NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 27 June 2023 at 9.30
Large Conference Room – Wellbeing and Development Centre
Fieldhead Hospital Wakefield

AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	**9.30**	**Welcome, introductions and apologies**	Chair	**Verbal item**	1	To receive
2.	**9.31**	**Declarations of interest**	Chair	**Verbal**	2	To receive
3.	**9.33**	**Questions from the public** *(received in advance in writing by e:mail to membership@swyt.nhs.uk)*	Chair	**Verbal**	5	
4.	**9.38**	**Minutes from previous Trust Board meeting held 25 April 2023**	Chair	**Paper**	2	To approve
5.	**9.40**	**Matters arising from previous Trust Board meeting held 25 April 2023 and board action log**	Chair	**Paper**	5	To approve
6.	**9.45**	**Service User / Staff Member / Carer Story**	Chief Operating Officer	**Verbal item**	10	To receive
7.	**9.55**	**Chair's remarks**	Chair	**Verbal item**	3	To receive

With **all of us** in mind.

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
8.	**9.58**	**Chief Executive's report**	Chief Executive	**Paper**	7	To receive
9.	**10.05**	**Performance**				
	10.05	9.1 Integrated performance report Month 2 2023/24	Executive Directors	**Paper**	40	To receive
	10.45	9.2 2022 NHS Staff survey update	Chief People Officer	**Paper**	5	To receive
	10.50	*Break*			*10*	
10.	**11.00**	**Risk and Assurance**				
	11.00	10.1 Incident Management Annual report	Chief Nurse/Director of Quality and Professions	**Paper**	10	To receive
	11.10	10.2 CQC inspection reports updated	Chief Nurse/Director of Quality and Professions	**Paper**	5	To receive
	11.15	10.3 Premises Assurance Model annual report	Director of Finance, Estates and Resources	**Paper**	5	To approve
	11.20	10.4 Data Security and Protection Toolkit	Director of Finance, Estates and Resources	**Paper**	5	To approve

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.25	10.5 Guardian of Safe Working hours report	Chief Medical Officer	**Paper**	5	To approve
	11.30	10.6 Assurance and receipt of minutes from Trust Board Committees and Members' Council - Audit Committee 26 June 2023 - Collaborative Committee 5 June 2023 - Clinical Governance & Clinical Safety Committee 16 May 2023 - Equality, Inclusion and Involvement Committee 14 June 2023 - Finance, Investment & Performance Committee 19 June 2023 - Mental Health Act Committee 16 May 2023 - Members Council 9 May 2023 - People and Remuneration Committee 23 May 2023 - WYMHLDA Committees in Common 26 April 2023	Chairs of committees/Members' Council	**Paper**	10	To receive
	11.40	*Break*			*10*	
11.	**11.50**	**Integrated Care Systems and Partnerships**				
	11.50	11.1 South Yorkshire update including and South Yorkshire Integrated Care System (SYICS)	Chief Executive/ Director of Strategy and Change	**Paper**	10	To receive
	12.00	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/Director of Provider Development	**Paper**	10	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	12.10	11.3 Provider Collaboratives and Alliances	Director of Finance, Estates and Resources/Director of Provider Development	**Paper**	10	To receive
12.	**12.20**	**Governance matters**				
	12.20	12.1 Compliance with NHS provider licence conditions and code of governance - self-certifications	Director of Finance, Estates and Resources	**Paper**	5	To receive
	12.25	12.2 Trust Seal	Chair	**Paper**	2	To approve
13.	12.27	**Trust Board work programme for 2022/23**	Chair	**Paper**	3	To approve
14.	12.30	**Any other business**	Chair	**Verbal**	3	To receive
15.	12.33	**Date of next meeting** The next Trust Board meeting held in public will be held on Tuesday 25 July 2023	Chair	**Verbal**	2	To receive
	12.35	*Close*				

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 25 April 2023
Large Conference Room, Wellbeing and Development Centre, Fieldhead Hospital

Present:	Marie Burnham (MBu)	Chair
	Mike Ford (MF) (via MS Teams)	Senior Independent Director
	Erfana Mahmood (EM)	Non-Executive Director
	Natalie McMillan (NM) (via MS Teams)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	David Webster (DW)	Non-Executive Director
	Mark Brooks (MBr)	Chief Executive
	Carol Harris (CH)	Chief Operating Officer
	Adrian Snarr (AS)	Director of Finance, Estates and Resources
	Dr.Subha Thiyagesh (ST)	Chief Medical Officer
	Darryl Thompson (DT)	Chief Nurse/Director of Quality and Professions
	Salma Yasmeen (SY)	Deputy Chief Executive/Director of Strategy and Change
Apologies:	Mandy Rayner (MR)	Deputy Chair
In attendance:	Greg Moores (GM)	Chief People Officer
	Sean Rayner (SR)	Director of Provider Development
	Julie Williams (JW)	Deputy Director of Corporate Governance
	Andy Lister (AL)	Company Secretary (author)
Observers:	Julia Zebelys – Care Quality Commission	

TB/23/31 Welcome, introduction and apologies (agenda item 1)

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

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 reported Mike Ford (MF) and Nat McMillan (NM) are attending the meeting via Microsoft Teams today.

MBu informed attendees that the meeting is being recorded for administration purposes, to support minute taking, and once the minutes are completed the recording will not be retained. Attendees of the meeting are advised they should not record the meeting unless they have been granted authority by the Trust prior to the meeting taking place.

MBu reminded members of the public that there will be an opportunity at item 3 for questions and comments, received in writing.

TB/23/32 Declarations of interest (agenda item 2)

Salma Yasmeen is the chief executive designate for Sheffield Health and Social Care NHS Foundation Trust.

It was RESOLVED to NOTE the updates to the declarations of interest.

TB/23/33 Questions from the public (agenda item 3)

There were no questions from the public.

It was RESOLVED to NOTE there were no questions received from members of the public.

TB/23/34 Minutes from previous Trust Board meeting held 28 March 2023 (agenda item 4)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 28 March 2023 as a true and accurate record.

TB/23/35 Matters arising from previous Trust Board meeting held 28 March 2023 and board action log (agenda item 5)

TB/23/24a - agency spend - Nat McMillan (NM) noted the timescale of May/August 2023 and queried if the timescale could be any more specific given the need to focus on this matter? Greg Moores (GM) reported he is to take a paper to people and remuneration committee (PRC) PRC in May 2023.

It was RESOLVED to NOTE the updates to the action log and the Board AGREED to close all actions with updates for April 2023 and any other actions where closure is proposed in the comments.

TB/23/36 Service User/Staff Member/Carer story (agenda item 6)

Carol Harris (CH) introduced Peter (P), Casey (C) and Kirsty Brooke (KB), Manager of the Poplars ward. P and C have attended Board today to tell their story about Julie's (J) care on the Poplars ward. J was P's wife and C's mother.

MBu introduced all board members to P, C and KB.

P spoke of his late wife J, informing the Board that J was a dancer and choreographer and he described her as "fit as a fiddle". P reported J was diagnosed with Alzheimer's disease in 2015. P stated people associate Alzheimer's disease as slow memory loss as a result of old age, but from his own experience this is not the case.

After J was diagnosed in 2015, J and the family went through a massive life change. The family began looking after J at home, with support from people they hired to help, and then friends helping to look after her. This continued for a few years.

J's condition was deteriorating daily and reached the point in February 2022 where P felt he couldn't offer J the level of care she needed at home. P said this was a huge decision and they managed to find a nursing home just around the corner from where they lived. The family believed they had chosen the best and most suitable care available. J was placed in the normal care wing initially, but was quickly moved to the dementia wing.

From this point the deterioration in J's behaviour seemed to accelerate and a number of unwitnessed falls took place. P reported he did not hold the staff to blame for these falls, they were understaffed and under pressure.

J then came to Fieldhead hospital for a week. At the time, J had Covid 19 and so the family were unable to visit her. Shortly after this J was moved to the Poplars ward.

P said he could say with accuracy and true feeling from the first moment of walking into Poplars, he felt the calmness and the serenity of the ward, and it helped the family feel confident in leaving J in the care of others for the first time.

The family visited J daily, but on leaving her, they always felt safe in the knowledge that J was being properly cared for. Information provided by the ward was always accurate and consistent, all the staff were aware of J and her care and treatment requirements. When the family made requests of the ward, they were actioned straightaway by KB and her team. P said C had summed things up well when he said they could not have got better care for his mum if they had paid for it.

C told the Board how hard it had been to put his mum in to care. When she was in the care home the family felt nervous and had uncertainty all the time, her mental health deteriorated and the staff were struggling to support her.

C stated the family didn't see J for two/three weeks due to Covid-19, but as soon as they walked through the door of Poplars any worries went out of their mind. J's smile had returned, and her mental health had improved, despite her condition worsening. C reported when the family had taken J to the acute hospital previously, she had just been put in a room, there was no real care. P reflected that the acute hospital had looked to treat the illness and not any form of J's condition.

KB added that J's physical health had deteriorated very quickly on Poplars and staff had used a specialist type of chair to help move around the ward.

C reported if it had not been for this chair his mum would have been bed bound.
Staff had helped by asking C, P and their family how they were, and acknowledging that as a family they were going through a hard time. C stated with Poplars he was confident in his mum's care. When it came to the end, C and P felt very informed of what was taking place. It meant the world to them because they could make a very informed decision. C said the level of end-of-life care was unbelievable, stating his mum's care was perfect, it made the unbearable, bearable.

KB informed the Board Poplars staff had sat down and discussed the position with the family and done the best job possible with what they had to offer.

In response P stated KB and her staff had gone way beyond their best. When J was in her last days, the level of care was amazing.

