with the Restraint Reduction Network. The training focuses on a Human Rights value based approach with the view of reducing the need for restraint.
- Establishing working groups including a seclusion review group and advanced statement group which includes an expert by experience.

- Supporting specific service areas where some service users require intensive physical health investigations and physical health needs
- Roll-out of EDITION training intervention in Barnsley and the Unity Centre. This training ensures the patient is at the centred and uses a Trauma informed care approach.

What next?

- Completion of the 2022-2025 Trust Suicide Prevention Strategy including implementation plan.
- Testing alternative seclusion exit strategies to support a reduction in prone restraint.
- Working with pharmacy to explore alternative intramuscular injection sites.

SAFE Quality Initiative – Medication Safety

What we Prioritised

We aimed to reduce missed medication doses in acute, forensic, learning disability and older adult wards.

What we did

This quality improvement project was initiated in 2020 based on data about missed doses on inpatient wards, suggesting that there were occasions when it was not documented that people had received their medication. An omission is when prescribed medication is not administered within the appropriate timescale, and the medication card is left blank with no reason given as to why the medication had not been administered. The project involved teams from acute wards and Psychiatric Intensive Care Units (PICUs), older adults, learning disability and forensic services. The safe medicines group oversees performance and shares change ideas that wards have implemented for others to adopt and adapt.

The 'safety cross' was chosen as an innovation that would support teams visually, showing when medications had been fully administered (green) and when there were misses with no reason recorded (red), and how many. Most teams chose to continue the process however the impact of COVID-19 on staffing levels has made the practice very difficult to follow for some teams. To support them, spot checks are carried out where the process is not in use and a datix is completed where the proportion of doses missed is 25% or more. When spot checks show that a ward has not met the monthly standard of 82%, safety crosses are used until improvement is sustained.

The table below shows achievement over time against the following agreed goal of 82% and minimum standard of 75%. Overall, and in spite of the challenges, improvements have been made in most areas.

Ward	Nov 20-Average	March 21-Average	May 21-Average	Sept 21-Average	Nov 21-Average
Ward A	71%	82%	86%	95%	79%
Ward B	77%	64%	73%	98%	No longer completing
Ward C	82%	86%	84%	75%	70%
Ward D	80%	78%	84%	79%	86%
Ward E	76%	66%	66%	88%	79%
Ward F	68%	66%	75%	98%	91%
Ward G	72%	82%	82%	92%	80%
Ward H	53%	63%	59%	75%	75%
Ward I	71%	86%	72%	84%	79%

	Ward J	70%	68%	70%	70%	48%
	Ward K	67%	58%	62%	75%	75%
	Ward L	No longer completing	No longer completing	No longer completing	88%	82%
	Ward M	No longer completing	No longer completing	No longer completing	49%	49%
	Ward N	No longer completing	64%	72%	79%	97%

What next?

Improvement ideas currently being tested include:

- At tea-time medicine round, nurses check medication charts for omissions and where there are gaps, these are identified, and action is taken before the end of the shift. Any incidents are reported on DATIX
- Staff completing e-learning and competency training on medicines management.
- Medication cards are taken into handover and both nurses check though them as part of the handover

Electronic prescribing is now being rolled out across our in-patient wards. Where electronic prescribing has been implemented, there is no longer a need for the use of the safety cross.

A further quality improvement project is underway to ensure that that opening date is always recorded on short shelf-life medication. This is reviewed monthly by the pharmacy team who do a quality assurance checks on all in-patient areas.

Quality Priority - EFFECTIVE

Effective means informed by consistent and up to date high quality training, guidelines and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing wider determinants of health; delivered in a way that enables continuous improvements based on research, evidence, benchmarking and clinical audit.

Effective quality initiatives in 2020/21

The quality initiatives prioritised for action in 2021/22 as part of the quality account process were as follows:

- Outcome measures
- Clinical record keeping

EFFECTIVE Quality Initiative – Outcome measures

What we Prioritised

Although the national CQUIN scheme was paused for both 2020/21 and 2021/22, we have been monitoring compliance against CQUIN CCG 7a and 7b (CQUIN 7a: Routine outcome monitoring in children and young people's services and perinatal mental health services, CQUIN 7b: Routine outcome monitoring in community mental health services) and currently have just under than 30% of service users with paired outcomes against a target of 40%. Therefore, we have implemented a number of initiatives to focus on improving outcome measure use and reporting in clinical practice in mental health.

What we did

The Trust has worked to implement the use of outcome measures into routine clinical practice to facilitate a deeper understanding of the impact of the individual's condition on their health and social functioning, and the effectiveness of the interventions they are supported with.

In Mental Health services, completion of Mental Health Clustering Tool (MHCT) and use of the subsequently identified 'cluster' is not seen as clinically valuable and considered time-consuming. As a result, completion rates have declined. A solution has been developed which promotes use of Health of the Nation Outcome Scales (HoNOS) as a clinician reported outcome measure (CROM) and from which cluster can be derived by an algorithm.

We are also developing a digital solution to collect and report Patient Reported Outcome Measures (PROMs) data on laptops, smartphones or other handheld devices. This aims to remove some of the traditional barriers to collecting PROMs where paper questionnaires often get filed and forgotten and re-inputting the data into the electronic clinical record is time consuming, is duplication and poses risks in transcribing errors.

What next?

- We have commissioned RESTART to build a solution where patient outcomes can be completed digitally and reportable within our inter-operability portal. This has a delivery date of June 2022 and will be rolled out within early implementor teams in Phase 1.
- Embedding clinical outcome measures into routine clinical practice in mental health services, using the support of SystmOne/data champions within teams
- PROMs data collection and reporting system development work will continue with a potential to roll out to community services
- To work with services to re-focus the use of CROMs as an outcome measure for improving clinical effectiveness and service user outcomes and experience rather than being focused on payment by results
- We will be monitoring PROM data against the 2022/23 CQUIN target of 40% of services users with paired outcomes

EFFECTIVE Quality Initiative – Clinical record keeping

What we Prioritised

We focused on improving record keeping, specifically clinical risk assessment and care planning which had been reported in the Trust's CQC Inspection report of 2019. Quality Improvement methodology was adopted to support the improvement work however the work was interrupted through 2020/21 due to the pandemic.

What we did

When the CQC inspected the Trust in 2019 they identified that the Trust was not meeting the required regulatory standards in relation to acceptable record keeping, particularly risk assessment and care planning on inpatient wards. To address these issues, we adopted a quality improvement (QI) approach and established a project structure to support improvement work.

Quality improvement methods were used to identify the multiple factors contributing to levels of risk assessment and care planning across different settings. In March 2020, the Directorate of Nursing, Quality and Professions leadership team and Trust Covid-19 pandemic decision making command structure took the decision to put the QI project on hold in line with the national directive to prioritise

resource to support Covid-19 pandemic activities. The project restarted in September 2020, was paused again in October 2020 and re-instated in February 2021. Quality improvement focussed work will continue in 2022/23.

The following progress has been made:

- Introduction of ward manager and matron checklists for record keeping
- Introduction of new car plan and risk assessment tools on SystmOne which are more relevant, user-friendly and person-centred.
- Launch of revised care planning and risk assessment training
- Revision and launch of Clinical Risk Assessment, Management and Training Policy
- Introduction of lead roles across the Trust for risk assessment and care planning
- Revision and piloting of clinical record keeping audit
- Creation and launch of a 'good practice in care planning guide' for staff

What next?

- Improve quality of clinical record keeping (ongoing)
- Improve quality of care planning
- Clinical risk assessment & management – set standards of practice, improve performance against expected targets and monitor clinical outcomes

Quality Priority - CARING

Caring quality initiatives in 2021/22

Caring is part of delivering a positive experience:

- Responsive and personalised – shaped by what matters to people, their preferences and strengths; empowers people to make informed decisions and design their own care; coordinated; inclusive and equitable.
- Caring – delivered with compassion, dignity and mutual respect.

The quality initiatives prioritised for action in 2021/22 as part of the quality account process were as follows:

- Staff experience and wellbeing
- Patient experience
- Equality, involvement, communication and membership

CARING Quality Initiative – Staff experience and wellbeing

What we Prioritised

We focused on improving the results of the national staff survey

What we did

The Trust's Workforce Strategy 2021-2024 aims to deliver the strategic objective of making the Trust a Great Place to Work as a key enabler to achieve the Trust's Vision and Mission. It contains a number of pledges which include 'We will provide support to keep staff physically and psychologically well, enabling them to work flexibly and ensure they have manageable workloads'. In addition, one of our strategic objectives is to 'Enhance the Occupational Health Offer including a focus on Creative and Physical Activities'. The Trust is committed to the prevention of ill health as well as providing a comprehensive wellbeing support offer when colleagues experience ill health. We have an in-house Occupational Health and wellbeing service providing a range of services as well as our own staff counselling service.

<u>NHS staff survey results 2021/22</u>

The NHS staff survey is conducted annually. From 2021/22 the survey questions are aligned to the seven elements of the NHS 'People Promise', retaining two previous themes of engagement and morale. These replace the ten indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2021/22 survey among trust staff was 43% (2020/21) and 41% in 2021/22. Scores for each indicator together with that of the survey benchmarking group mental health and learning disability Trusts) are presented below.

Indicators ('People Promise' elements and themes 2021/22	**Trust score 0-10**	**Benchmarking group score**
We are compassionate and inclusive	7.6	7.5
We are recognised and rewarded	6.4	6.3
We each have a voice that counts	7.0	7.0
We are safe and healthy	6.4	6.2
We are always learning	5.4	5.6
We work flexibly	6.7	6.7
We are a team	7.0	7.1
Staff Engagement	7.1	7.0
Morale	6.2	6.0

Previous performance - 2019/20 and 2020/21
Scores for each indicator together with that of the survey benchmarking group are as follows:

Theme results	**2020/21 Trust score**	**20/21 Benchmarking group score**	**2019/20 Trust score**	**2019/20 Benchmarking group score**
Equality, diversity and inclusion	9.2	9.1	9.1	9.1
Health and wellbeing	6.4	6.4	6.2	6.1
Immediate managers Morale	7.2 6.5	7.3 6.4	7.2 6.3	7.2 6.3
Quality of appraisals	Not included	Not included	5.7	5.7
Quality of Care	7.4	7.5	7.4	7.4
Safe Environment-Bullying and Harassment	8.3	8.3	8.2	8.2
Safe Environment-Violence	9.4	9.5	9.4	9.5
Safety Culture	6.9	6.9	6.7	6.8
Staff Engagement	7.1	7.2	7.0	7.1
Team Working	6.9	7.0	6.8	6.9

The 2021/22 NHS Staff Survey response rate reduced from 43% in 2020/21 to 41% in 2021/22. The 2021/22 results show that 5 out of 9 SWYPFT theme results are better than the national average compared to similar provider organisations. Our 'safe and healthy' and 'morale' scores are 0.2 above average. 2 themes are average, 'we each have a voice that counts' and 'we work flexibly'. Two key theme scores are below average 'we are always learning' and 'we are a team'.

Due to changes in the content of the 2021 survey it is not possible to confirm whether there have been statistically significant changes in key theme scores from 2020 except for the 'morale' score which has seen a statistically significant negative change from 6.3 to 6.2. There has been a national reduction in the average score 'morale' from 6.2 to 6.0. The Trust's Staff Engagement score at 7.1 was the same as 2020/21 but is now above the national average of 7.0.

Key areas for improvement are 'we are always learning' and 'we are a team'. The Trust had to pause non-essential learning and development in 2021 due to the Covid 19 pandemic and feedback indicates that team working has also been affected by increases in home/remote working. The Trust also conducted a Wellbeing at Work survey in 2020 in partnership with Robertson Cooper, occupational psychologists. Results showed improvement in several key scales compared to the wellbeing survey conducted in 2018. Colleagues reported more concern around their physical and psychological wellbeing compared to 2018, which was likely to be due to the pandemic rather than specific work factors.

Future Priorities and targets

Since the start of the COVID-19 pandemic we have enhanced our wellbeing support offer by providing additional support for both physical and psychological ill health. Work has included developing a formal risk assessment process for Black and Asian Minority Ethnic (BAME) and other vulnerable groups at risk of Covid 19, establishing a BAME wellbeing taskforce, employing a BAME health and wellbeing practitioner and rolling out of COVID-19 and flu vaccinations.

We use data from a variety of sources to understand the challenges colleagues are facing in different parts of our organisation, with support of the Board where this data is reported routinely. This includes feedback from our Wellbeing at Work Survey, NHS Staff Survey, feedback from our Trust and service workplace wellbeing groups and champions as well as reviews of key workforce data. The 2020 Wellbeing at Work Survey, administered by Robertson Cooper (Occupational Psychologists), showed an increase in concern over colleagues physical and psychological ill health which is likely to be due to the COVID-19 pandemic. Other work-related factors showed improvement. The NHS Staff Survey 2020 showed that colleague's satisfaction with our wellbeing support offer had significantly increased.

During 2021-22, we have made considerable progress in implementing our workforce strategy and Great Place to Work priorities. We have:

- Strengthened our occupational health offer and developed some new wellbeing roles, with the support of NHS Charities funding to introduce a Staff Dietician, Physical Wellbeing roles and creativity-based approaches to wellbeing.
- Worked with partners in Kirklees and Calderdale to introduce Schwartz rounds to support staff to deal with the emotional demands of their role.
- Raised awareness of menopause and its impact, provided advice and support to staff experiencing menopause symptoms as well as training and advice to line managers in supporting colleagues experiencing the menopause.
- Introduced a working carer's passport to support staff to manage their work and caring responsibilities.
- Rolling out our Tackling Violence plan and starting an improvement project in Community Mental Health Services
- Recruited Civility and Respect Champions to provide support to staff concerned about behaviours at work.
- Introduced a resolution approach to managing disciplinary cases which has seen a reduction in formal disciplinary processes.
- Continue to support service wellbeing groups and champions, encouraging colleagues to take forward local activities to improve wellbeing in their service/team.
- Designed a development programme for ward managers/team leaders including a focus on their wellbeing and supporting the wellbeing of colleagues.
- Worked on our flexible workforce model to increase access routes to careers and roles in the Trust

What next?

- The Trust health and wellbeing sub-group will be initially focussing on 2 key areas: mapping and the improving the communication of our health and wellbeing offer to everyone in the Trust, and a review of employment policies to ensure our policy framework supports workplace wellbeing.

- Continued focus on psychological and physical health, and the prevention of illness in line with our workforce strategy objectives.
- Further roll out of Schwartz rounds, working with partners in the integrated care systems (ICSs).
- Recruitment of a staff dietitian and promoting this offer to staff.
- Continued work on creativity/arts and physical activity for staff to prevent ill health and improve physical and mental wellbeing.
- Administer the 2022 Wellbeing at Work Survey in April.
- Using our Staff Survey data to make further improvements to our support offer.
- Further embed the Wellbeing champion role.

CARING Quality Initiative – Patient experience: Friends and Family Test

What we Prioritised

We focused on achieving tailored targets for some specific services and a Trust wide target.

What we did

Evidence demonstrates that service users who have a better experience of care have better health outcomes. There is also a link between experience and cost of care. A poor experience leads to higher costs as service users may have poorer outcomes, require longer stays or admitted for further treatment. We have been working to improve measurement of patient experience in our services.

In 2021/2022 we focused on:

- Development of Patient Experience representatives across the Trust to support the Patient Experience agenda. Due to the pandemic this work was put on hold, and this will continue to be a development for 2022/ 2023.
- Review of the Patient Experience Framework. The framework is currently under review by NHS England and NHS Improvement, and it was agreed that due to this and resource issues that this work would be continued once the review was completed. At present there is no date for the review to be completed from NHS England and NHS Improvement.
- Review text messaging collection service to improve data quality. The Trust is currently piloting a new text message in CAMHS to improve the qualitative data received from text messaging. This work will be reviewed and continued to be developed throughout 2022/ 2023.
- Expanding the text messaging as a data collection method for the collection of Friends and Family Test across Community Health. The text message service was expanded across three community services. This increased the responses across community services by 53% based on a comparison of the previous three months from the text message going live. This will continue to be developed in 2022/ 2023.
- The Quality Improvement and Assurance Team to work with operational teams to ensure they are collecting, reviewing, and acting upon service user and carer feedback. A relaunch of the Friends and Family Test across the Trust including new cards and promotional materials has taken place to ensure that operational teams have the correct tools to support data collection. Advice surgeries are taking place across the Trust to support teams in using alternative methods to collect Friends and Family Test. All teams receive automated monthly reporting to support teams reviewing their feedback and acting upon their feedback. Drop-ins are held regularly to support staff understanding Friends and Family Test, data collection methods and understanding their results.
- Continue to work with teams to develop a practical way to collate actions being taken across the Trust to demonstrate the changes that are being made because of feedback. This continues to be a challenge for the Trust and is being developed as a priority in 2022/ 2023.