MBr thanked P and C for sharing their personal story with the Board. MBr noted that C had mentioned his own mental health and asked if there was anything more the Trust could have done?

C reported the family were cared for when they visited. The ward psychologist offered one to one support, but at the time C wanted to be with his mum as he did not know how long she had left.

C stated his mum was diagnosed at 51, it was very early, and the last ten years had been very hard. C felt he was ready to get support now for this mental health, he added that he has tried

to access services before and waiting lists have been very long. C stated it's hard to make the first steps to ask for help and it would be good if services were aware of the situation and offered help, rather than C having to make the approach himself. C is considering doing this, but it costs a lot of money. C told the Board his memories of his mum's passing and the trauma's involved are still very clear.

CH reported she would speak to KB and see what support could be offered.

Action: Carol Harris

Dr.Subha Thiyagesh (ST) thanked P and C for their story and informed them that the Trust is in the process of older people's services transformation and asked if P and C would be willing to share their experiences to help improve the service for others? P and C agreed.

Action: Subha Thiyagesh

KB reported that P is doing some fundraising to provide an additional chair for the ward to help other patients like J.

Salma Yasmeen (SY) reported the Trust charity EyUp! could support any fundraising initiatives and could help publicise the event. SY would contact Jana Harris to contact P to see how they could be of support.

Action: Salma Yasmeen

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

TB/23/37 Chair's remarks (agenda item 7)

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

- Private risk register
- Collaborative Committee minutes.
- South Yorkshire Committees in Common joint working agreement and terms of reference
- Complex incidents update
- Operational planning for 23/24
- Investment appraisal six monthly report

It was RESOLVED to NOTE the Chair's remarks.

TB/23/38 Chief Executive's report (agenda item 8)

Chief Executive's report

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

- Today's meeting focuses on business and risk, and when considering risk, the Trust is looking at the impact of industrial action, the tightening of NHS finances nationally and regionally, ongoing challenges with acuity and demand, and continued workforce challenges. These risks are presented today in the board assurance framework (BAF) and organisational risk register (ORR)
- The integrated performance report will be presented later today. The Trust uses quality improvement methodology which can take some time, but improvements in risk assessments and care planning metrics are now being seen
- MBr gave his heartfelt thanks to Trust staff for managing the recent junior doctors industrial action that took place after the Easter break. As a result of everyone's efforts there was minimal impact and safe services were maintained throughout.

- The Royal College of Nursing has declined the governments most recent pay offer and so further industrial action is likely and a re-ballot is expected.
- The Hewitt review has been published which looks at the future of integrated care systems. It is a detailed report that includes reducing the number targets on ICBs, a focus on prevention and the role of provider collaboratives.
- Financial planning was due to be completed by the end of March, but has been extended to early May due to a reported national £3bn deficit against the funds available based on the latest submissions
- We need to also keep good news in focus and we have just heard about an outstanding episode of care in today's board story from Peter and Casey
- The Trust's perinatal team have gained a chief nurse officer's care support excellence award
- MBr was at Baghill House in Pontefract last week, and noted the continuing level of innovation and improvement that staff are making is now second nature to them. There were many thank you cards on the wall, one showing how a staff member had gone over and above to help a family get new accommodation, which had been life changing
- The board papers include an update on how we can influence the system with Dr.Subha Thiyagesh (ST) including a report in her role as executive learning disability champion.
- MBr offered congratulations to Salma Yasmeen (SY) as the chief executive designate for Sheffield Health and Social Care NHS Foundation Trust. The Trust needs to declare an additional interest due SY's impending move.

Action: Andy Lister

NM endorsed MBr's comments and asked the Board to recognise the operational pressures and reflect on the good work of teams across the Trust, and noted this is reflected regularly through reports received by the clinical governance clinical safety committee.

The Board fully supported NM's comments.

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

TB/23/39 Risk and assurance (agenda item 9)

TB/22/39a Board Assurance Framework (BAF) (agenda item 9.1)

Adrian Snarr (AS) introduced the item and reported the board assurance framework (BAF) is the document that records risks that may prevent the Trust achieving its strategic objectives:

- This is the Q4 report for 2022/23
- The executive management team (EMT) have conducted a full review of the BAF
- There has been a recommended grading change to 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. Integrated care boards are now established and given our engagement with them and role in each place the risk has been reduced and there is a proposed to move to yellow.
- Operational challenges are reflected in the document, 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 - EMT discussed that current level of demand and complexity, levels of sickness/absence, the creation of new services and roles and notes these will continue to impact on supply and resources, to remain Amber.
- 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 and 4.3 - Failure to support the wellbeing of staff - have been reviewed by EMT and represent significant challenge but retain their gradings

Mike Ford (MF) reported he is supportive of the proposed changes and queried risk 2.1 - The increasing demand for strong analysis based on robust information systems means there is insufficient high-quality management and clinical information to meet all of our strategic objectives. MF reported this strategic risk feels within the Trust's control to change, and any extra analysis or reporting could be beneficial to other strategic risks.

MBr reported the Trust is doing a good job in terms of its own development in the use of data. At the executive management team (EMT) meeting last week there was a demonstration of a future platform that can be used to boost the coordination of the integrated performance report, enabling more internal time to be spent on analysis. The challenge is external, in terms of the demand for information, and Trust capacity to meet this demand. This is why the Amber grading has remained. MBr agreed this is a risk that should be able to move to yellow shortly.

SR added to MBr's comments and reported the Trust is inputting into several business intelligence discussions at place, looking at what service user needs are across our places.

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

TB/23/39b Strategic Risks for 2023/24 (agenda item 9.2)

Adrian Snarr (AS) introduced the item:

- EMT have reviewed all BAF risks and narrative descriptions
- The paper includes a proposed set of changes for 23/24
- Proposed changes have been reviewed by a group of non-executive directors (NED's) – Kate Quail (KQ), Erfana Mahmood (EM) and Mandy Rayner (MR)
- Following NED feedback there was further review of risks 3.4 and 4.2 and consideration of a new risk – failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience.
- The table in the paper shows the key changes for 2023/24 risks

Erfana Mahmood (EM) noted there had also been discussion in the NED group about digital changes in the system and people being expected to book onto services online and how this may exclude certain service users, and noted this has been included in the review.

Julie Williams (JW) noted a new board assurance framework schematic has been presented for approval in addition to the revised risk descriptions.

KQ noted it had been useful to be involved in the process and was assured to see the recommendations and suggestions taken into account.

It was RESOLVED to NOTE the report and APPROVE the updates to the strategic risks to be included in the Board Assurance Framework for 2023/24 and APPROVE the updated schematic as recommended by the Audit Committee.

(MBu welcomed Julia Zebylis from the Care Quality Commission (CQC) to the meeting, who joined virtually via MS teams)

TB/23/39c Corporate / organisational risk register (ORR) (agenda item 9.3)

Adrian Snarr (AS) introduced the item and highlighted the following points:

- All executive director leads have reviewed their sections of the ORR
- A significant review of controls and assurances has taken place

- There is an emergent risk regarding delayed transfers of care to consider
- The paper details the key reviews and amendments that have taken place for this quarter

MBu asked the Board to agree the changes outlined in the paper.

The Board agreed to approve the new risk - There is a risk that the cumulative impact of staff shortages, high turnover of staff, high use of temporary staffing, low supervision rates, opportunity to release staff for training and high acuity, could have a detrimental impact on the culture of a team which could then lead to patient harm.

The Board agreed to approve the new risk - Failure to implement a comprehensive system to monitor, manage and maintain medical devices in line with relevant legislation may lead to patient harm.

DT explained the context of the medical devices risk. DT reported the issue had come to light through the clinical governance group. The resuscitation lead had become aware some devices were outside of their servicing schedule. A project manager is now in place to ensure all devices are fully serviced and implement a robust process for future servicing schedules.

The Board agreed to increase the score of risk 1758 - The risk of disruption to services and reduction in staff due to industrial action and our inability to deliver care - from 12 to 16.

MBr reported this is a risk that will fluctuate in score dependant on circumstances at the time.

Risk 1614 – National clinical staff shortages resulting in vacancies which could lead to the delivery of potentially reduced quality, unsafe and / or reduced services, increased out of area placements and / or breaches in regulations - The Board agreed for this risk to be monitored by the people and remuneration committee (PRC) in addition to the clinical governance and clinical safety committee (CGCS), in light of the staffing challenges.

The Board agreed to reduce the score for risk 1689 – the Trust cannot evidence that it has mitigated against or addressed health inequalities in both the provision and restoration of services.

MBr reported the amount of work that has taken place in relation to heath inequalities has led to a decrease in the risk score, but this remains a fundamental Trust objective to be addressed. The equality, inclusion and involvement committee (EIIC) is now receiving much-improved information flow as a result of this work.

The Board agreed to increase the score for risk 1568 – Risk that a seclusion room will not be available due to damage that occurred placing staff and service users at an increased risk of harm.

CH reported the risk score represented a moment in time due to the damage that has been incurred. NM endorsed the increase in risk score following her visit to the Johnson ward having seen damage to one of the seclusion rooms.

The Board agreed to increase the score for risk 1511 – Risk that carrying out the role of lead provider for adult secure services across West and/ or South Yorkshire will result in financial, clinical, and other risk to the Trust.

MF reported the increase in risk for provider collaboratives was as a result of financial issues not quality or clinical issues.

The Board agreed to increase the risk score for risk 1368 – Risk that given demand and capacity issues across South & 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 finding placements for children is becoming increasingly difficult especially in terms of specialist residential placements.

MF reported the audit committee continues to discuss the cyber risk and look at ways in which the risk can be brought within risk appetite.

NM added that risks discussed during CGCS are included in the triple A report in a later item on the agenda.

MF noted the average risk score in the report is the same as the last report, but queried if this is correct given the number of risk score changes? AS agreed to check this.