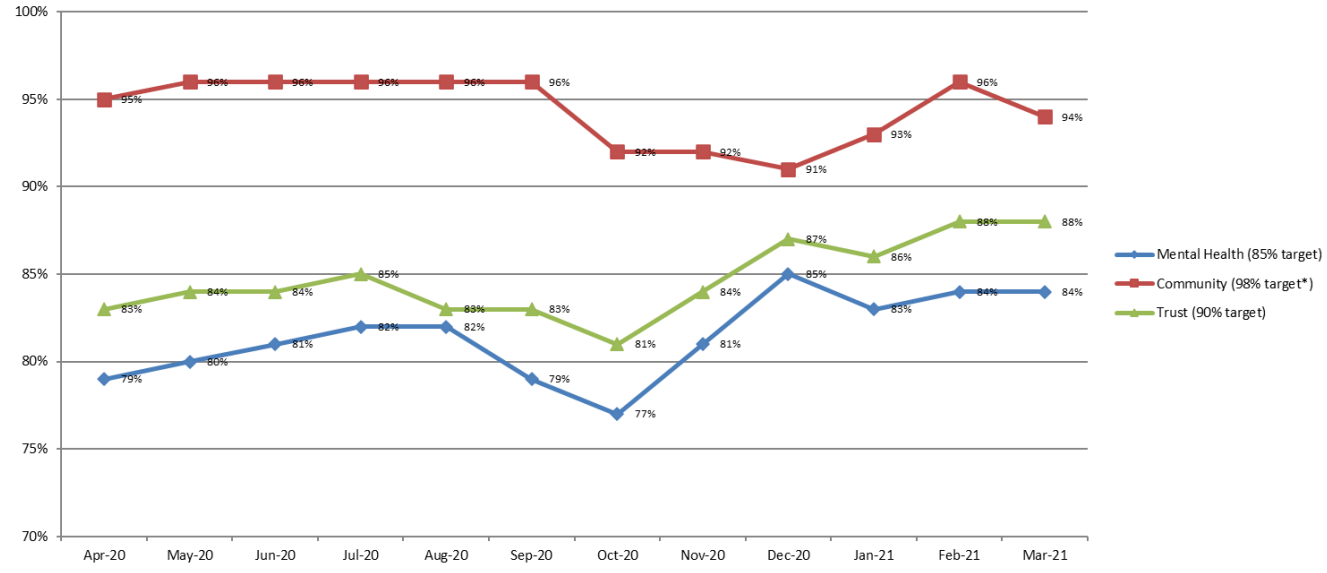
Friends & Family Test:

The NHS Friends and Family Test (FFT) is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. This feedback should be used to improve services for service users. The FFT question asks overall, how their experience of our service was and offers a range of responses from 'very good' to 'very poor', including a 'don't know' option. When combined with supplementary follow-up questions, the FFT question provides a mechanism to highlight both good and poor service user experience.

The free text comments are a rich source of information, which provide staff with a greater depth of understanding about the experiences of their service users. The results are available more quickly than traditional survey methods, enabling providers to take swift action when required. The FFT results are also a useful source of information which can help to inform choice for service users and the public. The results are available on the NHS England website and the NHS Choices website.

The FFT was implemented in the Trust in 2015. The Trust is on a progressive journey of continually refining and improving systems and processes for the collection of service user feedback and uses this to improve quality. In 2021/ 2022 the Trust received 11342 FFT responses, an average of 945 per month compared to 4808 FFT feedback received in 2020 / 2021 which was an average of 400 responses per month.

The chart below shows the number of respondents that rated the service as either 'very good' or 'good'. Community Health services generally achieve a higher satisfaction rate than Mental Health. Due to this Community Health services have a satisfaction rate target of 98%.

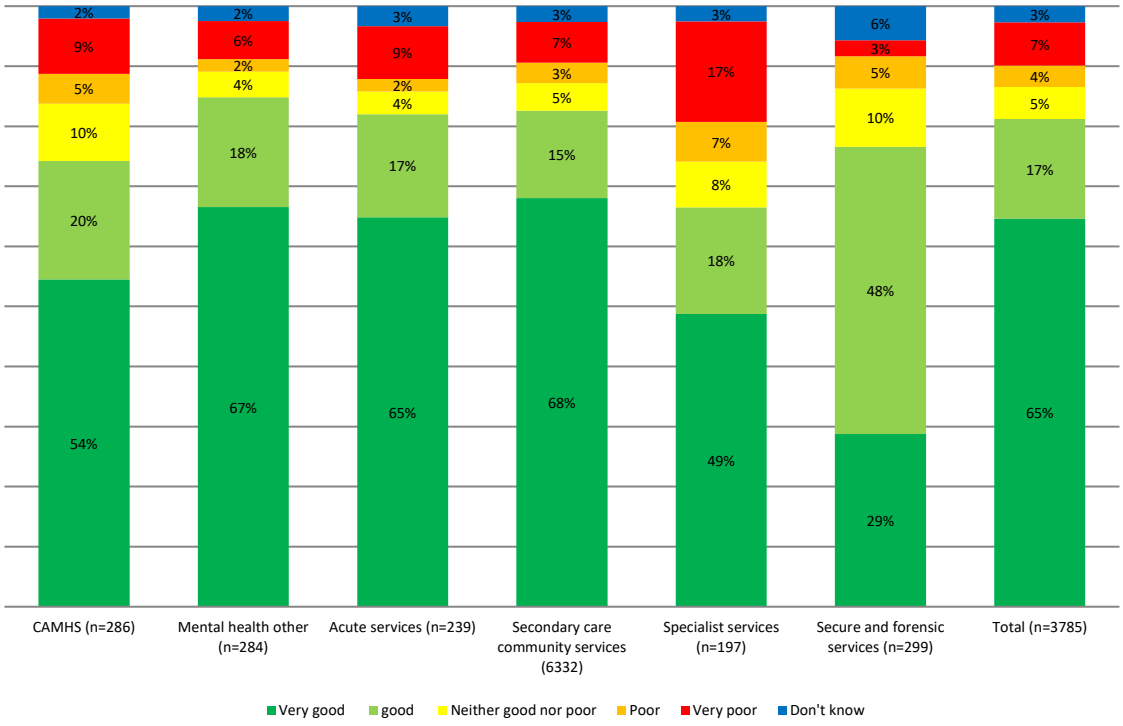


Friends & Family Test	Target	Reporting Period	Q1	Q2	Q3	Q4
CAMHS	75%	Quarterly	67%	73%	74%	80%
Learning Disability Service	85%	Quarterly	82%	91%	85%	82%
Forensics	60%	Annually	77%			

Top three themes from Friends and Family Test feedback:

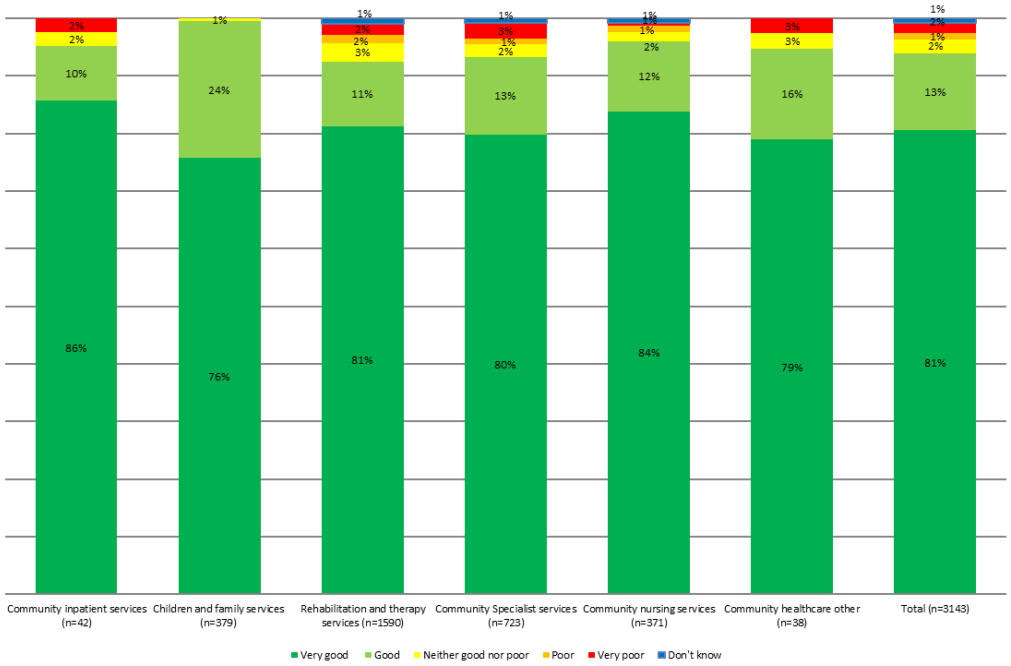
	Positive Themes	Negative Themes
Community	1. Staff 2. Access and waiting times 3. Communication	1. Staff 2. Access and waiting times 3. Admission and discharge
Mental Health	1. Staff 2. Communication 3. Patient care	1. Staff 2. Communication 3. Access and waiting times
Trust wide	1. Staff 2. Communication 3. Access and waiting times	1. Staff 2. Communication 3. Access and waiting times

Mental Health Service Friends and Family Test Results 2021 / 2022



84% of respondents rated the service they received as either ‘very good’ or ‘good. 11% rated the service as ‘very poor’ or ‘poor’. The percentages for those who would rate the service as ‘very good’ or ‘good’ fell below the 85% target by 1%.

Community Service Friends and Family Test Results 2021 / 2022



94% of respondents rated the service they received as either 'very good' or 'good. 3 % rated the service as 'very poor' or 'poor'. The percentages for those who would rate the service as 'very good' or 'good' fell below the 98% target by 4%.

New and continued developments for 2022/ 2023 are:

- Development of Patient Experience representatives across the Trust to support the Patient Experience agenda.
- Expanding the text messaging service across Community Health
- Continue to work with teams to develop a practical way to collate actions being taken across the Trust to demonstrate the changes that are being made because of feedback.
- Work with other support services to triangulate insight to inform quality improvement.
- Ensuring that feedback methods are accessible to service users, carers, and families.

CARING Quality Initiative – Equality, involvement, communication and membership

What we Prioritised

We focused on implementing the objectives of the Equality Strategy.

What we did

The Trust's integrated approach to equality, involvement, communication, and membership has ensured that we have continued to address inequalities, build a culture of diverse leadership, stronger voice and advancement of opportunity and allyship and deliver on our inclusion agenda.

Equality is about creating a fairer organisation in which everyone can fulfil their potential and diversity is about recognising and valuing difference in its broadest sense. This means treating everyone with fairness and understanding, not necessarily treating everyone the same. Our aims are that:

- Every person living in the communities we serve knows that our services are appropriate and reflect the population we serve

- Our workforce reflects communities, ensuring our services are culturally appropriate and fit for purpose.
- Service users, carers and families receive timely and accessible information and communication, ensuring a person-centred approach to care.
- Our services are co-created and designed with our staff and communities

The Equality, Involvement, Communication and Membership strategy (EICM) is available on our website including as an animation and in easy read. It sets out the core components that enable us to deliver a clear and comprehensive approach to meaningful involvement and inclusion.

The Trust is committed to being responsive and supporting the needs of the diverse population it serves, reflected in the Trust's values., it is central to all we do. The people who use our services are diverse and often represent the most deprived and under-served members of our community in terms of both health and social circumstances. To ensure we respond to this and comply with our statutory responsibilities under the Equality Act 2010, especially the Public Sector Equality Duty, (PSED) and the Health and Social Care Act 2014 we are committed to ensuring equality and involvement are at the core of service delivery and decision-making.

The Equality, Inclusion and Involvement (EII) Committee oversees the Strategy, its implementation and has delegated responsibility for signing off annual action plans. It includes people who use, work and volunteer for our Trust services and those who work in partnership with the Trust with the strategic aim of improving health, care, resources and making our Trust a great place to work.

Our continued work with our communities and partners means we are starting to hear the voice and views of all our communities in the development, design and delivery of services. This year to strengthen our approach the Trust formally approved an Equality Inclusion and Involvement (EII) Sub-Committee to support the EII Committee to further ensure the Trust collectively addresses and understands wider health inequalities and involvement.

This year the Trust has measured progress against the outcomes defined in the EICM strategy for 2021/22 and produced an annual report which sets out this year's progress. A copy of the annual report can be found here: Equality-and-Diversity-annual-report-2020-to-2021-FINAL.pdf (southwestyorkshire.nhs.uk):

We know we have got it right when	Our progress
We can demonstrate an improvement in outcomes and experience for people who use our services.	• The Trust have co-designed and launched a carer's passport which is now being rolled out. The passport will ensure that carers get the support they need. • We continue to support people's religious and spiritual needs by providing a multi-faith room in our inpatient settings • Co-action study to identify cultural competency in both forensic and CAMHS and a chance to replicate the approach in other services • We have reviewed ourselves against the Accessible Information Standard to ensure that people who have a disability, impairment or sensory loops receive information in a way they can access and understand, and any communication support that they need is identified and provided whilst continuing to work in partnership with Language Empire, our interpreting, translation, and transcribing provider.

	• As part of Active Calderdale, we have employed a change and innovation facilitator to work alongside our community teams to get physical activity embedded into care plans. This post is a new role and the postholder has developed a collaborative plan for this work. • We work closely with our Advocacy partner organisations to gain insight about the experience of those who access our services. The Acute Care Forums in Barnsley and Wakefield have representatives from the Advocacy Services in attendance. • We have reviewed our communications request form to include the ten most common translation requests and request this at the design stage so JPEG documents and a large print statement can guide people to accessible versions. • Digital inclusion work progressing including the launch of 'CHATPAD' on all wards to support contact with loved ones, advocacy and capturing views • Continued compliance of mandatory equality training at 95% throughout the pandemic and a specific focus on Trans Awareness through training, together with an annual celebration event arranged by the BAME staff network to support understanding of systemic racism • Dedicated piece of work to develop a data set to inform access, waiting times starting with people from a BAME background	
We can demonstrate meaningful engagement with communities to understand population needs, strengths and experiences.	• The development of a co-created integrated strategy for 'Equality, Involvement, Communication and Membership' and accompanying annual action plans • Ensuring that our Trust wide Digital strategy has a strong focus on our communities and protected groups to address digital exclusion and promote digital inclusion • Working as a partner in the wider ICS systems to develop and drive campaigns such as 'looking out for your neighbour', 'suicide prevention and awareness' and 'root out racism'. This includes being part of a hate crime podcast and other promotional materials and films featuring Trust staff • Our 'Choose well for mental' health guide was co-designed with staff, service users, carers and families and is available on our website to download. This includes and easy read and Urdu version Choose well for mental health - South West Yorkshire Partnership NHS Foundation Trust • The Trust value led recruitment approach recruits public panels resulting in a diverse range of service users, carers and volunteers who are now able to attend recruitment of senior roles (band 7 and above). This means that there is BAME representation on all senior appointments which will be extended to all key appointments • Recovery colleges in each of our places Barnsley, Calderdale, Kirklees, and Wakefield have invested in a dedicated website – the website went live in July 2020 during the pandemic to ensure people can continue to access courses as a part of a digital offer. • An investment in the Third Sector to map and support relationships with communities in each of our places to ensure we reach diverse groups	

	• The development of a quarterly insight report including equality themes to capture feedback from communities, Governors, and partners such as Healthwatch • The Calderdale Creativity and Cultural programme has been developed over several years, following the approval of the living a larger life creativity arts and culture strategy that was supported by the Calderdale Health and Wellbeing Board.
The Trust has a representative workforce that demonstrates we are reflective of our population and exemplars in employing people with lived experience.	• Dedicated Equality and Inclusion Task Force and BAME staff workforce Taskforce to support our work to address health inequalities through the pandemic, including leading on dedicated BAME workforce support, accelerated risk assessments and a dedicated intranet and staff for Occupational Health and a BAME workforce WRES lead. • The Trust has further developed a coaching and mentoring framework. This includes the provision of coaching via 'Crucial Conversations', 360-feedback, peer coaching and executive coaching programmes to which we have added medical mentoring and reciprocal mentoring for and from our BAME colleagues. • A new staff network for carers, partner network for carer organisations and the launch of a carer's passport which resulted in the appointment of a dedicated carers lead for the Trust Carers-passport.pdf (southwestyorkshire.nhs.uk) • A dedicated programme of work to roll out recruitment of Peer Support Workers and ensure lived experience is part of our approach has resulted in the development of a dedicated training programme and increase in internal posts. Peer support workers - South West Yorkshire Partnership NHS Foundation Trust • The Trust remains committed to Project Search in partnership with Mid Yorkshire Hospitals NHS Trust. The project is a pre-employment programme which helps young people with learning disabilities gain the skills they need to obtain meaningful paid employment. Due to COVID-19 restrictions an internship has not been possible, however, the commitment remains, and we intend to offer an internship when possible.
All services will have an equality impact assessment (EIA) with annual review and delivery of actions monitored through governance arrangements.	• A focus on using and improving equality impact assessments (EIA) to drive our work including a dedicated COVID-19 EIA to ensure impacts during the pandemic were collated and impacts mitigated against • A quick decision EIA and process to ensure decisions made during the pandemic considered impact as part of urgent planning • Ongoing monitoring of EIA compliance
All change programmes will be co-produced where appropriate and include equality considerations informed by EIA.	• A recovery and reset toolkit for staff which includes a clear steer on ensuring equality, diversity and insight is central to decision making • A clear process for change programmes using a checklist and dedicated inbox to assess EIA and approach for involvement at the beginning of a programme of work