Action: Adrian Snarr

It was RESOLVED to NOTE comments on the risk register and Trust Board confirmed they are ASSURED that current risk levels are appropriate, considering the Trust risk appetite, and given the current operating environment.

In addition, Trust Board AGREED to:

- **add the new risk in relation to the culture of a team**
- **add the new risk in relation to medical devices**
- **increase the risk score for risk 1758**
- **the addition to monitoring and assurance for risk 1614**
- **the reduction in risk score for risk 1689**
- **an increase in risk score for risk 1568**
- **an increase in risk score for risk 1368**

TB/23/39d Data Security and Protection Toolkit (DSPT) update (agenda item 9.4)

AS asked for the paper to be taken as read and highlighted the following points:

- On track with actions for the completion of the DSPT
- Submission is due on 30 June 2023
- 92 of 113 actions are complete
- Compliance with data and security mandatory training is currently at 86% and needs to be at 95%. Focussed work including weekly monitoring is taking place to address this
- Training is being provided to teams in person where necessary
- Managers are being contacted and hotspots have been identified

It was RESOLVED to NOTE the update for the Data Protection Security Toolkit.

TB/23/39e Draft Annual Governance Statement (AGS) (agenda item 9.5)

AS asked for the paper to be taken as read and highlighted the following points:

- Significant parts of the AGS are prescribed.
- The corporate governance team conduct checks each year to make sure the AGS is compliant against required standards

- There are sections of the AGS that report Trust performance and some of this data will be provided as part of year end processes
- The report has been reviewed by the Chief Executive as the accounting officer for the Trust

MBr reported the AGS has already been through audit committee, and this process is part of development of final statement. It is good practice to see it at Board at this stage.

MF confirmed an early version was received at audit committee earlier in the month and he will provide comments on the updated version in due course.

It was RESOLVED to NOTE the Draft Annual Governance Statement and comments made.

TB/23/39f Executive Champion for Learning Disabilities role (agenda item 9.6)

Dr. Subha Thiyagesh (ST) introduced the item and highlighted the following points:

- The Trust fully recognises the need to address health inequalities for people with a learning disability.
- To provide even greater focus, a decision was made by EMT colleagues to nominate an executive sponsor for the Trust's Learning Disability (LD) services.
- The paper explains the role to the board and how it will profile and increase the visibility of the LD service and the needs of people with a learning disability, internally and externally

MBr reported the reason ST will carry out this role is due to the inequalities experienced by those with a learning disability. The Trust is sending a clear message of our commitment to improve lives by nominating our medical director to lead this work, we can not only influence our own services but also the wider system to ensure the voice of those with a learning disability is heard.

Nat McMillan (NM) reported the proposal has been through CGCS and it is good to see this work being taken forward.

Greg Moores (GM) reported this is positive from a people perspective, we can bring this into the organisational development work that is taking place.

EM noted it is good to see LeDeR being brought into this role. Some of the priorities are for 2023/24 and it would be useful to see some deliverables and areas of service ownership.

KQ reported it would be useful to have regular updates to CGCS about progress in relation to this role and it will be good to also look at the over use of medication for people with a learning disability which is a national programme.

Action: Dr.Subha Thiyagesh

ST reported community pharmacists are involved in this work to ensure that overprescription isn't taking place.

CH reported strategic health facilitators are also part of this work and will support this work in each area, noting that they support physical health needs as well and link closely with GPs.

SY reported in Barnsley, the alliance with the GP federation has used the annual physical health checks to review medication. SY queried if the data in relation to over prescription was broken down by ethnicity as this gives useful insight. This should be a priority for inequalities work for next year.

Action: Salma Yasmeen

MBu noted this is a really positive move for the Trust and pleased ST has undertaken this role.

It was RESOLVED to NOTE the overview of the Executive sponsor role and the clinical and strategic approach of the service to improvement priorities over the next year and NOTE the comments made.

TB/23/39g Assurance and receipt of minutes from Trust Board Committees and Members' Council (agenda item 9.7)

Collaborative Committee 4 April 2023
MF highlighted the following:

- The committee is continuing to develop, having been in place for a year, and receives regular reporting on finance, contracting, quality and risk for the West and South Yorkshire adult secure provider collaboratives for which the Trust is coordinating provider.
- New for this meeting was an overall assurance report for West Yorkshire
- There are some challenges to make reporting consistent for the two provider collaboratives. This is due to them reporting from different data sources, but the committee is receiving assurance as required for the different areas of performance
- The risk around finalisation of contracts with certain providers has led to an increase in risk score. MF assured the Board that the risk is not quality related, it is a financial issue that is being progressed with NHS England
- The balance between information being received as a coordinating provider and information on being a provider in other collaboratives is being progressed

KQ queried what assurance the committee is receiving in relation to quality issues?

MF reported there are a number of different reviews taking place across the provider collaboratives, both internally and externally. Where issues have arisen, action plans have been put in place.

AS reported there are a number of quality oversight meetings that DT and Carmain Gibson-Holmes (CGH) chair. DT chairs South Yorkshire and CGH West Yorkshire. There is a process by which an organisation can be placed on enhanced oversight, if the need arises, to receive more detailed scrutiny. Triggers for this measure would be issues such as negative CCQ reports, or any quality issues that arise through oversight meetings. There are a number of West Yorkshire providers on enhanced scrutiny measures at present but none in South Yorkshire.

MBr noted not all contracts have been signed at this time and asked given the tightening financial picture for next year is there any additional risk for the Trust.?

AS reported there is one provider in South Yorkshire who hasn't signed their contract yet. The contract cannot be taken on until it is signed by NHS England (NHSE). We are negotiating with NHSE to see if we can ringfence that one provider on a separate agreement, and sign contracts with all other providers. NHSE are supporting this proposal, and this is being progressed.

MF noted Kate's reflection on quality issues and stated he would consider this in future triple A reports.

Action: Mike Ford

Audit Committee 11 April 2023
MF highlighted the following:

- The committee received the triangulation report that compares the risks from the BAF and ORR against the Integrated Performance Report (IPR). Some operational risks are not included in the IPR and the committee received assurance these are being monitored by other committees. There was consideration as to whether risks on the BAF and ORR should have measures by which they can be monitored in the IPR.
- Annual effectiveness reports for all Board committees were received with good levels of assurance. There have been some lessons learned and changes to the effectiveness surveys will take place for next year. This is being actioned through the Audit Committee.
- Induction training for new Non-Executive Directors on the Audit Committee and its key functions will also be addressed.
- Committee members met with internal audit and external audit for their annual meeting

MBr noted the Trust is progressing well to achieve significant assurance for the head of internal audit opinion which is positive, noting the Trust has a strong process for the follow up of internal audit actions.

Clinical Governance Clinical Safety Committee 11 April 2023
Nat McMillan (NM) highlighted the following:

- Mechanical restraint – there was a lengthy discussion around this matter at committee. The question around oversight was not about use of mechanical restraint, it was about the approval route for it.
- The safer staffing report is on today's agenda. The care group quality and safety report (known as the trio report) provides the committee with additional assurance on this matter.
- Tees Esk and Wear Valley report regarding learning from incidents in CAMHS has been released, learning from this report will be shared with board at a later date.

Action: Darryl Thompson

- A quality monitoring visit to Johnson ward went very well. The leadership on the ward was strong, staff and patients were very open, the ward was very clean and well presented
- The clinical and ethical advisory sub-group is under review
- The waiting list management report was received and has progressed well. AS to discuss with NM and DW about FIP and possible performance metrics to monitor waiting lists from a quality perspective.

Action: Adrian Snarr

Finance, Investment and Performance Committee 17 April 2023
David Webster (DW) highlighted the following:

- The national 23/24 NHS financial plan is in a challenging position
- A paper regarding an artificial intelligence (AI) tool for attention deficit and hyperactivity disorder (ADHD) was received by committee. The committee were satisfied with the commercial proposal but additional clinical assurance is required and is on the agenda for the private session in the afternoon
- A balanced financial plan has been submitted and DW gave thanks to AS and his team for all the work that has taken place to submit a balanced plan

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

TB/23/40 Performance (item 10)

TB/22/40a Integrated Performance Report (IPR) Month 12 2022-23 (agenda item 10.1)

AS highlighted the following in relation to priority programmes:

- Sharing of care plans and risk assessments metrics have improved
- Priority programmes have been reviewed by EMT and a paper will be taken to FIP in relation to proposals for 23/24

EM noted she was pleased to hear some programmes would continue into next year

MBr reported taking a proper quality improvement approach in relation to risk assessment and care plans has resulted in consistent improvement in recent months. The approach takes a little longer but should have longer-term impact.
There is an EMT timeout session in a couple of weeks where the IPR dashboard metrics for 23/24 will be reviewed and the outcome will be brought back to Board for discussion and agreement.

Quality
DT gave the following highlights from the report:

- Quality metrics are typically running well
- There were no complaints in March with staff attitude as an issue
- Information Governance breaches were over threshold in March
- Prone restraints all remain at 3 minutes or less
- Percentage of people dying in a place of their choosing has returned to 100%
- 96% of incidents resulted in low or no harm – this indicates a positive reporting culture
- There has been a continued reduction in falls. There is now a falls coordinator in place and all falls are being monitored for learning
- Friends and Family Test – all services are above target, except for our attention deficit and hyperactivity disorder (ADHD) service, but they only had ten responses, and are working to improve their level of feedback
- Acuity within services remains high and restraint numbers are a reflection of acuity. The reducing restrictive processes and interventions (RRPI) constantly monitor for incidents around restraint for learning purposes

MF noted there is a difference in the metrics complaints with staff attitude in the quality section to those presented in the care group section.

DT reported complaints for staff attitude in the quality section are those that have been received. In the care group section, the numbers represent those that have been upheld.

JW reported this would be made more explicit in future reports.

Action: Adrian Snarr

NM noted the learning in respect of the reduction in falls should come to CGCS to be discussed in more detail.

Action: Darryl Thompson

NM noted pressure ulcers are still red on the quality dashboard and asked for further scrutiny of this through CGCS.

DT agreed with NM's observation and noted while low in numbers they are impactive for the patients concerned. DT reported there is already an action in place to take an update on pressure ulcers through the chief nurse report. DT and NM to discuss if a further detailed report is required.

Action: Darryl Thompson

MBr noted restraint incidents are increasing and reducing restrictive practice and interventions (RRPI) training isn't where it needs to be, so there needs to be some focus on this.

Action: Greg Moores

NHSE national Indicators

AS reported:

- Strong performance across national metrics with two metrics of note
- 6 week wait for diagnostic procedures (pediatric audiology). We fall short on this metric given recent staffing issues. This is small service area and is subject to fluctuation
- Percentage of children and young people with an eating disorder designated as urgent – Board are to note the low patient numbers. We achieved on seven out of eight patients, but this means we are short of the target.

AS updated the Board on the approach for the redesign of the IPR noting EMT and FIP have received a presentation. The redesign will start with the national metrics as they are stipulated and remain relatively static. Once the priority programmes have been established redesign will progress into the rest of the IPR and will be able to see trend performance rather than the absolute measure.

Locality report

CH reported:

- CH noted AS mentioned the deterioration in 6 week wait for diagnostic procedures (pediatric audiology). In real terms this means that 37 out of 183 children waited longer than six weeks for an appointment. While some of this is due to appointment cancellations and short-term staffing issues, there has been a 47% increase in referrals since 2020/21 and there is a growing trend of children being referred as part of the autism assessment pathway. A quality improvement approach is in place, and we hope to be back on track by October 2023 but will achieve this sooner if possible. This issue has been added to waiting list report that goes to CGCS.

Adult and Older People Services

- Acuity, demand and occupancy are high
- SPA are having to prioritise people at high risk
- The 100-day discharge challenge has finished but we are looking to maintain the standards as part of normal practice
- We attended a regional meeting with directors of adult social care looking at how we can work with local authority colleagues to address patient flow issues
- Risk assessment and care planning metrics are improving

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

- Adult ADHD and ASD – this remains a high priority for the service.
- 3,257 people are waiting for an assessment with a service capacity of 560 per year (when fully staffed). Work is ongoing with South and West Yorkshire integrated care boards (ICBs)to address this issue collaboratively
- Autism – some recently published NHSE guidance for ICBs states that only clinically appropriate referrals should be accepted for assessment. We have had to change processes at the front end of the service which means we have 24 people waiting for an assessment, and these are all booked. Appraisal and supervision rates are at 100% for this service.
- LD services – quality improvement work on reduction of waiting times continues and this is being overseen by CGCS.
- In Forensic services there is high acuity. Following damage to seclusion rooms, all but one are back up and running. DT has been in contact with the Care Quality Commission(CQC) to explain the measures that are being taken to prevent further damage taking place. We will use learning from this work to prevent damage and maintain the safety of all seclusion rooms in the Trust and throughout the adult secure provider collaboratives
- Forensics use an additional risk assessment, and this is showing 100% compliance

Child and adolescent mental health services (CAMHS)

- Neurological developmental pathway – work continues on demand. We have improved screening processes and are working with the adult team to improve the transition process. Demand still continues to outstrip capacity, discussions are taking place with the integrated care boards to look at a system solution as this is a national issue.
- Tier 4 beds have already been discussed during the ORR item. There have been a number of recent MP enquiries in relation to this matter, and work is ongoing through the provider collaborative to improve patient flow

Communications, Engagement and Involvement

SY asked to take the paper as read.

Finance and Contracts

AS highlighted the following points:

- The financial year-end target of a £3.2m surplus has been achieved
- Agency is the one red metric, the outturn was £10m which is 4.2% of the Trust's wage bill. The target for next year is 3.7%
- Green indicator around financial sustainability and efficiency, this was achieved non-recurrently and so for next year we need this sustainable and recurrent
- Cash remains strong – but there is a reduction in balance at the year-end as we pay public dividend capital (PDC) at the end of the year and also the team have focused on ensuring we pay people as quickly as possible at year end.
- Capital has been a challenge – it shows as green but as the Board is aware we didn't progress the Bretton scheme. There is learning to be taken around the forecasting timeline for next year

EM noted that quality metrics are holding up, and this is being supported partly by agency spend and although this might not be positive financially, it supports maintaining safety and quality in our service provision.

People

GM highlighted the following points:

- Establishment has grown over the year by 348 full time equivalent staff (FTE)
- Further growth in headcount is anticipated over 23/24 especially in relation to the mental health investment standard (MHIS) and
- Workforce has increased by 153 FTE in 22/23 compared to 74 in 21/22
- Workforce growth is predicted to continue at the 22/23 rate into 23/24
- Staff turnover reducing steadily over the year. 15.5% has decreased to 13% and we are amber against the threshold. Based on data available from December 2022 the Trust has lowest turnover for trusts of our type in West and South Yorkshire ICS's. Turnover by geographical area and professional groups is more variable and there is targeted work taking place to look at this
- There were 58.1 FTE starters against 43 FTE leavers in March
- Sickness has increased over the year from 4.6% to 5.3%, this aligns to national trends, we are lower than national average (5.5%). Based on data available from December 2022 we have the lowest rate of sickness for trusts of our type in both ICSs
- Appraisals are lower than anticipated, they have moved from 56% to 71.8% in the last five months but only improved by .3% this month. There have significant improvements in mental health inpatients and learning disability appraisal compliance is 72.7% which is positive.
- Manual appraisal benchmarking has taken place following a request from MF. The data is not available through NHS digital. We have looked at other trusts' IPRs and we have the highest appraisal rate in West Yorkshire and second highest in South Yorkshire.

- Statutory and mandatory training is typically ahead of target with a consistent picture across care groups, but there are hotspots areas, RRPI training is one example of focus. A new package has been sourced for food safety training
- March was a challenging month for agency spend which is a concern for 23/24. An agency panel has been created that will include GM, CH and Rob Adamson the deputy director of finance. A rostering audit is taking place to see where better rostering could improve agency spend.

EM noted there are some really positive messages in the report. Single point of access (SPA) appears to be an area of concern.

CH reported issues with SPA are affecting the 14-day routine assessments. Resources are being utilised to see people with highest need and the highest level of risk. Operations are working with the People directorate to look at new roles and what can be done to encourage staff into these roles.

MF queried the information governance (IG) training metric, noting it is relatively straight forward and queried why this is an issue.

CH reported the message about compliance with IG training is being strongly supported through the operational management group (OMG).

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

TB/23/40b Financial and Operational Planning (agenda item 10.2)

AS introduced the items and highlighted the following points:

- The plan went to FIP on 20 March 2023, and private Board on 28 March 2023
- It is presented today for formal approval
- Plans were due on 30 March, NHSE rejected the original trust and ICB submissions given the scale of the deficit submitted.
- Plans are to be resubmitted on 4 May 2023, the Trust plan will remain unchanged and is a breakeven plan
- There is some divergence between the mental health and acute sectors in West Yorkshire, there have been focused discussions on good system partnership working and we have committed to this for 2023/24, as we did in 2022/23.

MBr noted there is a national commitment to maintaining the spend on the mental health investment standard and this is being honoured in West and South Yorkshire integrated care systems.

It was RESOLVED to RECEIVE the summary of the final Trust Operational Plan 2023/24.

TB/23/40c Safer Staffing Report (agenda item 10.3)

DT introduced the item:

- There is a focus on care hours per patient day – this is an indicator of quality delivery at the front line, learning disability services has been a challenged area in this respect
- The overall number of substantive frontline staff has increased but the report also identifies where there are vacancy hotpots
- The report includes the mental health optimal staffing tool, this shows the evidence base against which we are rating ourselves and also workforce planning

- DT explained the context of staffing fill rates, high fill rates often represent high levels of acuity.
- Face to face international recruitment events have taken place in Eswatini and Botswana where we have offered 102 posts to registrants
- All staffing related Datix incidents are reviewed in the weekly clinical risk panel by the executive trio

SY queried if the community transformation work is having an unintended consequence on single points of access (SPA) teams?

CH reported she did not believe the new roles were causing the pressures in SPA which was an initial concern, but at this stage the full impact, if there is one, cannot be ascertained. The eventual outcome of the new roles should have a positive impact on SPA.

MF queried staffing fill rates and noted if 100% can't be a benchmark, how do we know if the situation is good or bad?

DT reported triangulation takes place. Staff will escalate staffing issues through line managers and report it on Datix, these reports are then presented to the clinical risk panel along with formal and informal feedback for review.

MF noted the IPR monitors unfilled shifts and this measure does not feature in this report. MF suggested unfilled shifts should feature in future reports.

Action: Darryl Thompson

EM reported she was pleased to see the community safer staffing information in the report but would like to see more analysis of this in the next report.

Action: Darry Thompson

It was RESOLVED to NOTE the content of this report and AGREE the actions identified for the next reporting period.