We will improve data capture and accuracy of recording in respect of protected characteristics, monitoring of service access by ethnicity in relation to the local population.	• Targeted work to encourage staff whose disability data is recorded as null/not known to update their status on ESR resulting in a significant reduction in the percentage of staff with an undeclared/unknown status. • Improvements in collecting and reporting on equality data during the pandemic and for use in service settings, including a live dashboard for vaccine roll out and take up • Progress of a campaign to increase data collection
Services will evidence equality considerations in support of Equality Delivery System (EDS2) to demonstrate how driving equality improvements can strengthen accountability to service users and the public	• Completion of EDS2 Goals 1 and 2 includes our Workforce Race Equality System (WRES) and Workforce Disability Equality System (WDES) data and survey results. • Completion of EDS2 Goals 3 and 4 includes 2 workshops that involved the voice and views of 42 stakeholders reflective of our geography and population. A range of evidence was presented • Overall Trust grading for EDS2 was 'Achieving'
We will monitor any complaints and reported incident about access to services where discrimination was a factor.	• Monitoring systems in place using DATIX recording to identify and flag incidents • Process in place to ensure incidents are recorded and reported and individuals supported
An increase in positive stakeholder perceptions via Friends and Family Test and feedback via customer services and dedicated surveys.	• Capturing consistent equality data when gathering views and patient experience in line with census • A Trust-wide survey toolkit to support the collection of patient experience and feedback allowing for a central collection of data and equality monitoring ensuring insight is reflective and equality themes highlighted
Our staff wellbeing survey results see improvements in feedback regarding equality of opportunity in training, support and career progression.	• The Moving Forward Plus programme is a development programme for staff who are from Black, Asian minority ethnic and other under-represented communities who want to develop their leadership capability. It consists of a series of workshops and development tools for participants to undertake to further develop and enhance their leadership skills. We currently have 22 staff on the programme. • Our Shadow Board programme provides development for aspiring system leaders wanting to gain knowledge and experience about the roles and functions of a Board. The programme consists of workshops covering a number of topics including role of Board; strategy; finance & governance; system leadership. The programme also included shadow Board meeting facilitated by board members. Peer coaching is a critical part of the programme

	to support aspiring leaders' development. We currently have 10 participants on the programme at band 7 and above • We further developed the leadership programmes for medical & clinical leaders in 2020/21 including further Masterclasses, access to 'Introduction to Leading & Managing' and launched a 'Medical Leadership Development Programme' in January 2021 for new medical consultants. • A review and refresh of our Leadership & Management Development strategy has been completed. 'Stepping Up' and 'Ready Now' programmes are embedded into our Leader & Manager Pathway. Access for staff will continue when NHS Leadership Academy programmes resume these programmes, post-pandemic. • As a Trust, we piloted a Reciprocal Mentoring programme in 2019/20, subsequently incorporated into our refreshed Leadership and Management Pathway with two further cohorts commencing in May 2021, access to which has also been extended to staff with protected characteristics.
NHS staff survey feedback will report increased staff satisfaction with equality of opportunity.	• The Trust has also established a clinical network, called Race Forward, to reduce bullying and harassment from service users and carers on staff from BAME backgrounds. As part of this, we are recruiting to a new role to drive this forward and review all staff incidents that relate to protected characteristics in the weekly Clinical Risk Panel to ensure senior oversight. • Workplace health and wellbeing has been a key priority for 2021/22. Actions included dedicated BAME staff members and intranet support during COVID-19 pandemic • Building on the previous work undertaken to tackle bullying and harassment issues we are establishing and developing civility and respect champions across services and teams to support local action plans and improve team cultures. A champion has been recruited from the disability staff network.

What next?

- Ensure we gather good quality data which can be used to support performance monitoring of service use and improve outcomes among those from the most deprived neighbourhoods
- Ensure we provide person centred care which promotes inclusive, culturally and gender sensitive services, delivered by a diverse and representative workforce who seek to understand and pro-actively address inequalities and challenge discrimination
- Ensure we work in partnership with partners and communities including the voluntary, community and faith sector to improve access to services and ensure those from our most deprived neighbourhoods have equal access to pathways of care
- Develop and sustain an equality competent organisation that demonstrates inclusive and diverse leadership and workforce addressing the balance of power and ownership at all levels and improve equality of opportunity for staff and volunteers
- To ensure people who access health and social care services, families, carers and the public are involved in shaping health and care proposals and plans. To use what we already know as a starting point, so we do not repeat conversations or create involvement fatigue
- To use equality and demographic data to ensure we inclusively involve the right people at the very beginning of a process in order to influence the development and design of services
- To use the assets in our communities and create the right conditions to involve local people, going to where people and ensuring they remain involved

- To ensure we are an exemplar in co-production - through equal and reciprocal relationships with communities and professionals; recognising that both partners have vital contributions to make and ensuring we have a clear reward and recognition approach
- To record, report and publish insight so people can see the information driving our service decisions and actively demonstrating how we are using the intelligence we capture to deliver service improvement and patient centred outcomes

Quality Priority - RESPONSIVE

Providing services that are responsive and personalised – shaped by what matters to people, their preferences and strengths; empowers people to make informed decisions and design their own care; coordinated; inclusive and equitable.

Responsive quality initiatives in 2021/22

The quality initiatives prioritised for action in 2021/22 as part of the quality account process were as follows:

- Waiting times – Learning disability
- Improve access to Child and Adolescent Mental Health Services (CAMHS)
- Reducing the number of people inappropriately placed in Out of Area beds
- Complaint closure and resolution times

RESPONSIVE Quality Initiative – Learning Disability waiting times
What we Prioritised We focused on reducing waiting times for assessment and treatment in community Learning Disability services. During 2021/22, a number of initiatives improved waiting times for first assessment and treatment however the pandemic, coupled with issues such as difficulties in the recruitment and retention of staff in Learning Disability (LD), had led to increases in the number of people waiting.
What we did The Trust delivers community Learning Disability (LD) services in four different geographical areas and runs a specialist in-patient assessment and treatment unit called the Horizon Centre. Each community service has a multidisciplinary model for routine care, and Intensive Support and Psychiatry which offer an immediate response to people who are experiencing a crisis. Access has been maintained to assessment however it is understood that service users and carers have been reluctant to be seen due to the risk of catching COVID-19, pushing up waiting times for treatment. The evidence tells us that people with a learning disability have been significantly adversely impacted during the pandemic. Dynamic risk registers are used for people assessed as being at high risk and welfare calls were implemented whilst people are waiting to be seen. This has allowed teams to assess and respond to need, fast-tracking people for support where required. The Trust has also increased Quality Monitoring and Quality Audits to keep track of performance against standards and revised Business Continuity Plans. During 2021/22, all community teams have strengthened the service offer by: • Implementing the use of the Formulation-Informed Risk Management (FIRM) risk assessment

- Creating a new Standard Operating Procedure for the use of a Care Planning Approach (CPA)
- Implementing innovative roles to advocate for and support people to live independently. Health Facilitators are now working in Wakefield to help people navigate systems and support them in accessing care such as annual health checks or screening appointments, ensuring that other services have made reasonable adjustments. These roles have now been recruited to in Kirklees and Calderdale. Calderdale also has an innovative Matron role who is working across residential homes, supporting higher quality care and personalisation
- Promoting the Friends and Family Test within learning disability services
- Reviewing the service with engagement of staff with recommendations to follow
- Working alongside Primary Care to increase COVID-19 vaccination of people with a learning disability
- Continuing to work with partners in Kirklees to support people living with a learning disability and additional needs such as mental health problems or dementia.
- Continuing to work with Children's Services in each area to develop processes to prepare young people for transition to adult services, supported by dynamic risk assessment. The Transition pathway has been mapped across the four Community LD teams in each area that the Trust covers to understand the local variation. A Transition group is overseeing improvement work on Transition and a Standard Operating Procedure is currently being ratified.
- Establishing a working group to use the Greenlight Toolkit Audit as a basis for service improvement.

During 2021/22, The Horizon Centre has strengthened the service offer by:

- Introducing the use of the FIRM risk assessment
- Introducing daily safety huddles
- Reviewing and strengthening the CPA process
- Recruiting Advanced Nurse Practitioners
- Introducing a newsletter to share good practice and updates
- Introducing an LD-focused induction package
- Implementing more inclusive staff meetings
- Introducing staff wellbeing groups to support resilience and signpost for additional support including Occupational Health services
- Introducing additional training following a training needs analysis
- Promoting the Friends and Family Test
- Starting quality improvement work on risk assessment, care planning, supervision passports
- Introduced support from specialist teams to review clinical activity and offer supplementary support and training

Funding has been agreed for additional and more recruitable positions such as Strategic Health Facilitators in Calderdale and Kirklees that are now in post and a care home Advanced Nurse Practitioner in Calderdale that enhances the support offered to people with a Learning Disability in care homes. These posts have alleviated some of the pressures on our community teams in addressing specific health needs.

What next ?

- We will continue to work with our partners across all communities to support people living with a Learning Disability in order to reduce duplication and improve efficiency across the partnership.

- We will continue to work with Children's Services in each area to develop processes to prepare young people for transition to adult services, supported by pathways as well as the dynamic risk register processes.

- Our priorities for 2022/23 include:
    - Embedding risk assessment
    - Revising the CPA process

- Developing and establishing new roles

RESPONSIVE Quality Initiative – Improve access to Child and Adolescent Mental Health Services (CAMHS)

What we Prioritised

We focused on improving waiting times from referral to treatment. Our aim is to ensure that children and young people experiencing emotional and mental health wellbeing difficulties have early access to the right support, at the right time and in the right place.

Improving waiting times from referral to treatment in CAMHS remains a Trust, commissioner and national priority. Previous Care Quality Commission (CQC) inspection identified that waits were a concern, particularly given the potential risk that children and young people may experience a worsening of their mental health when waiting.

What we did

- Significant progress had been made in reducing waiting times for treatment over the past three years across CAMHS.
- In more recent times progress has been affected by the COVID-19 pandemic as referral rates have increased and the capacity within the service has been affected due to COVID-19 procedures. This situation is in line with the national picture.
- Appointments have continued by telephone and video-link (digital solutions).
- Face to face support has also been provided based on service user choice and clinical need.
- Face to face support is increasing due to increased clinical need
- Referral levels remain increased with more referrals for children in crisis and with complex needs.
- Care packages are more wide-ranging and lengthier to meet the needs of children including those who have experienced a delay in admission to an inpatient hospital bed. This includes intensive home-based treatment.
- There has been an increase in referrals for children with eating disorders.
- The services have faced challenges in recruiting staff despite funding being available.
- A CAMHS Bronze-level control group has continued to meet weekly, as part of the emergency command structure.

Information on current numbers waiting in CAMHS pathways in each area is monitored by the Board and internally within Trust governance system. In order to address the increasing waits, the following work has been undertaken during 2021/22:

Service evaluation - 'Changing the Ways We Work'

- Digital technology (telephone and video) was highlighted as positive for most children/families
- The risk of 'digital exclusion' with the potential disproportionate impact on the most vulnerable has been highlighted
- The initial satisfaction with digital appointments during the pandemic has begun to reduce with an increasing number of families requesting Face to Face appointments.
- Family Therapy has proved successful via Video link
- The virtual approach to groups offered by Barnsley CAMHS is valued by children and families

Waiting list initiatives

- Capacity has been temporarily increased through additional investment.
- Most initiatives have been maintained throughout the pandemic with ongoing review of care pathways to ensure they are efficient and effective.

- In Wakefield an assessment team pilot has been implemented which improves how decisions are made at the point of referral. This was nearing completion however has been affected by the temporary staff in the pilot leaving in Dec 2021. Further funding has been secured to continue the pilot and recruitment is being progressed.

Important Developments

- Wakefield CAMHS now have a Community Mental Health Support Team (MHST) which will support children with mild/moderate mental health needs and is currently in the recruitment phase
- Wakefield CAMHS are increasing the group work offer
- Barnsley CAMHS have reviewed the pathway for Attention Hyperactivity Deficit Disorder (ADHD) which includes flexible approaches such as technology and the use of varied staff in teams. This includes the launch of the 'QB test' (a computer-based test to measures symptoms of ADHD) in February 2022. Funding has also been secured for Non-Medical Prescribing posts.
- The Kirklees Community Mental Support Team (MHST) has strengthened the school-based support available for mild/moderate mental health needs. A further phase will see team capacity increase across 50% of Kirklees schools and have a positive impact for children and schools. It is expected this will further reduce the referrals to Specialist CAMHS.

Neurodevelopmental pathways in Calderdale and Kirklees

- In 2022/23 investment has been made into Neurodevelopment Assessment services in both Calderdale and Kirklees.
- In Calderdale, the enhanced service has been funded to deliver 21 assessments per month from December 2021. The service has exceeded this amount since then and the total caseload on the waiting list has reduced from approximately 400 to 350.
- The Kirklees Neurodevelopmental service has recently been going through a relocation to the Princess Royal site in Huddersfield which will become operational from April 2022.
- The Kirklees SWYPFT service has been commissioned to deliver 43 assessments per month from the point it can fully recruit into the team. Recruitment is still ongoing into the service, and although it has recently delivered close to the target amount, it will only be able to consistently achieve this when vacancies are filled.
- As well as this, 2 external partners were commissioned as part of a waiting list initiative to reduce demand. One of these commenced assessments in October 2021 and the second, Clinical Partners, has now withdrawn. In the 6 months, the backlog initiative has delivered 92 assessments.
- However, in this same period, referrals have been coming through at an average of well over 100 per month and this has seen the overall waiting list increase from approximately 800 to over 1,100 children and there remains a gap between referrals and commissioned capacity.
- Priority work now includes working with the local single point of access in Kirklees, Northorpe Hall, to better understand demand, the backlog of referrals they hold, and reasons for the recent increase as well as ensuring our service can operate at the commissioned level at the new site.

What next?

- Ongoing review of business continuity plans and agreement of a re-set position
- Optimising level of recurrent investment in strengthening CAMHS capacity and addressing gaps in levels of investment to meet demand (within developing Integrate Care System (ICS) level arrangements
- Agreement and implementation of business cases regarding neurodevelopmental pathways
- Further Business cases to address the challenges in meeting the needs of children in Crisis and those with eating disorders are planned for 2022.

RESPONSIVE Quality Initiative – Reducing the number of people placed in Out of Area beds

What we Prioritised

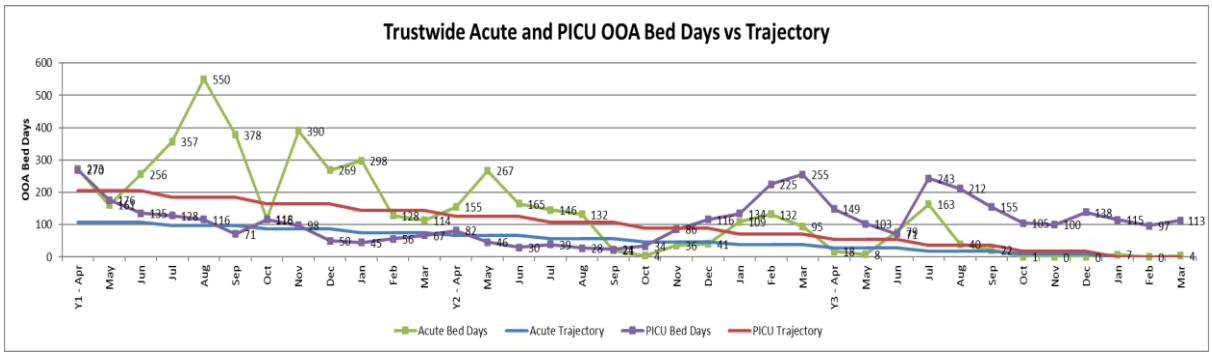
We focused on sustaining reductions in the number of people placed in beds out of area. As a Trust we use out of area beds for several reasons, including:

- When a patient requires a single sex psychiatric intensive care unit bed, which the Trust cannot facilitate
- When local demand exceeds available beds in the Trust, in spite of all efforts to make best use of Trust beds.

What we did

Prior to the pandemic, the Trust had a successful quality improvement programme focused on the aim of reducing out of area (OOA) bed days to 0 by April 2021. In 2019/20, OOA bed days reduced by 50% with further improvements evidenced in 2020/21. The quality improvement programme focused on whole system improvements across both acute and community pathways.