TB/23/41 Integrated Care Systems and Partnerships (agenda item 11)

TB/23/41a South Yorkshire update including South Yorkshire Integrated Care System (SY ICS) (agenda item 11.1)

MBr asked to take the paper as read and reported:

- There was a development session which also included the impact of industrial action
- Financial planning challenges were discussed
- A separate meeting approved the transfer of commissioning of pharmacy, ophthalmology and dentistry from NHS England into the integrated care board
- There were initial conversations regarding the process to be undertaken to achieve the significant reduction in running costs that will be required over the next 18 months
- There hasn't been an MHLDA provider collaborative meeting since our last Board meeting

SY updated in relation to Barnsley:

- Priorities have been agreed and are in place for the Barnsley place partnership
- The alliance with primary care – the work on the three priorities area have continued to make positive progress. Priorities are being set for 2023/24

It was RESOLVED to NOTE the South Yorkshire ICS update

TB/23/41b 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:

- Development sessions for the ICB in place for Kirklees and Wakefield took place, focusing on future strategies and priorities for the districts. They have also been reviewing and seeking feedback on progress since becoming a legal entity in July 2022, and the work that has been undertaken.

MBr noted the report in totality highlights the approach the Trust takes to partnership working and work across systems.

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/23/41c Provider Collaboratives and Alliances (agenda item 11.3)

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

- Eating disorder and CAMHS Tier 4 provider collaboratives are in a reasonable financial position
- Staffing challenges continue
- The Board supported the phase 2 provider collaborative go live for forensic CAMHS with the Trust as coordinating provider, NHSE supported this, and it went live in 1 April 2023

MBr noted one of the benefits of provider collaboration is identifying how we can work better and improve efficiency and effectiveness, and this is being demonstrated by the reduction on out of area placements in both West and South Yorkshire.

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

TB/23/42 Governance (agenda item 12)

TB/23/42a Compliance with NHS provider licence conditions and code of governance - self-certifications (agenda item 12.1)

AS introduced the item and highlighted the following:

- This is a retrospective review looking back over the year 22/23 and Monitors Codie of Governance still applies for this period.
- AS note the report needs a slight amendment in relation to commissioner requested services (CRS), the statement in the second section (Cos2) needs amending for a typing error.

It was RESOLVED to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance and CONFIRM that it is able to make the required self-certifications in relation to compliance with the conditions of its Licence.

TB/23/42b Audit Committee annual report including committee annual reports and terms of reference. (agenda item 12.2)

MF introduced the item and reported the following:

- The audit committee is required to review the effectiveness of other committees of the Board
- The committee received annual reports and updated terms of reference and workplans for each of committees
- The report includes brief highlights for each committee over the last twelve months

- The provides the Board with strong assurance of the committee structure and its effectiveness

MBr stated this is a comprehensive report and demonstrates how committees comply with their terms of reference and duties.

It was RESOLVED to RECEIVE the annual report from the Audit Committee as assurance of the effectiveness and integration of risk committees, and that risk is effectively managed and mitigated through; committees meeting the requirements of their Terms of Reference; committee work programmes are aligned to the risks and objectives of the organisation within the scope of their remit; and committees can demonstrate added value to the organisation,

- **and APPROVE the update to the Terms of Reference for the;**
- **Audit Committee; Mental Health Act Committee; Clinical Governance and Clinical Safety Committee; People and Remuneration Committee; Equality, Inclusion and Involvement Committee; Finance, Investment & Performance Committee and Collaborative Committee.**

TB/23/42c Going concern statement (agenda item 12.3)

AS introduced the item and reported this has moved away from being just a financial measure to now looking at future plans as well.

It was RESOLVED to APPROVE the preparation of the 2022/23 annual accounts and financial statements on a going concern basis by adopting the following statement:

'After making enquires, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.'

TB/23/43 Strategies and policies (agenda item 13)

TB/23/43a Strategic objectives, priorities and programmes 2023/24 (agenda item 13.1)

SY introduced the item:

- The paper was discussed at the last Trust Board meeting in private
- The Board agreed the priorities and programmes for 2023/24
- A comprehensive process has taken place to produce this document
- It is presented today for final approval

MBu noted this is a comprehensive process and document that has been co-produced.

It was RESOLVED to AGREE the proposed priorities and areas of focus.

TB/23/43b Policy on policies (agenda item 13.2)

AS introduced the item:

- This document was last reviewed by Board in 2020 and presented to Board today in line with its schedule for renewal
- The paper includes the changes that have been made
- It has been through a number of iterations and meetings prior to being presented to Board today
- It sets out how we standardise the way on which we construct and format policies

It was RESOLVED to APPROVE the Policy on Policies .

TB/23/43b Standards of Conduct in Public Service Policy (conflicts of interest) (agenda item 13.3)

AS introduced the item:

- The policy has been approved by EMT and is brough to Board today for formal approval

It was RESOLVED to APPROVE the Standards of Conduct in Public Service Policy policy.

TB/23/44 Trust Board work programme 2023/24 (agenda item 13)

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

TB/23/45 Any other business (agenda item 14)

Nil

TB/23/46 Date of next meeting (agenda item 15)

The next public Trust Board meeting will be held on Tuesday 27 June 2023

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 25 April 2023 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 25 April

Min reference	Action	Lead	Timescale	Progress
TB/23/36	CH to ascertain what support could be obtained for C following todays Board story in relation to the Poplars ward	Carol Harris	June 2023	A package of support was offered from the ward psychologist**.**
TB/23/36	Dr.Subha Thiyagesh (ST) thanked P and C for their story and informed them that the Trust is in the process of older people's services transformation and asked if P and C would be willing to share their experiences to help improve the service for others? P and C agreed.	Subha Thiyagesh	September 2023	
TB/23/36	Salma Yasmeen (SY) reported the Trust charity EyUp! could support any fundraising initiatives and could help publicise the event. SY would contact Jana Harris to contact P to see how they could be of support.	Salma Yasmeen	June 2023	Contact information shared so support can be offered from the fundraising manager for EyUp! for any fundraising activity.
TB/23/38	The Trust needs to declare an additional interest due SY's impending move to Sheffield Health and Social Care trust as chief executive	Andy Lister	June 2023	Declarations updated.
TB/23/39c	Average Risk Score on the Heat map to be checked for accuracy for the Q1 report 2023/24	Adrian Snarr	July 2023	

TB/23/39f	KQ reported it would be useful to have regular updates to CGCS about progress in relation to the role of Learning Disabilities champion and it will be good to also look at the over use of medication for people with a learning disability which is a national programme.	Subha Thiyagesh	July 2023	
TB/23/39f	SY reported in Barnsley, the alliance with the GP federation has used the annual physical health checks to review medication. SY queried if the data in relation to over prescription was broken down by ethnicity as this gives useful insight. This should be a priority for inequalities work for next year.	Salma Yasmeen	June 2023	The work to reduce overprescribing is a headline initiative in the Social Responsibility and Sustainability Strategy and is therefore a priority for our inequalities work over the next 12 months.
TB/23/39g	MF to consider how to present assurance to the Board on quality issues raised at the Collaborative Committee through future triple A reports	Mike Ford	July 2023	
TB/23/39g	The Tees Esk and Wear Valley report to come to Board once it has been presented to CGCS to identify any learning	Darryl Thompson	July 2023	
TB/23/39g	The waiting list management report was received by CGCS and has progressed well. Discussion to take place about FIP and possible performance metrics to monitor waiting lists from a quality perspective. AS to discuss with DW and NM	Adrian Snarr	July 2023	
TB/23/40a	DT reported complaints for staff attitude in the quality section are those that have been received. In the care group section, the numbers represent those that have been upheld. This would be made more explicit in future reports.	Adrian Snarr	June 2023	Updated in June IPR
TB/23/40a	NM noted the learning in respect of the reduction in falls should come to CGCS to be discussed in more detail.	Darryl Thompson	July 2023	

TB/22/40a	DT reported an update on pressure ulcers will go to CGCS through the chief nurse report. DT and NM to discuss if a further detailed pressure ulcer report is required.	Darryl Thompson	July 2023	
TB/22/40a	MBr noted restraint incidents are increasing and reducing restrictive practice and interventions (RRPI) training isn't where it needs to be, so there needs to be some focus on this.	Greg Moores	June 2023	Verbal updated to be provided in the meeting.
TB/23/40c	Safer staffing report - MF noted the IPR monitors unfilled shifts and this measure does not feature in this report. MF suggested unfilled shifts should feature in future reports	Darryl Thompson	November 2023	
TB/23/40c	EM reported she was pleased to see the community safer staffing information in the report but would like to see more analysis of this in the next report.	Darryl Thompson	November 2023	

Actions from 28 March 2023

Min reference	Action	Lead	Timescale	Progress
TB/23/23	MBr asked for a report to come to Board in relation to West Yorkshire and South Yorkshire ICB's revised operating models as a result of forthcoming cost saving initiatives	Adrian Snarr/Sean Rayner	July 2023	
TB/23/24a	KQ raised the number of children on adult wards and raised what assurance the Board can receive that the wider system is addressing this issue. CH reported she will look at how the Board can receive assurance on this matter.	Carol Harris	June 2023	Updates from the provider collaborative work will be included in the monthly partnerships report into Trust Board.
TB/23/25a	The Patient Safety Incident Reporting Framework needs to be scheduled to go to the non-executive directors monthly meeting	Mandy Rayner	June 2023	Added to the NED meeting agenda

TB/23/25e	NM reported that risk assessments and care planning is an issue across all mental health organisations. Once the Trust sees a continued improvement because of the work that is taking place this should be shared with other Trusts. To be monitored by CGCS.	Darryl Thompson	July 2023	
TB/23/25f	MF noted the Audit Committee is responsible for the treasury investment decision but noted FIP holds responsibility for the best return on cash. AS to meet with MF to confirm committee responsibilities.	Adrian Snarr	May 2023	Meeting in diary 28/6/23
TB/23/28a	MF noted the FIP committee is to receive training on the NHS capital regime and MF requested to be included in this training. AS reported the invite would be extended to all non-executive directors.	Adrian Snarr	May 2023	Training will be delivered post Trust Board (July meeting). Hold the date sent 23/6/23.