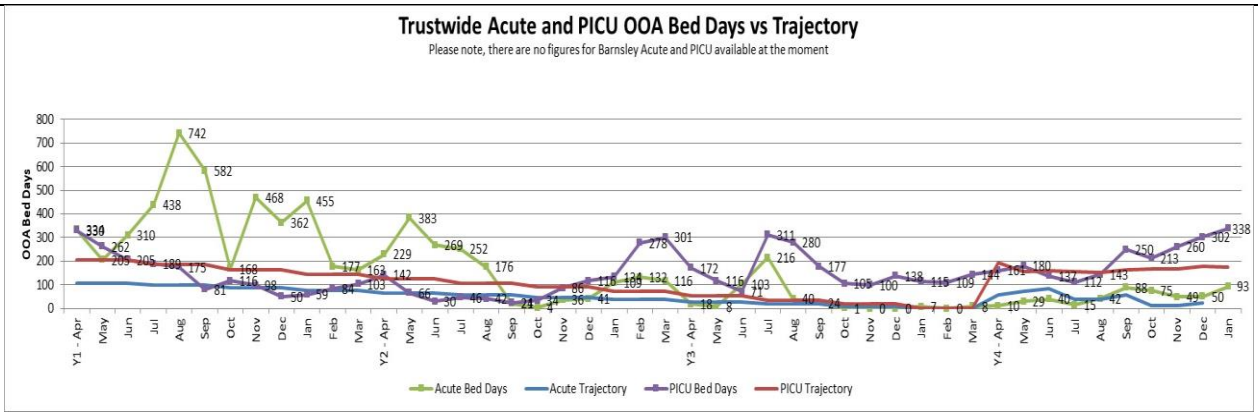
The chart below shows the performance toward the trajectory as of March 2021. Whilst the acute placements did achieve the initial trajectory, there remained a need for some PICU out of area beds, most of which were gender specific needs (therefore not commissioned for us to provide):



Through 2021/22, a number of new factors emerged that are now having an impact on us being able to continue to reduce OOA placements to anticipated levels. Many of these factors link to the inpatient pressures and include:

- Ongoing higher demand and higher mental health acuity in the system.
- Workforce challenges (as identified by the inpatient programme), including medical colleague recruitment. This has led to some wards recently limiting the numbers of admissions they can take
- COVID-19 pressures impacting on staff absence.
- Infection prevention and control (IPC) restrictions in place for us as a healthcare provider, together with the ongoing presence of COVID-19 / outbreaks – with the numbers of COVID-19 related restrictions having a significant impact, This was further exacerbated in late 2021 / early 2022 with the omicron variant COVID-19 outbreak and has also led to various wards have had periods where they've been required to be closed to admission.

The chart below shows the updated position to end of January 2022, with both acute and PICU bed use increasing, particularly from August 2021 onwards.



In the wider care system, national demand has increased for OOA beds against limited supply, with many other provider Trusts experiencing these challenges sooner than us and block buying private sector beds, which has affected timeliness and location of placements, with increasing financial costs to the Trust and increasing numbers of placements further away from people's home.

The Trust has recently agreed to set a trajectory of now achieving zero out of area placements by September 2022. However, there is still an expectation that gender specific placements will be required even then, and NHSEI would expect a plan to address this.

As such, to achieve this zero we are likely to need to apply the continuity of care principles, which are a set of good practice principles and mean that if an agreed operating procedure can be put in place, a placement with an out of Trust provider would not be reported as out of area because it would meet the same levels of continuity of care as a placement within the Trust bed base. This is in line with the practice of other NHS trusts.

Towards the end of 2021/22 data showed that the flow of patient discharges from the wards had reduced and the Trust was discharging fewer people every week. A priority for the programme now is to take action to establish greater flow across the wards which will create the capacity to cease placements and repatriate people from out of area placements where appropriate.

The programme has also identified that proactive action is required now to ensure that the current service users in out of area placements are discharged or repatriated in a timely way.

A separate programme board has been established to focus on the new corporate priority to address inpatient challenges and this focusses on workforce challenges and ensuring the right interventions for people on the wards.

What next ?

- Active action to move people in a timely way.
- Coordination and input into current Out of Area beds
- Ensuring effective role of home-based treatment and community services in timely flow.
- Agreeing continuity of care principles
- Inpatient programme priorities (managed via the separate governance) to support effective ward management.

RESPONSIVE Quality Initiative – Complaint closure and resolution times

What we Prioritised

Efficient and effective handling of complaints ensures that NHS organisations continuously review and improve the quality and safety of the care they deliver.

In 2021/22, we focused on meeting and exceeding the national standards for closure and resolution times for complaints. Our aim was to exceed the NHS Complaints Regulations 2009, which stipulate that a response should be provided within six months from the date it was received.

What we did

In 2021/22, COVID-19 continued to impact on the improvements we had made on our complaint response times in 2019/20, and it was not possible to sustain the improvement in achieving the 40-day timescale for responding to complaints. In response to the challenging circumstances that COVID-19 pandemic has posed, a trial of complaint response times based on the complexity of the complaint was implemented in May 2021 to July 2021; this was extended and is currently being evaluated

Levels	Acknowledgement (days)	Response Timeframe (days)
1 Informal concerns	1-3	3-5
Members of Parliament	1-5	10
2 Minor	3	25
3 Moderate	3	40
4 Complex	3	60

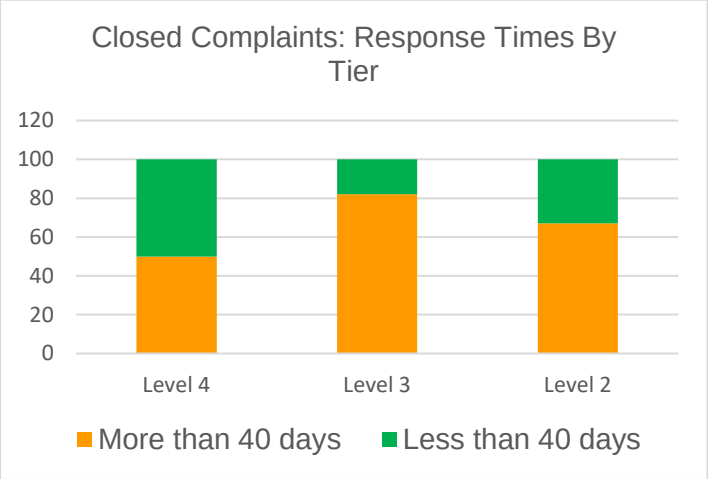
Initial findings indicate that the tiered approach has improved adherence to expected response times and has ensured that where possible, complaints are dealt with directly by the service involved. It has helped to better manage complainant's expectations as the NHS Complaints Regulations 2009 stipulate that a response should be provided within six months from the date it was received. The Parliamentary Health Services Ombudsman (PHSO) is guided by this and simply asks that organisations keep complainants updated about when they expect to respond.

Data for 2021/22

Number of complaints closed = 87

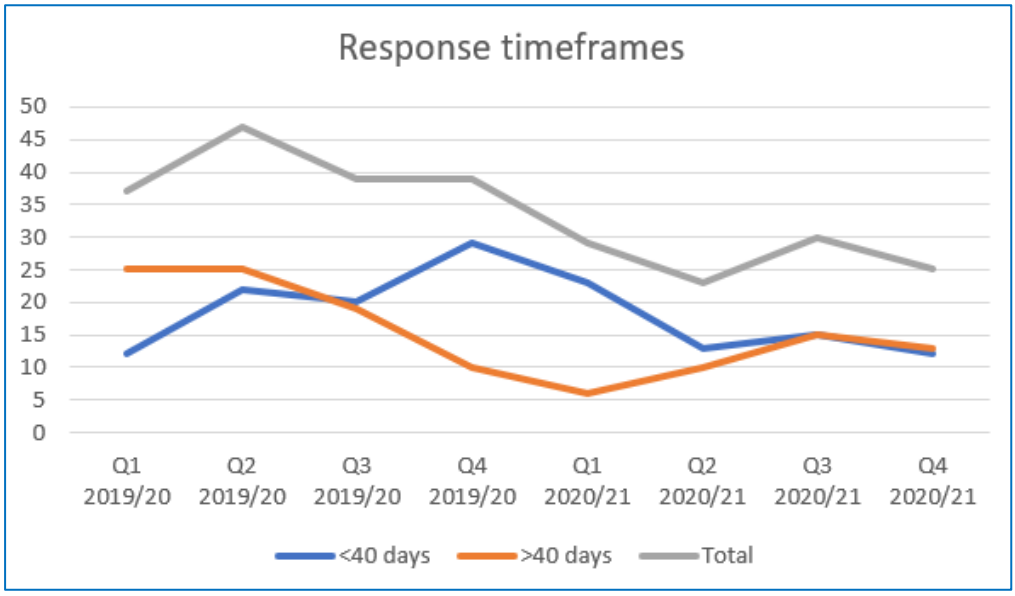
Between May 2021 and January 2022, 87 formal complaints have been closed. Of these, 66% exceeded the Trust's original target of closing within 40 working days and 34% met the target.

Response times for tiers



During 2021/22, our ability to meet the target response times for all tiers has been affected. Our analysis of the complaint pathway shows that the main reason for delays both internally and where external partners are involved was staffing pressures due to COVID-19, and we are also reviewing bottlenecks in the process to find ways to improve.

Response times



The performance of our response to complaints within 40 days fluctuated throughout the period as frontline staff maintained their priority focus of working to maintain safety for people who used our services in responses to the changing landscape of the pandemic.

We were unable to meet the 40-day target for a number of reasons:

- Clinical capacity to allocate complaints investigations
- Delays receiving the completed investigation (toolkit) from clinical services
- Complexity in complaints – complaints over many services and departments which are protracted and multifaceted
- Delays in the sign off process
- Capacity in customer services to manage complaint demands

What next?

- Running a programme of engagement events across the Trust to ensure that the process is understood.
- Implementation of an electronic survey of people who have raised a complaint and with partner organisations to give us a better understanding of their experience of the process and the extent to which the resolution met their needs. This insight will inform continuous improvement of the complaints process.
- Making improvements from feedback: Customer Services work closely with lead investigators to ensure that any learning from feedback is identified
- Delivery of a Trust wide complaints training programme
- Continue to monitor outcomes by tracking the number of complaints reopened and those referred to the Ombudsman.

Quality Priority – WELL-LED

A well led organisation is driven by collective and compassionate leadership, which champions a shared vision, values and learning; delivered by accountable organisations and systems with proportionate governance; driven by continual promotion of a just and inclusive culture, allowing organisations to learn rather than blame. By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Well-led quality initiatives in 2021/22

The quality initiatives prioritised for action in 2020/21 as part of the quality account process were as follows:

- Quality Dashboard development
- Learning lessons and feedback from incidents
- Quality assurance and improvement accreditation scheme

WELL-LED Quality Initiative – learning lessons and feedback from incidents

What we Prioritised

Continuous improvement of our systems for learning from incidents and feedback.

What we did

In 2021/22 we were unable to make as much progress with this as planned due to the impact of COVID-19, which limited capacity throughout the organisations and had an especially significant effect on wards.

Learning takes place at different levels in the organisation – in teams, facilitated by Quality Governance leads; across services and across the entire Trust. All serious incidents are reported and learning cascaded.

The Patient Safety team support effective learning, embedding principles of a Just Culture in the reporting and review of all incidents. During 2021/22, we successfully ran a Trust-wide learning event (these events are planned to run every six months). In addition we have:

- Completed a thematic review of the five fatal choking incidents and will be running a learning event in May 2022. The Trust-wide strategic improvement plan will support ongoing continuous improvement in managing choke risk.
- Commissioned our internal auditors, 360 Assurance, to undertake a review of our serious incident action oversight, and will implement an improvement plan in response to our learning from this in 2022/23
- Reviewed our oversight of serious incident investigations, to ensure senior clinical oversight at all stages, and consistent application of the root cause analysis model replace with Systems analysis model, we don't use term RCA anymore
- Established the Trust's complex case review group to ensure close overview of a number of serious incidents, with direct reporting to Trust Board.
- Continued to share Blue Light Alerts across the Trust, in response to serious incident learning either locally or nationally
- Supported the Trust's Senior Matron to contribute to national developments around the best practice in managing in-patient ligature risk
- Continued with improvements to Trust ward areas, including a programme to roll out anti-barricade doors across bedrooms that also have a door top sensor to alert staff should a person be using the door to ligate.
- We have identified two Patient Safety Specialists in the Trust in line with the NHS Patient Safety Strategy to provide senior leadership, visibility, and expert support with patient safety work including improving our safety culture and systems and processes, and ensuring that the patient is at the centre of all patient safety activity.
- Patient safety training level 1 (essentials for all staff) and level 2 (access to practice) have been developed by Health Education England and is available to staff. The training supports understanding how all roles support patient safety, learning and improvement and foster a culture of openness and safety. Work is underway to develop a business case to support the training delivery.
- We have reviewed our Incident reporting system to ensure the experience of reporting is efficient and user friendly for staff.
- We have improved the way we theme serious incident actions to enable better extraction of data for further analysis. This work will continue in 2022/23.

What next?

- Refresh our approach to learning based on the Patient Safety Incident Response Framework (PSIRF), and include learning from excellence in our systems
- Improve team-based learning, sharing best practice across the Trust
- Run Trust-wide learning events in response to emerging learning from serious incidents
- Systematise the reporting of learning captured at team level, ensuring that learning is routinely recorded and shared in a central resource bank

WELL-LED Quality Initiative – Quality dashboard development

What we Prioritised

Continuing improvements to dashboards and their use. Roll out to new services.

What we did

The Trust has an ongoing programme of work to support the effective use of data within services and to support assurance and improvement. We have developed a range of ways that data can be used to support both operations and performance review.

At a corporate level, performance is monitored through the Integrated Performance Report which is made up of a selected set of indicators and includes a sub-set of indicators about quality. Metrics are aligned to Trust objectives and CQC domains and each metric has a director-level 'owner'. This ensures there is appropriate accountability for performance and helps identify how achievement of our objectives is being measured. This information is reviewed within the governance structure including at Board, and is available publicly. A copy of our Trust Board Quality dashboard can be found at https://www.southwestyorkshire.nhs.uk/about-us/performance/performance-reports/.

Services also have access to data dashboards such as:

- Inpatient White board – shows a view of all current inpatients and dates when risk assessments, care plans etc have been undertaken, expected discharge date, MHA status along with other relevant data items.
- CAMHS dashboard – this is widely used by CAMHS services to monitor performance against a number of metrics such as number of referrals received, emergency referrals, response within 4 hours, assessments, treatment, along with some quality indicators such as compliments, complaints, mandatory training compliance, IG breaches.
- Team dashboards – The Team Dashboard allows easy visualisation of data at team level, as well as benchmarking with other teams.
- HCP Dashboard - The Health Care Practitioner (HCP) Dashboard contains data on contacts and appointments at an HCP

During 2021-22, the Trust has:

- Created a dashboard for Neighbourhood teams in Barnsley which provides activity and quality data and which supports management and performance review and effective reporting to commissioners. The dashboard is widely used by team and service managers, and has also enabled the service to improve data quality.

What next?

We will use these dashboards to complement the development of the self-assessment quality scheme. This will provide teams with a body of evidence to review when they undertake this self-assessment.

Continuously improve the dashboard each year to ensure it aligns with the Trust's Quality Priorities and objectives

WELL-LED Quality Initiative – Quality assurance and improvement accreditation scheme

What we Prioritised

In 2020/21 the proposal was that, for the inpatient services across the Trust, quality monitoring visits would be replaced by the quality scheme, a self–governing accreditation assurance and improvement framework.

Due to the ongoing impact of COVID-19, increased acuity on the wards and staffing pressures both clinically and corporately there has been a pause in the roll out of the Scheme.

The Quality Scheme is intended as a 2-year programme, with 12 Quality Scheme standards that teams

would have to demonstrate they are meeting. This internal accreditation tool, linked to the CQC fundamental standards, aimed to empower teams to recognise their areas of strength and to identify their own gaps in practice, adopting a continuous model of improvement.

What we did

An implementation plan for the full roll out of the quality assurance and improvement accreditation scheme was developed in February 2020 and presented to our clinical governance and clinical safety committee for approval. The schedule was due to commence in April 2020, which was delayed by COVID-19. The Quality Scheme has successfully been piloted on Willow Ward with good feedback from the ward manager on the process. However, due to the ongoing impact of COVID-19and the omicron variant, there has been no further roll out of the Quality Scheme at this point.