Actions from 31 January 2023

Min reference	Action	Lead	Timescale	Progress
TB/23/06	Greg Moores (GM) noted the use of WhatsApp by the Specialist Paediatric Epilepsy Service and asked if there has been any sharing of this good practice and would Phil McNulty (PM) be happy to share this? PM reported with the evolution of smart phones WhatsApp has easily enabled the sharing of videos in a secure way. It is a fantastic solution – especially for families with learning disabilities, and videos are received on a Trust secured	Salma Yasmeen	June 2023	WhatsApp practice in Specialist Paediatric Epilepsy Service to be shared as an #allofusimprove case study.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2023
Agenda item 8

Private/Public paper:	**Public**		
Title:	**Chief Executive's Report**		
Paper presented by:	Mark Brooks - Chief Executive		
Paper prepared by:	Mark Brooks - Chief Executive		
Purpose:	To provide the strategic context for the Trust Board conversation.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	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:	**Trust Board members are already aware the Trust's adult mental health, learning disabilities, and adult secure inpatient services were inspected by the CQC in May.** A more detailed report is included in the Board papers along with the initial letters provided by the CQC following their visits. Trust Board is regularly kept updated regarding the demand, acuity, and staffing challenges our inpatient wards regularly face, so it is encouraging to note the positive observations made by the CQC inspectors. We also acknowledge there are improvements we can make and are working on those issues highlighted already. We expect a full draft report in early July. I would like to take this opportunity to thank all those staff involved in accommodating the visit, which was acknowledged by the CQC, as well as the CQC inspectors for the manner in which the visit took place. **As with the previous time I prepared this report for the Trust Board, it is being written as the latest period of industrial action by junior doctors comes to an end.** This action took place over three days in mid-June and thanks are again recorded to our staff who planned and covered the impact of the strike action to ensure safe patient care. Further ballots are taking place which could result in further action by medical consultants in July and members of the Royal College of Nursing. **We continue to engage with our integrated care systems given the significant reduction they need to make to their running costs.** Both West and South Yorkshire integrated care systems are engaging with partners to develop an updated operating model. Once the conclusions of this work become clearer, Trust Board will be informed accordingly.		

NHS England has published an equality, diversity, and inclusion (EDI) improvement plan. The plan highlights four strategic outcomes which are to address discrimination, increase the accountability of all leaders, support the levelling up agenda, and make opportunities for progression equitable. Six high impact actions are also articulated:

- Measurable EDI objectives for chairs, chief executives, and board members
- Overhaul recruitment processes and embed talent management processes
- Eliminate pay gaps relating to race, disability, and gender
- Address health inequalities within the workforce
- Comprehensive induction and onboarding programme for international recruited staff
- Eliminate the conditions and environment in which bullying, harassment and physical harassment occurs

We very much welcome the publication of the document and it is pleasing the objectives of the plan are very much aligned to our own. The plan will be fully reviewed at the Executive Management Team (EMT) meeting and the Equality, Inclusion, and Involvement Committee. Any additional requirements for us, including the Trust Board, will be identified, and added to our action plan.

June is Pride month, and we are celebrating this in the Trust. The Rainbow flag is flying at Fieldhead and the emphasis is very much on inclusion and acceptance as we strive to make our Trust one that is truly welcoming for everyone.

Today marks the final Trust Board meeting for Salma Yasmeen, our director of strategy & change and deputy chief executive before she joins Sheffield Health & Social Care NHS Foundation Trust as their chief executive. Salma has been with the Trust for over six years and on behalf of the Board I would like to thank her for her dedication, commitment, energy, and many accomplishments during her time with us. She leaves, having made an indelible mark on many with a clear focus on improving services, addressing inequality and the wellbeing of staff. I wish her every success in her new role.

The recruitment process for a new director of strategy & change is well underway with good interest being shown. The process is expected to be completed by mid-July.

Following changes to national guidance the Covid restrictions within the Trust have been further relaxed. There is now reduced requirement for mask wearing and testing. Strong infection prevention control measures will continue to be encouraged and there are requirements to be followed for when outbreaks occur.

The first day of evidence to the UK Covid-19 Inquiry has now taken place. The Trust continues to keep abreast of the requirements of the inquiry and to collate any information likely to be required for it.

I would like to personally congratulate Barnsley Metropolitan Borough Council for being named council of the year at the national Local Government Chronicle awards. We know from the role we play in Barnsley

	there is a great deal of dedication and hard work that takes place to improve outcomes for the people of Barnsley. On 29th June a celebration event is taking place to recognise the 10-year anniversary of Creative Minds at the University of Huddersfield. **This event will enable the huge contribution Creative Minds has made to the lives of so many to be recognised.** Board members are invited to attend what promises to be an excellent occasion. **Several awareness weeks have taken place in recent weeks including mental health, volunteers, learning disabilities, and carers**. The Trust has fully supported each of these as have many of our partners. An excellent event for carers was held in Wakefield, and an increased focus on addressing health inequalities for people with a learning disability has seen a marked increase in the completion of annual physical health checks in all places. Our own approach to completion of Oliver McGowan training has been agreed at the Executive Management Team (EMT). Volunteers and carers make a huge contribution to society, including our own Trust and its service users, and this is something we should continue to recognise and be immensely grateful for. **As a Trust we place great focus on the need for continually innovating and improving**. NHS England has launched a shared approach to improvement – NHS Impact. This is very much aligned with our own approach and is made up of five components, building a shared purpose and vision, investing in people and culture, developing leadership behaviours, building improvement capability and capacity, and embedding improvement into management systems and processes. **There has been publicity recently regarding the pressure on the police in dealing with people with mental health issues**. We are working closely with NHS partners and the police forces in our systems to ensure we agree a joint approach to implementing 'Right Care Right Person' **The next phase of the New Hospital Programme (NHP) has been announced**. Our own Trust bid was unsuccessful and sadly no new capital investment was announced for mental health providers on this programme. Airedale NHS Foundation Trust was successful with its bid. **The focus of this Trust Board meeting is on performance and monitoring**. We typically continue to see many of our performance targets being achieved and we have now met the training target for information governance. Focus continues to be applied to all of our performance targets with significant work taking place to manage out of area bed placements and to improve adherence to some of our mandatory training targets. Operational pressures remain across our services and our staff continue to respond to provide safe and effective patient care. **Wednesday 5 July will mark 75 years since the NHS was founded.** All trusts were asked to engage with staff to appreciate and reflect on its importance in providing healthcare services to everyone, to acknowledge the challenges that the NHS currently faces, and consider how the NHS should develop in the future. We are grateful for those staff who took the time to support this exercise at relatively short notice, which enabled us to contribute

	to it. A small number of staff, accompanied by the Trust Chair, will attend a celebratory service at Westminster Abbey. **Our annual excellence awards too place on May 4th**. Feedback from the event has been very positive and it was excellent to see and hear the many examples of great care, dedication, and innovation from so many of our teams. Thanks are given to those Board members able to attend the event, the judges, all those who were involved in the organising of the day, and to all staff who were nominated or who made nominations. Our long service awards and training & development awards were held on the same day. We regularly hear examples of excellence and as ever I like to ensure an example is recognised in my report. **The following quote was received from a service user who wrote a letter to the Barnsley community stroke team praising specialist occupational therapist Storm Evans** "From the moment I began working with Storm, her professionalism and compassionate nature were evident. Her dedication, expertise, and unwavering commitment to my recovery have had an immeasurable impact on my ability to successfully return to my pre-stroke life and work. Every member of the Barnsley community stroke team has positively impacted my journey, thank you for all you do."
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The Brief

1 June 2023

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

NHS
South West Yorkshire Partnership
NHS Foundation Trust

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

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

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

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

Duncan Burton, deputy chief nursing officer for NHS England, visited Fieldhead Hospital in May to hear about the fantastic work of our perinatal peer support workers, and about our international nurse recruitment. He was very impressed with the teams he met, who are living our values through the care they give to service users and each other.

With **all of us** in mind.

Our priorities for 2023-24

NHS
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NHS Foundation Trust

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

Improving care – service users and staff across forensics celebrated Eid-Al-Fitr together this year with an uplifting community celebration.

Improving health - a two minute animation from the National Confidential Inquiry into Suicide and Safety in Mental Health explains some key findings from the 2023 annual report which can be used in practice to help prevent suicide.

Great place to work– our Trust has welcomed six new therapy assistants into our team of allied health professionals (AHPs) as part of our Trust bank. They will be invaluable in supporting our AHPs to help deliver on personalised care plans for people using our services.

The national, regional and local context

NHS
South West Yorkshire Partnership
NHS Foundation Trust

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

A drive to increase the uptake of regular health checks for people with a learning disability is making a positive, potentially life-changing difference to the lives of thousands of people in Calderdale. The project involves partnership work between GP practices, the wider NHS and the voluntary and community sector. At the start of the project 30% of people in Calderdale who were eligible responded to the invite for an annual health check. By the end of March 2023, this rose to 87%. You can read more from, Angela Burton, learning disability nurse who shares her experience.

Avoidant Restrictive Food Intake Disorder (ARFID) and disordered eating pathway opens in Wakefield CAMHS. Over the coming weeks the team will be facilitating sessions during team meetings for applicable services. Find out more on the intranet.

The Life After Stroke programme is a new 6 week rolling programme in partnership with Barnsley integrated community stroke rehabilitation team, Stroke Association and Tesco. The sessions are delivered in a local supermarket's community room making it easily accessible to stroke survivors. The informal setting allows for increased participation. The programme covers many aspects of life after stroke and is delivered by stroke specialists, including: psychology, physiotherapy, occupational therapy, speech and language therapy, dietetics and nursing.