The Trust continues to have a good governance system for assuring the quality of services. Ongoing assurance is provided through:

- A continued programme of Quality Monitoring visits (QMVs), including in-patient areas that would have been utilising the Quality Scheme
- A responsive approach to ensure risk based QMVs are scheduled and prioritised
- Improvement Plans from visits monitored by BDUs in their governance groups
- Improvement plans reported and updated in the Clinical Governance Group
- Oversight into the clinical governance and clinical safety committee

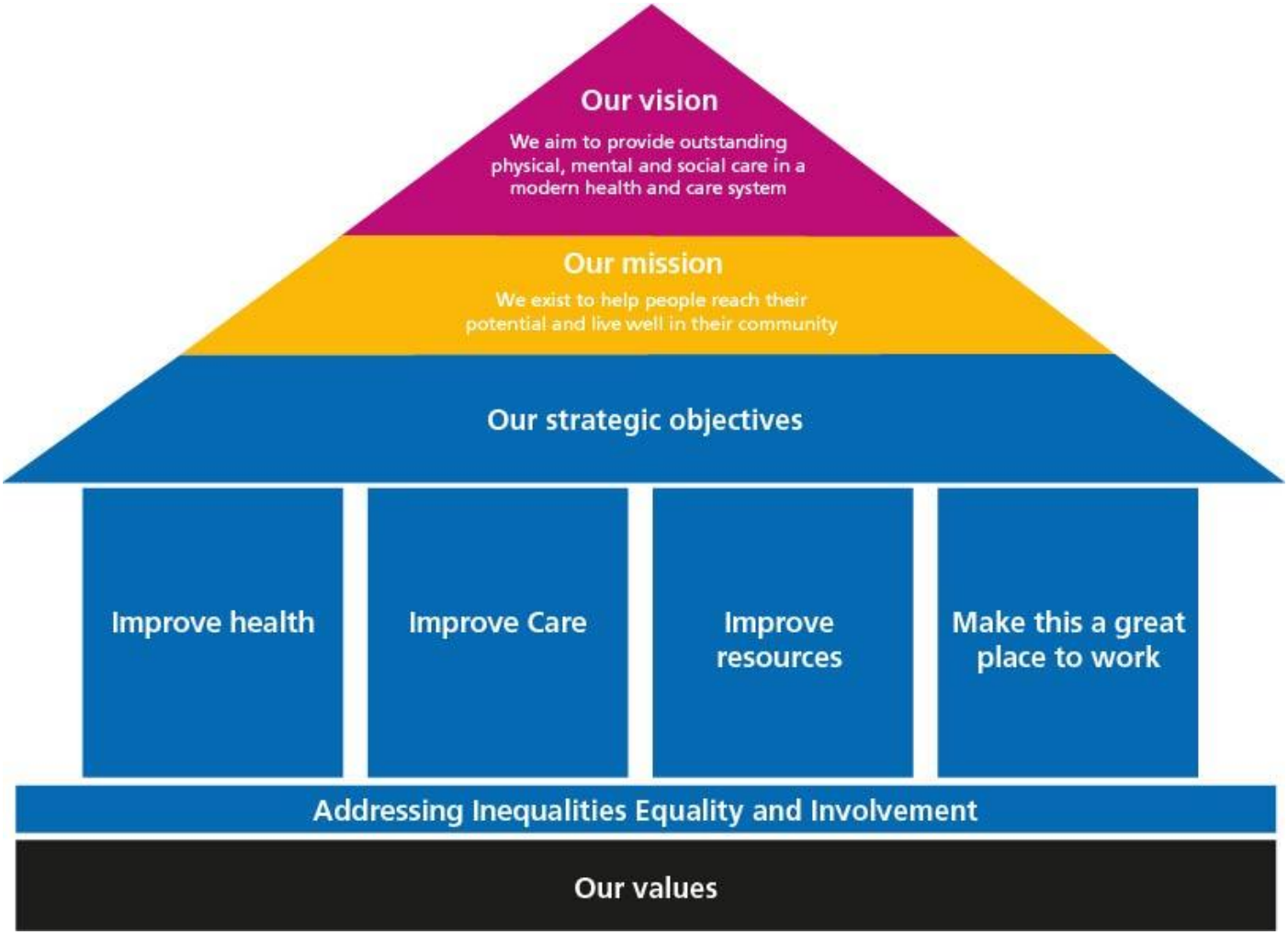
With respect to assurance for inpatient services, the acute inpatient service has several systems in place to assure the quality of patient care. These include

- Service manager assurance processes
- Use of intelligence for operational management and a comprehensive system of audit and assurance of policy and process for wards
- CQC Mental Health Act visits and improvement plans in response to these visits
- Operational management assurance – access to business intelligence information and workforce information
- Priority programme improvement work
- Inpatient improvement plan
- Recovery and reset development, as part of preparation for living with COVID-19
- Oversight into the ongoing inpatient improvement work

What next ?

The CQC ‘fundamental standards of care’ are being revised and rebranded as ‘quality statements’ which will replace their Key Lines of Enquiry (KLOEs) and prompts. This will launch summer 2022. There will be a plan for each core service completes a self-assessment using the revised standards, with the possibility of the CQC reviewing the self-assessments on a regular basis. We will refresh the current 12 quality scheme standards, considering the CQC revised quality statements. We will ensure that there is organisational readiness to roll out the self-accreditation scheme across all services, including the on-going development of the quality dashboards.

There is opportunity now to plan capacity and create a workplan to ensure readiness with a view to relaunching a refreshed scheme in September 2022, in line with Quality account proposed completion date of March 2023.



Over the last year, we have seen a continued commitment to delivering high quality care, with teams going out of their way to support service users, families and each other throughout the significant challenges of the pandemic. In this section, we highlight some additional examples of improvement and innovation that demonstrate how staff have worked to deliver our vision and mission during 2021/22.

SAFE

By this we mean care that is delivered in a way that minimises things going wrong and maximises things going right; continuously reduces risk, empowers and enables people to make safe choices and protects people from harm, neglect, abuse and breaches of their human rights; and ensures improvements are made when problems occur.

Digital wound management system – Wombwell Neighbourhood Nursing Team, Barnsley

The Tissue Viability Team have been piloting Healthy.io's SPOT digital wound management system since June 2021. The technology aims to transform wound management through central access to wound caseload data, consistent wound assessment with more accurate capturing of essential wound characteristics and improved visual tracking through standardised and enhanced wound imagery. The technology comprises an app that can be used with a standard smartphone or tablet, medical grade calibration stickers and a central portal designed for the visualisation of wound data.

This innovation has transformed the way the team assesses, documents and treats wounds, improving identification of stagnating, deteriorating and misdiagnosed wounds. Data based on wound characteristics can be flagged to clinicians and a real-time view of caseloads supports earlier intervention or adjustment to treatment plans. Patients can be actively engaged as the app allows clinicians to share images to understand progress over time.

The Team was awarded Gold at the Journal of Wound Care World Union of Wound Healing Societies Awards in the 'Cost-effective Wound Management' category.

Manging diabetic foot disease during the pandemic – Podiatry Services, Barnsley BDU

Multidisciplinary management and close collaboration of team members has been shown to delay the rate of amputations with diabetic foot disease and is best practice.

During the pandemic, many patients have been reluctant to attend a hospital site for face to face appointments. The Podiatry team responded by providing increased home visits, use of technology for virtual multidisciplinary team meetings with the microbiology and diabetes Consultants, and crisis response to support multidisciplinary management for people at home. This collaboration across disciplines and organisations has ensured continuity, clinical excellence and mitigated the risk of increased levels of sepsis and limb and life-threatening foot problems during the pandemic.

Responding to the pandemic – Wakefield Children's Mental Health Primary Intervention Team

The team introduced telephone and online self-referrals to ensure access to the service for children, young people and families during the pandemic. This allowed families to make direct referrals, reducing the burden on GPs and other professionals who usually referred on their behalf. The team has collaborated with each other and integrated feedback from families to implement this change, adapting face to face interventions for virtual delivery. These innovations have ensured continued access to all pathways. Waiting times have not increased and there has been a positive reception from parents.

Supporting COVID-19 vaccination for people with a learning disability – Wakefield Community Learning Disabilities Health Team

The team were approached by local GPs who were struggling to vaccinate people with a learning disability registered with their practices. The team worked with the CCG and primary care colleagues to put on vaccination clinics specifically for people with a learning disability, contacting them to personalise their care, offering vaccination in the car, in a quiet room with minimum staff in the clinic and using distraction aids. Six clinics were run and were so successful that people received vaccinations that had never received one before. Many adults were identified who had never accepted the offer of a flu vaccine, and appointments were opened up for them, making this the first team in the country to offer flu vaccines in this model. To indicate the impact of this, for some of the service users this was the first vaccine that they had ever received.

Developing a pathway to prevent & treat malnutrition within care homes using everyday food and drinks: Community Nutrition & Dietetics Service, CCG Medicines Management Dietitian and SWYT Quality Improvement and Assurance Team

Prior to initiating the direct to service electronic referral form for care homes (using Forms4Health Aire Logic), referrals to the Community Nutrition & Dietetics Service came from GPs and other health care professionals. These referrals would indicate the need for a dietitian, past medical history etc, but the details of what the patient was eating, how this may have changed, and any potential contributory factors, were not routinely included in the referral.

This meant that the first appointment/contact with the care home staff regarding the patient, involved gathering a lot of information. This was time consuming for care home staff and the Trust dietitian, and our phone call/visit might not always have been a convenient time to care home staff. More importantly though, it was recognised that more information was needed at the point of referral to prioritise incoming referrals based on clinical need, ensuring that patients who needed out service quickest, could access it appropriately.
An electronic referral form was developed and set up securely (checking off Information Governance, providing training and support to care homes, etc), with the following benefits:

- Care homes can refer directly to the service (reducing administrative load on GPs)
- Care home staff are best placed to describe what the service needs to know about their resident's: eating patterns, changes in behaviour, changes in physical health, what they've already tried (aiming to empower care home staff to implement some first line advice)
- The richer information that now accompanies the referral enables the service to see quickly which residents need our one-to-one input sooner, and those who perhaps need reassurance that what is currently in place is nutritionally sound and clinically appropriate.

The service still accepts referrals for care home residents from other sources (GPs, other visiting health professionals), but always signpost back to the care home, to request the in depth level of information we need to enable it to triage quickly and efficiently, ensuring a quality, equal service to all, in a clinically safe and effective manner.

Improving the appearance of meals: Catering and Wakefield Dietetic service

The IDDSI (International Dysphagia Diet Standardisation Initiative) is used to define food texture and drink thickness to improve safety during eating and drinking for those with chewing and swallowing problems.

Only main meal choices at lunch and evening were available for varying IDDSI levels. There were no dessert options, very limited breakfast/snack choices and no means for service users to place orders. The Catering Production Manager and Advanced Dietitian explored options for IDDSI level meals and desserts for different levels of the IDDSI framework. Following taste-testing and rating for appearance, smell, taste, flavour, texture, quantity and nutritional information, main meal and dessert choices were selected and brand new IDDSI level a la carte menus were created. Vegetable and starch options were included alongside main course options so service users can select the full meal they prefer.

Ambient dessert options that meet the IDDSI requirements were also explored to expand dessert choices. New menu layouts were created following ward and service user consultation and are now in use. A promotional event including tasting for staff and service users is planned, with the food supplier on standby for when COVID-19restrictions are relaxed. Work is underway to provide alternative hot/cold breakfast choices as well as snacks which can be made in-house to expand the existing cold snack range.

Service users had also reported that IDDSI meals appear less appetising and can lead to refusal, so presentation using ramekins was trialled. Whilst less suitable for some service users, Forensic services found this option helpful and melamine ramekins are currently being sourced with safety and risk management in mind.

Following choking incidents across the trust, problematic menu items were identified and options to replace them taste-tested. Replacements have now been introduced without any negative feedback from the wards. A supplier of crustless bread has been sourced for service users with swallowing difficulties but assessed as being able to eat bread.

Service user feedback was collated through the 'You said, we did' framework, Friends and Family Test and Ward Community Meetings, alongside observations of the multiple mealtime services on several wards,

helped with changes to the current main two-week menu for all Fieldhead wards. More vegetarian options, vegan sandwiches, a variety of dessert options, daily easy to chew options, fewer repeated choices and increased variety have been introduced. Ongoing feedback is being used to develop a new four-week main menu which will include daily popular, healthy, high energy, easy to chew vegetarian and vegan main meal choices, ensuring an easy to chew vegetable and starch option with the main course and easy to chew dessert option at lunch and evening mealtime services. An additional hot dessert option will be offered in the evening, in addition to the existing lunchtime offer. Cold options of salads and sandwiches will continue. Hot/cold options with oily fish will be available at least twice a week. New starch options and a variety of colourful vegetables will be served. The new menu is being assessed to ensure all choices complement each other, depending on the various combinations selected for that mealtime.

Following the Hospital Food Review, work is underway to streamline the food ordering process through electronic ordering which will enable individual ordering to be trialled as most people make food choices at the point of service. A copy of the current menu will be displayed on the wards at service user request.

Changes in the availability of products during the pandemic required collaborative working and fast acting changes to the main menu to ensure adequate provision and a nutritionally varied menu. Weekly updates to wards were started to inform them of the high turnover of changes taking place. Service user feedback forms were created and sent out to gather feedback on the replaced items and inform the new four-week main menu. Supplier changes and delisting of products, exacerbated by the pandemic, many items on the finger food a la carte menu are being revised. Available options have been collated and are being shortlisted, expanding the variety and range to ensure balanced yet exciting meals, with a wide choice of desserts.

As well as options for service users, planning for 24-hour provision for staff is in motion and has started in Kendray. The Catering team is currently revisiting offering a snack trolley service for Unity Centre Wards.

Strong networks and working relationships have been developed internally and externally to ensure regular communication and continuous improvement.

EFFECTIVE

By this we mean informed by consistent and up to date high quality training, guidelines and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing wider determinants of health; delivered in a way that enables continuous improvements based on research, evidence, benchmarking and clinical audit.

Physical health support for people in Forensic Care – Primary Care Team

People living with severe mental health problems and those who have a Learning Disability are at greater risk of poor physical health and reduced life expectancy compared to the rest of the population. The Primary Care Team, a GP and two nurses, provided a comprehensive physical health service to all service users across Forensic services. An assertive outreach approach was implemented including completion of a full health assessment, access to healthcare and support and monitoring of long-term health conditions. The team also ensured a high take up level of COVID-19and flu vaccination, achieving 80% COVID-19vaccination coverage in people who are vulnerable.

Vocational interventions for people accessing secondary mental health services – Calderdale Vocational and Individual Placement and Support Team (IPS)

The Calderdale Vocational and IPS teams work collaboratively to support people towards paid employment. The IPS team is made up of two employment specialists who integrate into the Core, Enhanced and Early Intervention in Psychosis teams, using the Individual Placement and Support. The Vocational Team provides Occupational Therapist-led support offering services such as work retention, support into volunteering and enabling social functioning. The IPS team works creatively to engage with local employers to raise awareness of the service and challenge stigma associated with mental health. The

IPS model is based on a 'zero exclusion' principle – referral is based on the individual's desire for paid employment, not the judgement of a clinician.

Since the service started in October 2019, 40 job outcomes have been achieved, 36 of which are permanent contracts. An outcome can include work retention, enabling reasonable adjustments, voluntary work and supporting people to navigate their way through unfair dismissal processes.

First Contact Practitioner (FCP) Musculo-Skeletal Physiotherapy (MSK) Service
The FCP MSK Service was launched in July 2021 in the height of the pandemic in partnership with Barnsley Primary Care Network. Six practitioners are working across the Barnsley neighbourhoods, providing clinical care and supporting greater understanding of the wider MSK pathways. People with MSK problems can access a practitioner where they will be assessed and triaged, provided with a treatment plan and onward referral where necessary. The service promotes self-management and shared decision-making. Close working with primary care has increased uptake of the service including developing an algorithm for administrative teams and shadowing GP consultations to support decision-making. In total, 1290 consultations were carried out in November and December 2021, with 76% given self-management guidance with no need for onward referral, 16% referred for physiotherapy and 3% to secondary care. Most appointments are offered on the same day and did not attend rates have been at 2.7%.

BAME Access and Retention Project – Yorkshire and Humber Forensic CAMHS Service (FCAMHS)
On reviewing data, the team in the forensic CAMHS service noticed that the majority of referrals were children from a white British background, indicating a potential challenge of service offer to BAME children and young people. The first step in understanding the problem was a literature review identifying the contributing barriers and gaps in services, and what can be done to address this inequality.
Supported by Social Work students, the team has been working with the Kirklees EIP team to understand the impact of having a more diverse service and to reflect on their strengths and development needs to make their own service more inclusive. The work has been shared nationally and the service is now working with Bradford University to take the research aspect further.

Health Promotion Roadshows for People with a Learning Disability – Calderdale Learning Disability Health Team
People with a Learning Disability experience very high levels of health inequality, and this has been made worse during the pandemic. Calderdale Learning Disability Health Team ran five roadshows to encourage conversations about health and increase access to health resources. Mini health checks were also offered, with a nurse providing health promotion advice (healthy eating, wellbeing, screening and support to stop smoking) and signposting.

People found the roadshows helpful for their day to day lives, and particularly valued the mini health checks. Building on this, in 2022, roadshows will be held monthly at a variety of venues across Calderdale.

Creative Cabin – Early Intervention Team, Adult Mental Health, Barnsley

Creative Cabin is a therapeutic art and craft group based on the Kendray Site in Barnsley and run by the Early Intervention in Psychosis Team. It has a calm atmosphere and people work with materials that come from donations and found in foraging in local woods, parks and from a beach trip that was funded by the group. Structured sessions support people to craft items that are sold locally, with funding used for trips or workshops. During the pandemic the group mainly made crafting packs and carried out doorstep drops of sewing packs that were donated by local haberdashery shops.

People who have participated in the sessions have gone on to try other creative groups and used their skills in volunteering. People who have had inpatient admissions have suggested creative sessions are also run on inpatient wards. The group supports wellbeing, self-esteem, reduces anxiety and increases social inclusion. Activities and trips are improved and designed together with service users.

POSITIVE EXPERIENCE

By this we mean that services are:

- Responsive and personalised – shaped by what matters to people, their preferences and strengths; empowers people to make informed decisions and design their own care; coordinated; inclusive and equitable.
- Caring – delivered with compassion, dignity and mutual respect.

Canine befrienders – Pastoral and Spiritual Care Team

The Pastoral and Spiritual Care Team have introduced some very friendly four-legged members to its volunteer team – the canine befrienders – who work in partnership with the human volunteers who visit the Trust's inpatient wards. They work with people in different ways – some people enjoy just being with the dogs, petting and stroking them; some get involved in walking them and one attends a social group (they are a very popular member!)

The dogs bring out the kindness and compassion in people. They have a way of boosting people's self-esteem – they are seen as non-judgemental and unconditionally accepting of everyone. They encourage an atmosphere of calmness, generate conversations that help people to open up, brightening the mood, bringing warmth, friendliness and laughter.

Occupational therapy sessions for people with a Learning Disability on Newhaven Ward

The Occupational Therapy Assistants on Newhaven Ward delivered sessions to service users at Newhaven throughout the pandemic, going above and beyond, adapting and innovating during a very difficult time to provide activity and occupation. This included baking and mini-Olympics. They contributed to stability in the unit and inspired the rest of the team. One family member talked about the two staff, 'My relative raves about [them] and the sessions they do. How they are so cheerful, the sessions they provide and how they have given hope in difficult times. They are a credit to the Unit'.

Raising Transgender awareness – Equality and Involvement Team

A Kinsey Institute Ambassador worked with the Trust to support staff in providing services to transgender and gender non-conforming communities. In total, 163 staff were trained via workshops that were so successful, further dates were added. Feedback was that staff who previously lacked confidence in how to approach someone and using appropriate language and terminology left confident and able to support someone.

SUSTAINABLY RESOURCED

By this we mean that we are focused on delivering optimum outcomes within financial envelopes, reducing the impact on public health and the environment.

The Yorkshire Smokefree Client Zone

The virtual Client Zone was created in response to the pandemic, replacing paper resources with a digital offer where resources can be accessed at any time. It has reduced the need for physical storage space, printing and improved access for clients. The website is tailored for local areas, and nominated staff have administrative access to the website, so can make changes themselves, adapting and developing it as required and in response to learning and feedback.

Using data to improve the effectiveness of Wakefield Older People's Service

Working closely with the Trust's Performance and Information Service, the team has developed tailored analysis and reporting from SystmOne that supports clinicians in improving service user outcomes and the management of the overall service. Data is used to monitor demand and capacity, supporting a better understanding of the profile of referrals and changes over time, better use of capacity in the service and use of clinical outcome data is used to improve the effectiveness of interventions.

Transforming a service to create capacity and better outcomes for children and families – Children's Speech and Language Therapy, Barnsley

With a typical caseload of over 1,000 children and young people and an annual service offer of around 400 training places for parents, carers and professionals, the Children's Speech and Language Therapy Service (Barnsley) had to make rapid and significant changes to service delivery in response to the global pandemic. Since March 2020 they have been able to maintain a continuous service by:

- Moving from face-to-face appointments in homes, health centres, and education settings to telehealth via telephone and video calls and a variety of platforms including WhatsApp, Microsoft Teams and Facetime with smartphones, laptops and iPads
- Moving from face-to-face delivery of training to both live and pre-recorded video presentation via Microsoft Teams
- Developing a YouTube channel, Barnsley speech and language therapy - YouTube to share communication, eating, drinking and speech and language advice, support, training, activities and ideas with parents, carers, professionals, children and young people. As of January 2022, the channel has 98 videos and over 23,063 views
- The development of a web-site based "toolkit" which allows parents, carers and professionals to access downloadable therapy resources including advice sheets, games and activities, Barnsley CSLT Toolkit Resources Archive - South West Yorkshire Partnership NHS Foundation Trust

The service continues to offer a blended service comprising telephone and video appointments and where clinically necessary, face to face appointments.

The service was already digitally-enabled but concerns about the risk of children with speech and language differences being further negatively impacted by the pandemic pushed the team to innovate using YouTube. As the skills of the team increased, they have developed further innovations:

- Advice sheets are augmented or replaced by videos and so people can go back and review strategies and interventions. They can share the advice with other people supporting the child. Therapists and assistants have found recommending videos has become intrinsic to their care.

- Sharing the positive experiences of those with communication differences with other children and young people e.g. stammering. These videos have been made by young people to normalise stammering and change the perceptions of society, reducing negative associations about stammering.
    - Children who stammer have a voice: 'I can talk for myself' - YouTube
    - Stammering - Transition to secondary school - YouTube

- Enhancing student placements by offering practice-based presentation, providing students with the opportunity to observe a wider range of therapeutic skill than possible in a single placement as well as practising their own skills in observation, assessment, diagnosis and treatment.
- Providing the local specialist school with a pre-recorded information on the role of speech and language therapists and information about intervention for students with complex needs to be used as part of the school's induction for their new staff

Throughout the pandemic, the rating from service users has continued to be 5 star, matching the feedback received pre- COVID-19. Success has been a team effort including sharing learning about digital platforms, filming and editing, providing scripts for videos, problem-solving how to make therapy digital and incorporating feedback from parents, carers and other professionals as well as the valuable contribution of children and young people who have shared their experiences

WELL-LED

By this we mean we are driven by collective and compassionate leadership, which champions a shared vision, values and learning; delivered by accountable organisations and systems with proportionate governance; driven by continual promotion of a just and inclusive culture, allowing organisations to learn rather than blame.

Role of Support Workers during the pandemic – Calderdale Community Mental Health Team for Older People

Support workers in the Community Mental Health Team for Older People supported the service without question, visiting additional patients when COVID-19 led to staff shortages, recognising gaps in service including visiting service users to take blood samples for phlebotomy and learning new skills such as venepuncture. Their leadership and commitment supports and motivates the wider team.

Student and newly qualified Social Workers – Community and Crisis mental health services

The Trust has continued to support student placements and newly qualified staff during the past year. Whilst Social Workers have always worked within Trust services, direct employment by the Trust is relatively recent. The Professional Lead for Social Worker and other Social Workers have worked to ensure that the systems for professional support and governance are in place and continued to work during the pandemic. This includes ensuring practice education training and external trainers are in place to support assessors and trainers, developing professional fora and raising awareness among service managers of developments in the profession such as changes in legislation and their implications for services.

COVID-19 has meant that newly qualified staff have taken on more than would normally be expected, including more complex cases and working more independently. Equally, supervisors have had to be very flexible to provide the levels of support needed when staffing has been reduced.

Student social workers have provided support for teams, reducing stress due to increased demand from staff absences and service user needs. In addition, one group of students supported the aforementioned research work with the Forensic CAMHS and the Early Intervention in Psychosis Team to explore how the diversity of the team impacts on referrals.

Race, Equality and Cultural Heritage (REACH) Network

Through the leadership of its Steering Group and sponsorship of the Trust Executive, the REACH Network has made considerable progress during 2021/22. Members of the Network experience it as a safe space where they can share, learn and support one another. The Network has been proactive in championing the rights of its members and increasing awareness of diversity and inclusion. It bridges the gap in the organisation on inclusion and has built links with the Board and Executive Management Team. Through its work, the Trust now has Equity Guardians who support people who experience racist abuse from service users. The Network has also played an active role in ‘safe space’ sessions that were provided for staff who were concerned about the COVID-19 vaccination, and initiated wellbeing and fitness activities to support staff.

Annex 1 Glossary

AHSN	**Academic Health Science Networks** are membership organisations within the NHS in England. They were created in May 2013 with the aim of bringing together health services, and academic and industry members
BDU	**Business Delivery Unit:** The Trust runs services on a district by district basis with support from a central core of support services. These district management units are called Business Delivery Units (BDUs). We have six BDUs; Barnsley, Calderdale, Kirklees, Wakefield and Forensics and Specialist Services.
CAMHS	**Child and adolescent mental health service:** Treatment for children and young people with emotional and psychological problems.
CMHT	**Community mental health team:** A community based multi-disciplinary team who aim to help people with mental health problems receive an appropriate community environment for as long as possible, and in many cases preventing hospital admission.
CQC	**Care Quality Commission** The Care Quality Commission is the health and social care regulator for England. Their aim is to ensure better care for everyone in hospital, in a care home and at home
CQUIN	**Commissioning for Quality and Innovation.** A payment framework that makes a proportion of providers' income conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for All (the NHS next stage review report) of an NHS where quality is the organizing principle.
DATIX	**Datixweb** is the web based version of the Trust's risk management system. It enables staff to report incidents that happen at the Trust, electronically
EMT	Our **Executive Management Team** (EMT) put into action the strategic direction and priorities set by the Trust Board. They are responsible for the day to day running of the Trust, making sure that resources are in the right place to provide high quality care and achieve our mission and objectives. They are held to account by our Trust Board.
FFT	**Friends and Family Test:** a service user experience and quality improvement tool used across the NHS
IAPT	**Improving Access to Psychological Therapies** is a National Health Service initiative to provide more psychotherapy to the general population
Key performance indicator	A performance indicator or **key performance indicator** is a type of performance measurement. KPIs evaluate the success of an organization or of a particular activity in which it engages.
NCISH	The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) is an internationally unique project. The study has collected in-depth information on all suicides in the UK since 1996. Their recommendations have improved patient safety in mental health settings and reduced patient suicide rates, contributing to an overall reduction in suicide in the UK. Their evidence is cited in national policies and clinical guidance and regulation in all UK countries.
NHSI	**NHS Improvement** is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
NICE	**National Institute for Clinical Excellence:** a national group that works with the NHS to provide guidance to support healthcare professionals make sure that the care they provide is of the best possible quality and value for money
SafeCare	A daily staffing software tool that matches staffing levels to patient acuity, providing control and assurance from bedside to board. The tool allows Trusts to

	compare staff numbers and skill mix alongside actual patient demand in real time, allowing us to make informed decisions and create acuity driven staffing.
Safety Huddles	A safety huddle is a short multidisciplinary briefing, held at a predictable time and place, and focused on the patients most at risk. Effective safety huddles involve agreed actions, are informed by visual feedback of data and provide the opportunity to celebrate success in reducing harm.
SystmOne	The electronic service user record system that is used in within our Trust.

Annex 2: Statements from our stakeholders

Report on behalf of Healthwatch Wakefield on the Quality Account 2021/2022 of the South West Yorkshire Partnership NHS Foundation Trust

Healthwatch Wakefield is the independent champion created to listen to and gather local people's experiences of using health and care services. It is a Charity Limited by Guarantee. We employ a small staff team and are helped by a significant number of volunteers. The draft Quality Account was circulated to our Trustees and Management team.

Undoubtedly the past year, with the ongoing affect and impact of the Coronavirus Pandemic, has continued to be extremely challenging for all aspects of the NHS & the South West Yorkshire Partnership Trust has not been exempt from this. Despite the national emergence from restrictions health services continued to experience challenges across all the past year and indeed well into the current financial year. It is important to appreciate the impact on local NHS services over these past two years.

The feedback we have collected over the past 12 months has been shared with the trust throughout the year. Overall, we collected 29 pieces of feedback about services offered by the Trust, and while it is appreciated that people are more likely to make negative comments than positive, 86% of the feedback we received was negative. For comparison, across all the feedback we collected for this fiscal year, 68% was negative. Therefore, the trust received a higher percentage of negative feedback than 'the norm'. The feedback was spread across the Trust relatively evenly, but the service we heard the most feedback about was CAMHS – with five pieces of feedback, three of which were negative.

The intelligence we have collected, this year and previous years, suggest that the waiting times at CAMHS has been a particular area of frustration. Therefore, it is good to see the trust putting some much emphasis into reducing these times.

During this financial year we were particularly excited to see the launch and development of the "Choose well for Mental Health" guide, which showcases examples of how a person may be feeling alongside some of the support available. We want to encourage the trust to continue publishing this guide, in particular as we know work has been done to develop the information in a variety of accessible formats.

In the section on 'learning from deaths' (Part 2.2), the report identifies that no research base for mental health services has been established on what constitutes as an "avoidable death" while using inpatient services. We acknowledge that this is not specifically an issue for this trust to resolve on its own, and we applaud the efforts into the area already undertaken, but we would like to challenge the trust drive this forward as much as possible. In previous Quality Accounts, the trust was able to present a graph of "Apparent Suicides", showing clearly the number of suicides of individuals that have been recorded with the Trust over a period of time which have been identified as being in receipt of care or treatment, or recently been discharged, from the trust. Unfortunately, an updated version of this graph was not presented in this year's account so it is unclear if progress has been made. We would encourage the Trust to continue presenting this in future years.

In the section on 'reporting against core indicators' (Part 2.3), the trust is compared against other trusts nationally. It would be beneficial for the reader to understand if the trust thinks about this – for example, are all the trusts nationally underperforming against this indicator and is there a desire to improve, or is the national standard for this high so the trust wishes to maintain this level of delivery.

There appears to be a low response rate to the NHS staff survey, for both this year and last year, with little information given on the trusts plans to increase the response rate from their staff. The Friends and Family test is a tool which we know the trust monitors closely throughout the year, so it is good to see this reflected in the quality account. However, while acknowledging the “rich source” of feedback received from the free text comments, there is no follow up information to what you have learnt from this, or what changes you have made as a result of people providing you this information.

The Glossary continues to be a very useful tool to read this document, and we would encourage the trust to continue developing this resource. For example, the PESTLE framework is mentioned in the report without any further explanation as to what this is, or how it will support analysis of the trusts strategic position. Perhaps a project throughout the year is to explore this with a lay person who can identify terms – as well as acronyms – which need additional information including in the Glossary ahead of the report next year. Furthermore, throughout the report there is a reliance on the use of acronyms, and it would support to make the report more accessible if there was less use throughout.

Finally, it would be interesting to see an organisational chart for the trust included with how all the boards mentioned throughout the report link up as there have been a number mentioned in this document.

Conclusion

While this is a very detailed report, which showcases a lot of great work undertaken by the trust, it still remains particularly inaccessible. Our staff and volunteers recognise the trust is vast, so presenting this information in other formats will be a challenge. However, we would encourage the trust to produce this information in other formats – such as an easy read document, of another version with the language change slightly targeting “lay people”. The people within the trust continue to be willing to answer any questions about the report when questions have arisen, which is highly commendable.

Overall, while there some areas we would like the trust to focus on further (mentioned above), this report illustrates a high-quality healthcare service is available to the population of Wakefield District, and wider, from the trust. We acknowledge the admirable approach from the trust to refresh their quality priorities and the level of detail which has been given to identify potential quality programmes. We also acknowledge the tremendous amount of work which has gone into identifying how the trust performed against last year’s priorities. We look forward to continuing to work with the trust moving forward to ensure they hear service user voices and continue developing and delivering a much-needed service for the district.

NHS
Calderdale
Clinical Commissioning Group

9 June 2022

Darryl Thompson
Director of Nursing and Quality
South West Yorkshire Partnership NHS Foundation Trust
Fieldhead
Ouchthorpe Lane
Wakefield
WF1 3SP

Dear Darryl

Thank you for providing the opportunity to comment on the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) Quality Account 2021/22. This response has been collated by NHS Calderdale Clinical Commissioning Group (CCG) as lead commissioner in conjunction with associated commissioners from NHS Kirklees CCG, NHS Wakefield CCG

The quality account provides a comprehensive and transparent reflection of service delivery and outlines existing levels of quality and acknowledges areas requiring improvement in the future. The Trust has demonstrated its ability to adapt change through different ways of working, to respond to increasing acuity and demand on services through innovation and commitment to quality improvement.

The commissioners would like to take this opportunity to acknowledge the challenges faced by the Trust throughout this year as we all continued to manage and recover from the Covid-19 Pandemic and thank all staff across the organisation for their continued dedication to patient care and service delivery. The commissioners would also like to congratulate the Trust on successes of the year recognised in local, regional, and national awards:

a. National award in the Healthcare People Management Association (HPMA) Awards in the Social Partnership Forum category, which celebrates partnership working between employers and trade unions
b. Barnsley tissue viability service was awarded Gold at the Journal of Wound Care World Union of Wound Healing Societies Awards in the ‘Cost-effective Wound Management’ category
c. Live Well Wakefield team won an award in the Social Prescribing awards 2021
d. Yorkshire Smokefree achieved the top 5 best quit rates in the region for people who have quit within 4 weeks, with Barnsley, Wakefield, Doncaster, Calderdale, and Sheffield being the top achieving services across Yorkshire and the Humber.

The launch of the adult ‘Choose Well for Mental Health’ guide is very welcomed, it is commendable that this is the first of its kind to be launched in the country, it links particularly well with the Community Mental Health transformation programme and will help the citizens of West Yorkshire navigate to the help most appropriate for them.

The Commissioners acknowledge the impact the pandemic had on capacity and planned work programme for 2020/21 quality priorities and the decision to re-prioritise taking into account Pandemic recovery with the intention of identifying a smaller number that would be given greater prominence in 2022/23. The quality account provides a comprehensive summary of what the Trust planned to do, outcomes identified, what was done and agreed next steps.

It was good to understand the process the Trust undertake to set their Quality Priorities and how they align with the Trust strategic priorities and the CQC key lines of enquiry. We are pleased to see that the priorities for 2022/23 will have a positive impact on the experience of people accessing the Trust’s services and the wider system, in particular:

- Safe and Responsive Care
- Equality, Inclusion and Equity

Commissioners recognise and support the Trusts commitment to improving the health, well being and experience of staff. The quality account demonstrates a continued focus on staff health and wellbeing including the introduction of clinical debriefing after incidents that might affect staff Mental Health & wellbeing. We look forward to seeing the positive impact on staff experience, participation in the annual staff survey will be a key metric.