Kirklees suicide memorial and bereavement quilts will be at venues across Kirklees in June and July. It aims to bring together people to share lived experiences, help reduce the stigma, encourage conversations and reduce isolation for those who are bereaved. Dr Moe Kapoor, one of our consultant physiatrists, will also be speaking at Huddersfield Sikh Temple where the quilt will be displayed.

The West Yorkshire Staff Mental Health and Wellbeing Hub has a new wellbeing message-taking and call-back service. All staff can use the confidential service free of charge. Call 0800 183 1488 and a member of the team will call back within 72 hours.

Improving Health
Teaching Trust status

NHS
South West Yorkshire Partnership
NHS Foundation Trust

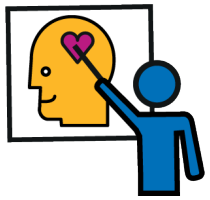
We already have a strong commitment to teaching, research and innovation; with established relationships with local universities and a track record in training medical, nursing and allied health professionals. We have an existing Associated Teaching Trust Agreement with the University of Leeds.

Our ambition is to be recognised as a Teaching Trust, to reflect our significant teaching, training and research work with our wide range of stakeholders, including our universities.

Why we want to become a Teaching Trust:

- Reflects our commitment to teaching and learning
- It's in keeping with our vision to provide outstanding physical, mental and social care in a modern health and care system
- It reflects our values of aiming to improve and be outstanding, and be relevant for today and ready for tomorrow
- Supports our strategic objectives in making our Trust a great place to work, and a great place to train our future workforce.
- Improves our visibility as a learning organisation
- Will support us in attracting a high calibre workforce, whilst delivering high quality care to our service users and carers.
- It will strengthen applications for research and development funding

We have started conversations with our executive management team, Trust Board and Members' Council and with NHS England. A Trustwide steering group has been also been established to oversee the work.
The next stage will be engagement with our staff, academic partners and other stakeholders.



With **all of us** in mind.

Improving Health
Our performance in April

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- **52.7%** of people completing Talking Therapies treatment and moving into recovery
- **99.8%** of Talking Therapies referrals beginning treatment within 18 weeks. **97.8%** within 6 weeks.
- **89.2%** of MH service users followed up within 72 hours of discharge from inpatient care
- **90.6%** of people with a risk assessment/staying safe plan in place within 24 hours of admission (for inpatients)
- **82.5%** of people with a risk assessment/staying safe plan in place within 7 days of first contact (for community)
- **87.5** of people died in a place of their choosing
- **2.4%** clinically ready for discharge (previously delayed transfer of care)
- **76%** in CAMHS services waiting less than 18 weeks for treatment

BP@Home is an offer from the Barnsley Integrated Community Stroke team which is given to people identified as having high blood pressure at the routine six week review. The year one audit showed that it has saved approx. £5,000 in GP appointments, is giving people a better experience, and encouraging people to have more ownership over their health.

Our **Calderdale and Kirklees NHS Talking Therapies** teams have been taking to the airwaves. They featured on Calder Valley Radio and Rangoli Radio throughout mental health awareness week, raising awareness about anxiety.

Survey evaluation of the QUIT Stop Smoking service - we are looking for staff who work in services where QUIT operates or staff who are smokers and have used the service to fill in a questionnaire. This will be used to support service improvement.

With **all of us** in mind.

Improving Care
Our performance in April

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- **447** inappropriate out of area bed days
- **3** young people under 18 admitted onto adult inpatient wards
- **60.4%** waiting for referral to assessment within 2 weeks
- **97.6%** waiting for assessment to treatment within 6 weeks
- **33** days is the average length of stay on adult acute mental health wards
- **85.5%** of service users on CPA offered a copy of their care plan
- **70.7%** of our mental health service users have their equality data recorded

94% of respondents in the friends and family test rated our general community services either good or very good; **82%** in our mental health services, **76%** CAMHS, **100%** for learning disability services, and **44%** for ADHD services.

Patients Know Best (PKB) will be rolled out across our Trust from 12 June 2023. PKB will give our service users access to their health information with the ability to share this securely with any health and care professionals involved in their care, alongside their carers and family members. Training dates are now available for teams and services to book throughout June and July. You can find out more on the intranet.

PATIENTS KNOW BEST®
THE PATIENT'S COMPANY

In May the **Care Quality Commission (CQC) visited our Trust on an unannounced inspection of our adult acute inpatient wards, PICU and forensic inpatient wards.** Thank you to all our teams and services who were involved. Initial feedback this reflected positively on the work of our staff and services, which is credit to all of you for the work you do each day. There are some areas for improvement, and we already have actions in place to address these.
We will share more detail once we have the report. As ever, we will use the outcome and our experience from this inspection to learn and improve together.

With **all of us** in mind.

Improving Care
Incidents in April

NHS
South West Yorkshire Partnership
NHS Foundation Trust

In April we reported:

- **1,172** incidents – **808** rated green (no/low harm)
- **295 were rated yellow and 55 rated amber**
- **14** rated as red (incident severity is reviewed and may be downgraded)
- **97%** of incidents resulted in no or low **actual** harm, or were external to our care
- **23** patient safety incidents that resulted in moderate or severe harm or patient safety related death. They were **14** category 3 pressure ulcers and **1** category 4 pressure ulcer, **4** self harm incidents, **1** slip/trip/fall, and **3** apparent suicides

We had **192** restraint interventions in April, a reduction of 11 incidents from March. **90%** of prone restraints were 3 minutes or less. We continue to offer support and advice to teams around reducing restrictive interventions.

We had **34** falls in April, which is a decrease from the previous month.

We had **24** pressure ulcers in April. Of these, **1** was identified as resulting from a lapse in care.

Talk to the trio is a chance for an open discussion with our executive trio about anything that interests you, or you want to discuss, promote or highlight. There is no set agenda – this is about you, your thoughts, feelings and experiences. More information is on the intranet.

Think. Check. Share.

There were **12 confidentiality breaches** in April. All of us can reduce the number of patient data or sensitive information breaches at the Trust.

With **all of us** in mind.

Improving care

Tea to improve quality

Your experiences are making a difference

NHS
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Tea to Improve Quality is:

Open to all staff and led by Carmain Gibson-Holmes, deputy director of nursing, quality and professions, with:

- Discussions and debates
- Learning from each other
- Sharing of information
- Identification of quick win improvements
- Opportunities to network, share good work and best practice

Over five sessions, here are just some of the things you've told us:

- **The job** – plans for the future and reflections on people's roles, morale, safer staffing, roles and responsibilities
- **Digital** - record keeping training, SystmOne and consent to share, care planning and risk assessment documentation and digital options
- **Experiences** – of being new, rotational posts, speaking up and time for finding out what's new

People have reported feeling heard, like getting updates and being able to get involved in broader work of our Trust.

What we will do:

- Continue to grow the Tea to Improve Quality sessions.
- Listen, be here, and continue to take action.
- Evaluate and learn so we can improve.
- Give you regular feedback and updates on what we have done.

Improving care
Tea to improve quality

Your experiences are making a difference

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Just one example - meals on wards

You said:

- Finding time to eat on wards is challenging
- There is a missed opportunity of therapeutic value in relationship building when eating together with service users.

We are now:

- Looking at how we can support staff to eat while on shift
- Considering if we can pilot therapeutic meals in one of our areas to give an evidence base for impact, cost and outcomes
- Minimise the amount of food waste through looking at how we utilise food which might otherwise go to waste.

When's the next?
Thursday 22 June, 10-12 midday, Mental Health Museum, Fieldhead Hospital

Can't make it?
If your team or service want to hold a Tea to Improve Quality, email ndadmin@swyt.nhs.uk who would be happy to arrange a session

Thank you to everyone who has come to a session so far. Read more about Tea to Improve Quality on the intranet and download the poster to share with staff and teams.

With **all of us** in mind.

Managing risk

NHS
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NHS Foundation Trust

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

Key areas of risk identified in the risk register are:

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

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.

You can find details about our learning from incidents and experiences in our learning library, available on the intranet. The aim is for these to enhance existing methods of sharing and learning which takes place at individual, team and service level.

We have relaxed some of our measures around COVID, which can be found on the intranet. However we must continue to do all we can to keep people safe. Please make sure you familiarise yourselves with our new guidance on testing, face masks, absence and outbreak measures.

With **all of us** in mind.

Improving resources
Our finances in April

NHS
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NHS Foundation Trust

Performance Indicator	Apr-23	Forecast 2023/24
Surplus / (Deficit)	£222k	Breakeven
Agency Spend	£939k	£8.7m
Financial sustainability and efficiencies	£568k	£12.0m
Cash	£78.5m	
Capital	£282k	£8.8m
Better Payment Practice Code	96%	

In April 2023 the financial position is a surplus of £0.2m which is in line with plan. The forecast position will be assessed by the end of the first quarter. The target is breakeven.

Agency spend for 2023/24 is planned to reduce from £10.0m to £8.7m. This is in line with national and ICB, reduction targets and caps. Spend in April is £141k (18%) above this trajectory.

The Trust financial plan includes a sustainability programme totalling £12.0m and is directly linked to the Trust priority of spending money wisely.

Cash in the bank remains positive and with continued levels of interest rates will be maximised. This helps to support the value for money agenda.

Capital spend is profiled to increase across the year. Spend in April is £282k which is more than planned.

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

Improving resources
Our financial improvement plan

NHS
South West Yorkshire Partnership
NHS Foundation Trust

We find ourselves in a much tighter financial environment this year, meaning we need to ensure our financial improvement plan for 2023-24 is strong and robust. We need to ensure we collectively understand and respond to the changing financial context we find ourselves in, while continuing to deliver effective services and live our values.

Our financial improvement plan sets out how we will achieve financial stability, ensure value for money and continue to excel and improve.