It is commendable that the Trust has continued to participate in all national clinical audits and national confidential inquiries as this allows benchmarking and sharing of best practice. The commissioners are encouraged by the actions taken by South West Yorkshire Partnership NHS Trust to review the audit findings and governance arrangements in place to action the audit recommendations. The commissioners endorse the focus on outcome measures including clinical reporting as a way of assessing the effectiveness of the trust's interventions. It is hoped that these are compatible with those being used for the Community Mental Health Transformation and other such partnership programmes of work to allow accurate benchmarking against other organisations and learn from others who are achieving improved outcomes. The establishment of a benchmarking group to review data and identify areas for opportunity to further increase quality and effectiveness and make comparisons with peers is also welcomed.

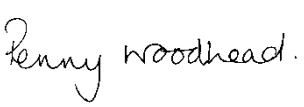
The Trust's implementation plan for the roll out of quality assurance and improvement accreditation following the successful pilot roll out was delayed due to the ongoing impact of the pandemic. However, the commissioners have taken the opportunity to participate in Quality Monitoring Visits across the Trust in a variety of settings including Children and Adolescent Mental Health Services, Community and Inpatient areas. The quality monitoring visits were supportive, in depth, transparent and ensured feedback from staff, patients, families and carers. The commissioners look forward to attending future quality monitoring visits over the coming year.

The commissioners acknowledge the Trusts update on the Patient Safety Strategy outlining the implementation plan with focus on quality improvement and governance arrangements, how each business development unit will have their own priorities owned and actioned at a local level. We look forward to seeing further developments with a patient safety specialist role and the introduction of patient safety incident response framework and the resulting impact that has on patients and staff safety.

We also recognise the Trust have achieved the national timescales of closure of complaints however due to the impact of the pandemic they have not been able to sustain their own target of 40 day timescale for responding to complaints. The reasons for delays included clinical capacity to allocate compliant investigations, complexity of complaints and delay in sign off process are noted. The Trust introduced a trial of complaint response times based on complexity of the complaint, initial findings did see some improvement and we are assured by the Trust's plans to continually improve this area through engagement, electronic data collection, quality improvement and a Trust wide complaints training programme.

In conclusion, the commissioners value the Trust's approach to quality and the trio model partnership of clinical, operational and governance within their leadership teams. This quality account contains inspiring examples of partnership working across the sector and quality improvement initiatives to improve patient safety, effectiveness and experience with a focus on the health and well-being of staff. Key areas for improvement have been identified and we look forward to working closely with the Trust and increasing our integrated approach to quality to support in the priorities identified and the journey from being Good to Outstanding in the Care Quality Commission (CQC) ratings.

Yours Sincerely



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30 May 2022

Darryl Thompson
Director of Nursing, Quality & Professions
Southwest Yorkshire Partnership NHS Foundation Trust

SOUTHWEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST QUALITY REPORT 2021-2022

Thank you for giving us the opportunity to comment on your quality report for 2021 – 2022. There is nothing within this report that is contradicted by any intelligence that we have received.

It was magnificent to see that your Barnsley tissue viability service, was a winner at an international award ceremony celebrating the world's leading tissue viability and wound care professionals. It was also great to see that Yorkshire Smokefree achieved the top 5 best quit rates in the region for people who have quit within 4 weeks, being the top achieving services across Yorkshire and the Humber. It was a shame that with the SAR-CoV-2 pandemic these awards did not perhaps get the recognition they deserved.

We have been pleased to help publicise your adult 'Choose well for mental health' guide, helping people to get the right support for their mental health and wellbeing at the right time. We will continue to support the publicising of similar advances for you this year.

The format of your report makes for easier reading, with the majority of the narrative prior to the statistical analysis.

We look forward to the roll out of Electronic Prescribing and Administration of Medicines (EPMA) to your Barnsley Inpatient Services to improve patient safety. We hope that EPMA will continue to be rolled out to Community Mental Health Services, Intensive Home-Based Treatment Team (IHBTT) and Community Health Services in Barnsley. An indication of the timescale for the completion of this would have been useful.

We must mention the foresight and enthusiasm of the Barnsley IHBTT in at first using Business Continuity Arrangements to take over the night-time staffing of the Barnsley Section 136 Suite. We look forward to this being made permanent covering all hours. This new initiative will ensure timely local response to people in severe mental health difficulties, improving assessment and patient satisfaction.

We were pleased to see that your trust is on track to meet the requirements of the National Patient Safety Strategy and has plans in place for the launch of the Patient Safety Incident Response Framework (PSIRF). The embedding of your Patient Safety Specialists and the roll out of Patient Safety Level 1 and Level 2 training, together with your replacement of Root Cause Analysis by Systems Analysis Models, will hold you in good stead when you start implementing PSIRF in 2022 – 23. However, we were disappointed that no mention was made of plans for the recruitment of Patient Safety Partners in the 2022 – 2023 year.

We are delighted to see the trust rolling out new anti-barricade doors across bedrooms, which have a door top sensor to alert staff should a person be using the door to ligate. When will this be completed in Barnsley?

It is difficult with the Trust wide aggregation of the figures in the report to tease out performance information for Barnsley. We would appreciate a meeting to look at the Barnsley figures.

Healthwatch Barnsley will continue to support the Trust and look forward to seeing continuing improvement in the quality of the services it provides.

Mark Smith
Vice Chair
Healthwatch Barnsley

17 May 2022

Darryl Thompson, Director of Nursing, Quality & Professions

South West Yorkshire Partnership NHS Foundation Trust

BY EMAIL: Darryl.Thompson@swyt.nhs.uk and deborah.newman@swyt.nhs.uk

Dear Darryl

Thank you for offering us the opportunity to review South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) draft Quality Account Report 2021-22.

SWYPFT has clearly maintained a focus on ensuring quality remains at the heart of care delivery, ensuring good patient experience and person-centred care. It is acknowledged that 2021-22 has continued to prove challenging for all health care providers however, the draft report clearly highlights and identifies many achievements against the Trust's priority areas. Of particular note is SWYPFTs *#allofusimprove* initiative again highlighting the Trust's focus on maintaining high standards throughout; for service users, carers and for staff.

Barnsley Hospital NHS Foundation Trust (BHNFT) values the relationship it has with SWYPFT and we look forward to hearing about your progress in implementing your three key quality issues for 2022-23

Yours sincerely

Jackie Murphy
Director of Nursing & Quality

Dear Darryl

Many thanks for the opportunity to see and comment on your Quality Account. I would like to submit the following form Mid Yorkshire Hospitals NHS Trust

" The Mid Yorkshire Hospitals NHS Trust (MYHT) is grateful for the opportunity to review and comment on the Quality Account for 2021/22.

MYHT was pleased to see the continuation of the drive to make service safer, more efficient and of a better experience for service users and staff. This has covered issues such as (though not the comprehensive set of data):

- Safe staffing
- Reduction in harm (including suicide prevention)
- More timely investigations
- Improved ability to learn lessons when things have gone wrong

It is heartening that quality improvement initiative into the above issues also include improvements in knowledge and personal development, involvement of service users, a focus on equality, diversity and inclusion and keeping the workforce well and happy.

MYHT looks forward to learning more about the improvements that South West Yorkshire Partnership NHS Foundation Trust make and understanding how our two organisations can work together on some of these initiatives"

Hope this helps

Best wishes

David

David Melia MSc RNLD RN
Director of Nursing & Quality
Mid Yorkshire Hospitals NHS Trust

Wakefield Council Adults Services, Public Health and the NHS Overview and Scrutiny Committee

South West Yorkshire Partnership NHS Foundation Trust Quality Account

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The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare providers to assess quality across all the healthcare services they offer and encourage them in a wider process of continuous quality improvement. Providers are asked to consider three aspects of quality: patient experience, safety, and clinical effectiveness. The visible product of this process – the Quality Account – is a document aimed at a local, public readership. This both reinforces transparency and helps persuade stakeholders that the organisation is committed to quality and improvement. Quality Accounts therefore go above and beyond regulatory requirements, which focus on essential standards.

The public, patients, and others with an interest in their local provider will use a Quality Account to understand:

- Where an organisation is doing well and where improvements in service quality are required:

- What an organisation's priorities for improvement for the coming year are; and

- How an organisation has involved service users, staff, and others with an interest in the organisation to help evaluate the quality of their services and determine their priorities for improvement.

In reviewing the Trust's Quality Account the Committee considered the following:

- Does the Trust's priorities match those of the public;
- Whether the Trust has omitted any major issues;
- Has the Trust demonstrated they have involved patients and the public in the production of the Quality Account; and
- Any comment on issues the Committee is involved in locally.

The Committee has considerd the quality measures and presentation formats used by Trust in their Quality Accounts including:

- **Content:** how many measures are used, which aspects of performance are covered and what types of measures are used.

- **Rigour:** whether information about performance over time is given, whether statistical tests are used, whether benchmarking information is given and whether measures are presented in context with appropriate interpretation and explanation.

- **Presentation:** how the data is presented such as how tables and 'traffic-lighting' indicators are used, how graphs are used and how readable the documents are.

The Committee considers that the presentation of the Quality Account largely follows the national prescription in terms of layout and content. Overall, the report is generally well presented.

It is accepted that the content and format of the Quality Account is nationally prescribed. The Quality Account is therefore having to provide commentary on a wide range of services to a broad range of audiences and is also attempting to meet two related, but different, goals of local quality improvement and public accountability.

However, the Committee would reemphasise the point made in previous Quality Accounts that for the public to make sense of information presented would require the provision of standard, consistent and comparable measures, published in a format that enable interpretation and comparison. Priorities for improvement should then be given benchmark or trend information to provide some context for interpretation. There is very little in the Quality Account by way of comparable performance. The Quality Account, as set out, appears to be a statement of actions rather than an assessment of improvement and it would be difficult for the public to ascertain whether the priorities for improvement had been achieved.

It is accepted that the Quality Account is set within the context of the continuing Covid-19 pandemic and the associated challenges to the Trust. Consequently, the Committee has had limited engagement with the Trust during this period to ensure the necessary balance in providing constructive challenge and support. The Trust is to be commended for its sustained effort in the most challenging of circumstances. The Committee welcomes the innovative way in which the Trust has met these challenges whilst maintaining or improving quality.

In terms of local scrutiny activity, the Committee did review the Trust's performance in relation to Out of Area placements and inpatient bed demand pressures during 2021.

Members were informed that significant work had been undertaken to understand and manage the bed pressures. Through recent years an improvement programme had been established to focus on which areas would have the biggest impact on reducing demand pressures and enabling a strategic longer-term approach to implementing a lower admission model. The work had been focused on providing all care as close to home as possible.

This programme of work had been taken forward in a partnership approach with commissioners and stakeholders, following the identification of key drivers for change, which included:

- Appropriate inpatient stays, achieved by:
    - Efficient discharge process, including planning and tracking progress to discharge
    - Developing whole system oversight to maximise bed usage
- Effective gatekeeping for people in crisis
- Reducing the demand into services and into the acute pathway, including focussing on pathways for people with trauma informed personality disorder.
- Understanding and responding to data.

The Trust provided evidence that these changes have had an impact. For example, the numbers of people from Wakefield placed out of area reduced from 85 in 17/18 to 12 in both 19/20 and 20/21. Trust wide, a reduction of the total out of Trust placements was more than 50% in this period.

The Committee agrees that the continuum of improvement should be maintained and supports the decision to further refine this with the identification of a smaller number of priorities that would be given greater prominence in 2022/23.

However, going forward the Committee would still like to see a more challenging approach to the setting of priority areas for improvement.

Finally, the Committee believes that the Quality Account is a fair reflection of the Trust's performance, challenges, and achievements during 2021/22.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 September 2022
Agenda item 12.2

Private/Public paper:	**Public**		
Title:	**Equality, Inclusion and Involvement Committee Terms of Reference update**		
Paper presented by:	Chair		
Paper prepared by:	Head of Corporate Governance		
Purpose:	The purpose of this paper is to provide assurance to Trust Board that the Committee operates effectively and meets the requirements of the Terms of Reference.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	All		
Any background papers/previously considered by:	Equality, Inclusion and Involvement Committee 20 September 2022.		
Executive summary:	Trust Board Committees are responsible for scrutiny and providing assurance to Trust Board on key issues within their Terms of Reference. The Terms of Reference have been amended to reflect the inclusion of sustainability in the duties for the Equality, Inclusion & Involvement Committee. The Committee will provide bi-annual updates to Trust Board about the management and resourcing of strategic objectives relevant to sustainability and both Committee and Trust Board workplans will be updated accordingly.		
Recommendation:	**Trust Board is asked to APPROVE the Terms of Reference for the Equality, Inclusion and Involvement Committee.**		

With all of us in mind.

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EQUALITY, INCLUSION AND INVOLVEMENT COMMITTEE
Terms of Reference
To be approved by Trust Board 27 September 2022

The Committee is a Committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by the Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Equality, Inclusion Involvement Committee's prime purpose is to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does, through involvement and promoting the values of inclusivity and treating people with respect and dignity. The Committee will develop and oversee a strategy, including an approach to positive action, to improve access, experience and outcomes for people from all backgrounds and communities, including people who work and volunteer for the organisation, those who use Trust services and their families, and those who work in partnership with the Trust to improve the health and well-being of local communities. On behalf of the Trust Board, it will have oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
The Equality, Inclusion and Involvement Committee is chaired by a Non-Executive Director. At least one other Non-Executive Director also sits on the Forum as well as relevant Directors of the Trust.

Membership as at 1 July 2022
Chair – Chair of the Trust – Marie Burnham
Non-Executive Director – Erfana Mahmood
Non-Executive Director – Mike Ford
Chief Executive – Mark Brooks
Salma Yasmeen – Director of Strategy (Lead Director)
Chief People Officer – Greg Moores

Attendance
Technical support is provided by the Trust Marketing, Communication, Engagement and Inclusion Lead who is a regular attendee at Committee meetings. A Governor (appointed by the Members' Council), the staff side representative with lead for equality and diversity, a representative from each of the staff equality networks (when required), and a representative for each BDU equality forum, is also invited to attend meetings. Other directors and relevant officers attend the Committee by invitation. Administrative support is provided by the Personal Assistant to the Lead Director.

Quorum
The quorum will be half of the membership which must include one Non-Executive Director

and one Director; however, members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

The Committee will meet a minimum of four times per year and be reviewed every twelve months.

Duties

- To promote the values of inclusivity, mainstreaming equality, diversity, involvement and inclusion across the Trust.
- To monitor, scrutinise and provide assurance to Trust Board that the Trust has a co-ordinated approach to promoting the values of inclusivity developed in partnership with other key stakeholders including service users, carers, staff and Members' Council.
- To monitor and provide assurance to Trust Board that the Trust is embedding diversity and inclusion and involvement in all its activities and functions.
- To provide assurance to Trust Board that the Trust is advancing equality of opportunity and fostering good relations with all communities that its serves
- To monitor, scrutinise and provide assurance to Trust Board that the Trust is compliant with legal and national guidance, including Equality Delivery System (EDS2), the Workforce Race Equality Standard (WRES), and the Workforce Disability Equality Standard (WDES).
- To agree an annual work plan that links to the Trust's strategic direction, workforce plan and the wider priority programmes and to monitor progress.
- To monitor implementation of strategic objectives relevant to sustainability, providing assurance to Trust Board that these are appropriately managed and resourced.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the approved minutes of Committee at the next Trust Board meeting following the Committee meeting at which they are approved. The Committee will also report to the Board annually on its work (see above).

All Trust Board committees have a responsibility to ensure they foster and maintain relationships and links between the Forums / Committees and Trust Board. Each committee also has a responsibility to ensure actions identified and agreed are placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

Trust Board will receive bi-annual updates from the Committee about the management and resourcing of strategic objectives relevant to sustainability.

Reporting requirements into the Committee

The Equality Inclusion and Involvement Committee received regular performance reports on Equality Standards, Equality Delivery System and Equality Impact Assessments., plus feedback from staff networks and development programmes.

The Committee receives the annual reports on equality and diversity, Workforce Disability Equality Standard and Workforce Race Equality Standard before submission to Trust Board.

The Committee will receive an annual Equality Inclusion and involvement report

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Next review due: April 2023

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 September 2022
Agenda item 12.3

Private/Public paper:	**Public**		
Title:	**Workforce and Remuneration Committee (proposed People and Remuneration Committee) Terms of Reference**		
Paper presented by:	**Deputy Chair**		
Paper prepared by:	**Chief People Officer**		
Purpose:	To provide assurance to Trust Board that following proposed changes to Board membership, its committees operate effectively and meet the requirements of their terms of reference.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	3 x people risks		
Any background papers / previously considered by:	Workforce and Remuneration Committee terms of reference have been considered at the following meetings: • Trust Board June 2022 • Executive Management Team 1 September 2022 • Workforce and Remuneration Committee 13 September 2022		
Executive summary:	In August 2022 a review of the Workforce and Remuneration Committee terms of reference took place. The review has suggested the separation of the People and Remuneration aspects of the Committee, and the terms of reference have been amended to reflect this new structure. The duties of the Committee have been updated to reflect this separation. Membership of the Committee remains the same, with the attendance of role specific People directorate staff updated for certain items. The Committee will deal with People matters at all meetings. Should any Remuneration matters arise, through update, or as part of an annual process, they will be added to the agenda. Remuneration must be discussed by the Committee at least once a year to approve the remuneration report as part of the Annual report and accounts in liaison with the Deputy Director of Corporate Governance.		

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	The attached terms of reference have been reviewed by both the Executive Management Team and Workforce and Remuneration Committee and are authorised for submission to Trust Board for approval. Trust Board is also asked to approve the proposal to change the name of the Committee to the “People and Remuneration Committee”.
Recommendation:	**Trust Board is asked to APPROVE the changes to the terms of reference and the change of the Committee name to People and Remuneration Committee.**

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PEOPLE AND REMUNERATION COMMITTEE
Terms of Reference
To be approved by Trust Board on 27 September 2022

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The People and Remuneration Committee (formerly known as Workforce and Remuneration Committee was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role and revised membership.

The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose

The People and Remuneration Committee has delegated authority for developing and determining appropriate pay and reward packages for the Chief Executive and Executive Directors and a local pay framework for senior managers as appropriate that actively contribute to the achievement of the Trust's aims and objectives.

The Committee also has delegated authority to approve any termination payments for the Chief Executive and Executive Directors. Additionally, the Committee is responsible for ratifying Clinical Excellence Awards for Consultant Medical Staff.

The Committee also supports and monitors the strategic development of human resources and workforce development and considers issues and risks relating to the broader workforce strategy.

On behalf of Trust Board, it reviews in detail key workforce performance issues, and takes ownership of workforce-related strategic risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, and giving assurance to the Board around the management of such risks.

The Committee will support the development of an organisational culture where staff feel free, safe and able to raise concerns at work without fear of suffering a detriment. This includes supporting the lead Freedom to Speak Up Guardian to actively encourage and promote the Trust's commitment to the principles of Freedom to Speak Up which ensures the safety and welfare of Staff, Service Users, Carers and Visitors.

In August 2022 a decision was taken to separate the people and remuneration aspects of the committee and the terms of reference were amended to reflect this new structure.

Membership, attendance and duties for each part of the committee are stipulated below.

The Committee will deal with people matters at all meetings. Should any remuneration matters arise, through update or as part of an annual

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process they will be added to the agenda. Remuneration must be discussed by the committee at least once a year to approve the remuneration report as part of the Annual report and accounts.

Membership

Membership of the Committee is comprised of the Chair of the Trust, two Non-Executive Directors and the Chief Executive.

Membership for People and Remuneration items as at 1 July 2022
Chair – Non-Executive Director – Mandy Griffin;
Non-Executive Director – Marie Burnham (Chair of the Trust);
Non-Executive Director – Nat McMillan;
Chief Executive (non-voting Committee member) – Mark Brooks.

Attendance

People items

The Chief People Officer is in attendance at meetings as lead Director and provides advice and support to the Committee. The Chief Operating Officer is also in attendance. Administrative support is provided by the Personal Assistant to the Chief People Officer. Also in attendance, at the request of the Committee will be members of the People Directorate, Senior Leadership team.

Remuneration items

The Chief Executive is a non-voting member of the Committee and will take no part in or be present for any items relating to his/her own personal remuneration or conditions of service. The Chief People Officer is in attendance at meetings as lead Director and provides advice and support to the Committee. Administrative support is provided by the Personal Assistant to the Chief People Officer.

Quorum

People and Remuneration

The quorum will be two Non-Executive Director members. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of the Chief Executive, the Chair of the Committee will decide whether it is appropriate for the Deputy Chief Executive to attend as a non-voting member.

Frequency of meetings

People

The Committee will meet no less than four times per year to discuss people matters.

Remuneration

The Committee will meet no less than once a year to discuss remuneration matters.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

Authority

People and Remuneration

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Sub-committees

People

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees including but not limited to:

- Clinical Excellence Awards Panel.

Remuneration

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees.

Duties

People

1. To approve recommendations of the Clinical Excellence Awards Panel for Clinical Excellence Awards to Consultant Medical Staff.
2. To support the strategic development of human resources and workforce development and consider issues and risks relating to the broader workforce strategy.
3. On behalf of Trust Board, to monitor progress of the Workforce Strategy and review in detail key workforce performance issues.
4. To have oversight of workforce-related strategic risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.
5. To consider future national developments which could impact on the Trust's strategic workforce objectives.
6. To have oversight of the Trust's approach to Freedom to Speak Up including receiving at least 2 reports every year, one of which should be the annual report, from the lead Freedom to Speak Up Guardian.
7. On behalf of the Trust Board, to monitor progress of the Freedom to Speak Up Strategy and action plan and review in detail relevant performance indicators.
8. To listen to staff experience and stories at each meeting.

Remuneration

1. To develop and determine appropriate pay and reward packages for the Chief Executive, Executive Directors and other designated senior managers and other locally determined pay arrangements that actively contribute to the achievement of the Trust's aims and objectives, are affordable and are in line with the Trust's financial strategy. Specifically to:
    a) determine the remuneration arrangements for Executive Directors and to agree individual salary levels for Executive Directors;
    b) to determine any annual uplift, for example, cost of living, for the Chief Executive and Executive Directors;
    c) to ratify remuneration arrangements for senior management posts;
    d) to approve any annual uplifts in pay structures and any performance-related pay arrangements for senior posts;
    e) to approve any termination payments to the Chief Executive and Executive Directors and ensure these are properly calculated and reasonable with regard to probity and value for money;
    f) to receive a report from the Chief Executive of any proposed termination payments to be made to senior managers.
2. Under delegated authority from Trust Board as deemed appropriate for each circumstance, to agree and oversee the process for the appointment of the Chief Executive and Executive Directors of the Trust.
3. To receive an annual report from the Chief Executive documenting the performance of executive directors in relation to the achievement of the Trusts Strategic Objectives.

Monitoring

People and Remuneration

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

People and Remuneration

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting. Confidential personnel matters will go to the private session of Trust Board, if appropriate, and the decisions of the Committee in relation to specific salary matters are reported to the Non-Executive Directors of the Trust only. The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups (TAGs).

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Trust Board September 2022
Agenda item 12.4

Private/Public paper:	**Public**		
Title:	**Internal meetings' governance framework update**		
Paper presented by:	**Deputy Director of Corporate Governance**		
Paper prepared by:	Head of Corporate Governance		
Purpose:	To review the Trust's internal meeting governance structures to ensure they support the delivery of the Trust's mission and values, strategic objectives and legal requirements and provide the Trust Board and committees of the Board with the required levels of assurance.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	All		
Any background papers / previously considered by:	Previous Paper to Trust Board November 2021 Draft updates reviewed by EMT on 4 and 18 August 2022		
Executive summary:	The Trust internal meetings' 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 meetings' governance framework identifies the first and second lines of assurance reporting into the formal sub-committees of the Board. The framework has been updated to reflect the following changes: 1st line of assurance (green) • Updated list of groups reporting into EMT • Alignment of the Safety TAG (Trust Action Group) to Audit Committee • Alignment of Allied Health Professionals Group to the Nursing and Quality group 2nd line of assurance (blue) • Alignment of Trust Research and Innovation Group to Clinical Governance Clinical Safety Committee		

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	• Alignment of Complex Case Meeting to Clinical Governance Clinical Safety Committee • Alignment of Trust Partnership Forum (+finance) and JLNC BMA Staff side to Workforce and Remuneration Committee <u>3rd line of assurance (purple)</u> • Alignment of the Charitable Funds Committee to the Corporate Trustee **Risk Appetite** The delivery of the internal meetings' governance framework supports the Trust in providing safe, high quality and equitable services within available resources through an integrated approach to delivery, management of risk and the provision of assurance at the right level. Improving the Trust's efficiency and effectiveness in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to RECEIVE the update to the internal meetings' governance framework.**

Internal Governance structure – 3 lines of assurance

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 NHS Foundation Trust

- Members Council
- Trust Board
- Corporate Trustee
- Nominations Committee
- Quality Group
- Co-ordination Group
- West Yorkshire Mental Health, Learning Disability & Autism Services Collaborative (WYMHLDA) Committee in Common
- Audit Committee
- Clinical Governance & Clinical Safety Committee
- Finance, Investment & Performance Committee
- Workforce and Remuneration Committee
- Equality, Inclusion & Involvement Committee
- Mental Health Act Committee
- Provider Collaborative Committee
- Charitable Funds Committee
- Linked Charities Governance Group
- Executive Management Team
- Clinical Policy Group
- Drug & Therapeutic Sub-Committee
- Clinical Governance Group
- Complex Case Meeting
- JLNC BMA Staff side
- Equality Inclusion and involvement sub-committee
- Hospital Managers
- MHA and MCA Code of Practice Group
- Trust Partnership Forum (+Finance)
- Operational Management Group
- Risk panel
- Resus & Oxygen TAG ECT TAG Non medical prescribing steering group
- Clinical Ethics Advisory Group
- Infection prevention and control TAG
- Quality Improvement Group
- Patient Safety Strategy Group (inc Suicide Prevention Group)
- Extended EMT
- Improving Clinical Information Group
- IM&T TAG
- Estates TAG
- Benchmarking Group
- Corporate Policy, Procedure and Risk Group
- Nursing Quality Group
- AHP Advisor Group
- Safeguarding Strategic Group
- Physical Health Optimisation Group
- Trust Research and Innovation Group
- NICE Steering & Overview Group
- Clinical Policies and Procedures Group
- Medical Devices & Safety Alerts Group
- BDU governance groups
- Reducing Restrictive Physical Intervention TAG
- Falls Group
- Transformation/ Improvement Boards
- Bids and Tenders Meeting
- CQUIN Meeting
- Clinical Record Keeping Improvement Group
- Safety TAG
- Allied Health Professionals Quality Group
- Patient Safety Clinical Reference Group
- Clinical Risk Training Group
- Medical Education TAG
- Undergraduate Non Medical Education Group
- Medical Staff Committee
- Training Governance Group
- Specialist Advisors Training Group
- Barnsley Integrated Services Care Group
- CAMHS and Children's Care Group
- Adults and Older People Mental Health Care Group
- Forensic Care Group
- Learning Disability and Adult ASD/ADHD Care Group
- Linked Charities
- Safe Medicines Practice Group
- Safeguarding Link Practitioner Forum
- Prevent Action Group
- Staff Side Comms Group
- Trust Partnership Forums
  - Individual CARE GROUPS
  - Corporate Services

Key

1st line – front line, specialists, operational, policy, KPIs, risk registers, reports on system, controls

2nd line – oversight of management activity, compliance, reviews

3rd line – independent, objective

--- report as required on an exception basis

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 September 2022
Agenda item 12.5

Private/Public paper:	**Public**		
Title:	**Use of Trust Seal**		
Paper presented by:	**Chair**		
Paper prepared by:	Company Secretary on behalf of the Chief Executive		
Purpose:	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.		
Strategic objectives:	Improve Health	✓	Please tick as appropriate
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	N/A		
Any background papers / previously considered by:	Quarterly reports to Trust Board.		
Executive summary:	The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance and Resources of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive. The Trust Seal has not been used once since the report to Trust Board in June 2022.		
Recommendation:	**Trust Board is asked to NOTE the Trust Seal has not been used since the last report in June 2022.**		

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Trust Board annual work programme 2022-23

	Business and risk
	Performance and monitoring
	Strategic Board Meeting
✘	Item deferred

Note that some items may be verbal

Agenda item / issue	26 Apr	24 May	28 June	26 July	23 Aug	27 Sept	25 Oct	29 Nov	20 Dec	31 Jan	28 Feb	28 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	✘		✘	✘		✘	✘	✘		✘		✘

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Agenda item / issue	26 Apr	24 May	28 June	26 July	23 Aug	27 Sept	25 Oct	29 Nov	20 Dec	31 Jan	28 Feb	28 Mar
Chief Executive's Report	✘		✘	✘		✘	✘	✘		✘		✘
Questions from the public (item 3)	✘		✘	✘		✘	✘	✘		✘		✘
Any other business (public and private)	✘		✘	✘		✘	✘	✘		✘		✘
Risk and Assurance												
Board Assurance Framework	✘			✘			✘			✘		
Corporate / organisational risk register	✘			✘			✘			✘		
Strategic overview of business and associated risk												✘
Review of Risk Appetite statement							✘					
Complex Incidents update (private session)	✘		✘	✘		✘	✘	✘		✘		✘
Serious Incidents quarterly report (public)			✘			✘		✘				✘
Risk assessment of performance targets, CQUINS and System Oversight Framework and agreement of KPIs	✘											
Assurance from Trust Board committees and Members' Council	✘		✘	✘		✘	✘	✘		✘		✘
Guardian of safe working hours annual report	✘											
Workforce Equality Standards						✘						
Medical appraisal / revalidation annual report						✘						
Ligature Annual Report								✘				
Freedom to Speak Up Annual report												✘
Medical Education Annual Board report								✘				
Data Security and Protection toolkit	✘											

Agenda item / issue	26 Apr	24 May	28 June	26 July	23 Aug	27 Sept	25 Oct	29 Nov	20 Dec	31 Jan	28 Feb	28 Mar
Annual report and accounts (including Quality Account for 2022)		✘										
Annual Governance Statement	✘											
Equality and diversity annual report							✘					
Serious incidents annual report			✘									
Health and safety annual report			✘	✘								
Patient Experience annual report			✘	✘								
Sustainability annual report						✘	✘					
Premises Assurance Model (new annual report 2021)			✘	✘								
EPRR Compliance report						✘	✘					
Integrated Care Systems and Partnerships												
South Yorkshire update including the South Yorkshire Integrated Care System (SY ICS)	✘		✘	✘		✘	✘	✘		✘		✘
West Yorkshire update including the West Yorkshire & Health & Care Partnership (WYHCP)	✘		✘	✘		✘	✘	✘		✘		✘
Provider Collaboratives and Alliances	✘		✘	✘		✘	✘	✘		✘		✘
Performance reports												
Integrated Performance Report (IPR)	✘		✘	✘		✘	✘	✘		✘		✘
Safer Staffing report	✘							✘				
System Oversight Framework												✘
Strategic Direction												
Board Development		✘			✘				✘		✘	

Agenda item / issue	26 Apr	24 May	28 June	26 July	23 Aug	27 Sept	25 Oct	29 Nov	20 Dec	31 Jan	28 Feb	28 Mar
Covid-19 Reflections		✘			✘				✘		✘	
Horizon Scanning – Focus On		✘			✘				✘		✘	
Investment Appraisal Framework (private)	✘						✘					
Strategic Objectives												✘
Trust Board Annual Work Programme											✘ (draft)	✘
Operational Plan (private)										✘ (draft / private)	✘ (draft / private)	✘ (draft / private)
Five-year plan (for review November 2023)												
Governance												
Constitution (including Standing Orders) and Scheme of Delegation *(October 2022)*							✘			✘ **(SFI's and SOD)**		
Compliance with NHS provider licence conditions and code of governance - self-certifications *(date to be confirmed by NHS Improvement)*	✘		✘									
Going Concern Statement	✘											
Assessment against NHS Constitution				✘								
Audit Committee annual report including committee annual reports and terms of reference	✘											
Use of Trust Seal			✘			✘		✘				✘
Strategies and Policies												
Digital strategy (including IMT) **update**							✘					
Estates strategy **update**				✘						✘		
Customer Services policy *(update required Sept 2022)*						✘				✘		

Agenda item / issue	26 Apr	24 May	28 June	26 July	23 Aug	27 Sept	25 Oct	29 Nov	20 Dec	31 Jan	28 Feb	28 Mar
Estates strategy *(September 2022) (July 2022 in draft prior to sign off – private board)*				✘								
Learning from Healthcare Deaths Policy (January 2023)										✘		
Sustainability strategy *(scheduled for July 2022)*	✘	✘		✘								
Organisational Development Strategy *(September 2022)*			✘			✘			✘ **(draft?)**	✘		
Workforce strategy *(April 2024)*												
Quality strategy *(September 2022)*						✘			✘			
Risk Management Strategy *(April 2022)*	✘											

Policy / strategy review dates:

- Trust Strategy *(reviewed as required)*
- Standing Financial Instructions *(delegated approval authority to Audit Committee, reviewed as required)*
- Treasury management strategy and policy (delegated approval authority to Audit Committee, reviewed as required)
- Constitution (July/October 2022) – (deferred to await ICS changes) (Scheme of Delegation may need to come back for further update)
- Equality, Involvement, Communication and Membership Strategy (October 2023)
- Emergency Preparedness Resilience and Response Policy (November 2025)
- Customer Services Policy *(September 2022)*
- Digital Strategy *(next due for review in March 2024)*
- Estates Strategy *(next due for review in September 2022)*
- Learning from Healthcare Deaths Policy *(next due for review in January 2023)*
- Organisational Development Strategy *(next due for review in June 2022 – deferred to January 2023)*
- Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) (amendment version June 2021) *(next due for review in February2023)*
- Procurement Strategy
- Quality Strategy *(next due for review in September 2022 -deferred to December 22)*
- Risk management strategy *(next due for review in April 2022)*
- Standards of Conduct in Public Service Policy (conflicts of interest) *(next due for review in September 2022)*
- Sustainability Strategy *(to be reviewed with the Estates Strategy, by July 2022)*
- Trust Board declaration and register of fit and proper persons, interests and independence policy *(next due for review in March 2024)*
- Workforce Strategy *(next due for review in March 2023)*