The plan includes:

- Mechanisms to increase value for money including how we generate efficiency ideas, monitor and report achievements, realise benefits and share and spread learning
- How we intend to coordinate all efficiency work which takes place across the Trust and at all three levels of the Integrated Change Framework
- The development of a plan to deliver an operational cost improvement programme (CIP) of 3.4%
- Opportunities to inform staff around financial management and value, linked to our #allofusimprove work
- Information on our golden thread on social responsibility and sustainability which delivers ideas which result in both carbon and financial reductions

More information on our financial improvement plan will be sent out shortly, including how you can get involved. We will also soon launch of an i-hub challenge where you can submit your own ideas for cost savings and efficiencies.

With **all of us** in mind.

A great place to work

Our performance in April

- **5%** sickness rate for the month. The rolling 12 months sickness rate is **5.3%**
- In March we had new **43** starters to the Trust, and **40** leavers
- We currently have **4,257** substantive members of staff
- **74.4%** of staff have a completed annual appraisal
- We are still below target on our **IG mandatory training**. It is now **90.6%.** We must reach 95% compliance by 23 June. Check you have completed yours.

Further industrial action by junior doctors has been confirmed for Wednesday 14 June to Saturday 17 June 2023, for a total of 72 hours. We are working through the plans and impact for our Trust. Information about what this means for staffing, and people who use our services will be communicated to teams and services, and made available on the intranet. The safety of our patients, and the wellbeing of our staff is our highest priority. We value all of you and respect your rights to engage in industrial action.

Excellence Awards 2023
Congratulations to all our Excellence award winners. Held on 4 May, the awards celebrate and recognise the difference that individuals and teams – both clinical and non-clinical – make to the lives of local people. You can find out who the winners were on our website and watch the videos from all our shortlisted teams and services on our YouTube channel.

EyUp! Charity have received a very welcome funding boost thanks to Leeds business Sugarman PLC. The sponsored walk around Eccup Reservoir raised a total of £1,362 for the charity.

The **Agenda for Change pay award offer was approved on 2 May** by the NHS Staff Council. The NHS Staff Council is made up of health and care Trade Unions and NHS employers. As a result Government will now implement this offer, which covers the 2022/23 and 2023/24 pay years. The one-off payment for the previous pay year (2022/23) will be paid as a non-consolidated lump sum to employed staff, and the new salary rates for this year (2023/24) will take effect from 1 April 2023 for both employed and bank-only staff. Further information is available on the intranet.

With **all of us** in mind.

A great place to work
NHS staff survey – insights and action plans

NHS
South West Yorkshire Partnership
NHS Foundation Trust

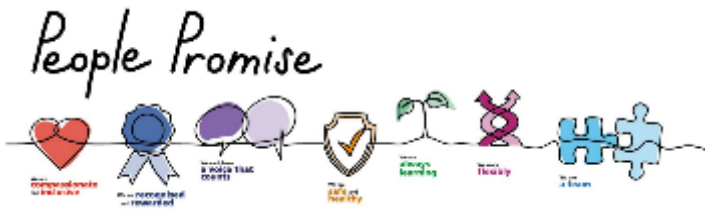
In the March Brief, we shared the 2022 NHS Staff Survey results. Thank you to 2300 colleagues who participated. Each service has now agreed an action plan to be implemented in the coming months.

Your feedback really matters. It helps us understand your experience at work – what works well and where we can improve to strengthen the Trust as a Great Place to Work for all.

In 2023, improvement actions plans are focused on several key themes:

- We are safe and healthy: embedding the role of wellbeing champions, wellbeing conversations, promotion of the Trust's comprehensive health and wellbeing support for staff
- We are always learning: increasing access to personal development opportunities
- We are a team: focusing on team effectiveness, ways of working
- We are recognised and rewarded: ensuring everyone feels recognised and valued

We want every team to get involved in this work to improve staff experience. Please speak to your service manager for further information.



With **all of us** in mind.

Connecting People

NHS
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NHS Foundation Trust

Your voice counts.
Help us to help people live well in their communities

If you are passionate about health services in your local area then use your voice and lived experience to help us improve health and care services in your community. By getting involved you can help make a difference for yourself, your friends, family and people who live in your neighbourhood.

'Connecting people' is about giving you a voice. It can also be about engaging your family, friends and your community, and supporting them to get more involved too.

Your contribution can be in any way which interests you, and you can decide how much involvement you want. Examples of ways you can contribute include:

- Personally, taking part in surveys, engagement and consultations
- Helping to organise and participate in events
- Getting involved in projects
- Distributing leaflets and information in your local gyms, community centres, churches, mosques etc.
- Gathering insight, information and feedback from your friends, family and the local community

Full training and support will be provided.

Getting involved in the connecting people programme is open to anyone who lives or works in Barnsley, Calderdale, Kirklees or Wakefield. This includes staff.

If you would like to find out more about connecting people or to register an interest in getting involved please email volunteer@swyt.nhs.uk or call 01924 316426 or 07721 649311.

Full details are on the intranet.

With **all of us** in mind.

Take home messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Safety always comes first. Do everything you can to keep you and those around you safe.

Our guidance around COVID has changed. Make sure you and your teams know what you need to do.

Discuss in your teams our aim to be a teaching trust and what this means for you and your teams.

Take part in our QUIT survey and help us to improve the service we provide.

Share your experiences and learning through our Tea to Improve Quality sessions.

Visit the learning library on the intranet and discuss in your teams how you can improve.

Help us be more efficient by contributing to our financial improvement plan.

Join our connecting people programme and help us improve care in local areas.

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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2023
Agenda item 9.1

Private/Public paper:	**Public**		
Title:	**Integrated Performance Report (IPR)**		
Paper presented by:	**Director of Finance & Resources/Director of Strategy & Change**		
Paper prepared by:	**Deputy Director of Corporate Governance**		
Mission/values:	Respectful, honest, open and transparent. Relevant today and ready for tomorrow.		
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for May 2023.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	The Integrated Performance Report, provides assurance to Trust Board on compliance with standards, identifying emerging issues and actions being taken for all strategic risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Trust performance management framework and reporting provides the ICBs with assurance that the Trust has an effective performance management system to contribute to the delivery of the ICB's strategic priorities and delivery plans		
Any background papers / previously considered by:	The IPR is reviewed at public Trust Board eight times a year. On months when public meetings are not held, it is circulated to Board members, and published on the Trust website. The IPR is reviewed monthly by the Executive Management Team (EMT) The IPR is reviewed monthly at the Organisational Management Meeting (OMG)		
Executive summary:	This executive summary provides an overview of key points from the IPR for May 2023. Trust board have reviewed all priority programmes and how they should be reported in the 2023/24 IPR. Key milestones have been updated with full reporting to commence from the end of quarter one (reported in August IPR). Within the IPR changes to metrics have been implemented as agreed with Trust board in May 23 to provide reporting in full against national and strategic objectives for 2023/24.		

Changes to the people metrics are in development and will be implemented in the August IPR.

Further developments of the IPR are ongoing in line with the development plan.

Strategic Objectives and priorities

- A key priority for the Trust is to improve the recording and collection of protected characteristics across all services. There is one national indicator which is for ethnicity, the Trust is performing at 96.6% against a target of 90%. For the Trust derived indicators, as at May 2023, disability shows 43.5%, sexual orientation shows 43.4% and postcode shows 99.8% of service users have had their equality data recorded. Whist recording postcode is not technically part of equality data it does help identify referrals from areas with higher levels of deprivation, which could indicate inequalities in relation to healthcare access, experience, and outcomes. Work continues to ensure data capture will be extended to all services, the Trusts Equality, Inclusion and Involvement Committee monitor this work.
- Specific actions the Trust is taking to address inequalities include co-designing services with communities, ensuring representation is reflective of the population and covers all protected groups and carers. Approaches being used include community reporters and researchers to capture patient stories, offering enhanced equality and diversity training and ensuring health assessments for people with a learning disability.
- Timely completion of equality impact assessments (EIA) for service and policy remains a key metric and currently 53.7% of service EIAs have been reviewed within 12 months. 100% of services have an EIA in place and work is taking place to ensure they are reviewed within the 12-month timescale.
- Referral to assessment within 2 weeks for mental health single point of access (SPA) continues to be impacted by demand and capacity. SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment has been at risk of being delayed in all areas and is below target performance in Barnsley and Calderdale and Kirklees. Rapid improvement work in SPA together with some progress in recruitment should contribute to an improved performance in the coming month.

NHS England Indicators (national)

The Trust continues to perform well against the majority of national metrics. The following under-performance should be noted:

- Inappropriate out of area bed days continue to be above trajectory with 574 days in May. This remains high and mainly relates to increased acuity and challenges to timely discharge. Workforce pressures also impact the successful management of acuity. The Trust had 17 people placed in out of area beds at the end of May. The inpatient improvement programme is aiming to address the workforce challenges. Systems are in place to manage and unblock barriers to discharge as well as effective coordination of out of area placements so that people can be repatriated as quickly as

- The percentage of service users seen for a diagnostic appointment (paediatric audiology) within 6 weeks decreased to 53.3% in May from 60.7% reported in the previous month, this continues to remain below the national threshold of 99%. This metric relates to the Trust's Paediatric Audiology service which is a small service and there have been a number of staffing issues that have impacted on clinic availability. Performance is not expected to reach 99% until October 2023 with additional pressures related to increased number of referrals also impacting.
- The percentage of children and young people with an eating disorder designated as urgent cases who require access to NICE concordant treatment within one week remained below target to 80% (target 95%). In May, 4 out of 5 urgent cases were seen within 1 week. The case that breached was due to patient declining an appointment that was offered within timescale.
- The percentage of children and young people with an eating disorder designated as routine cases who require access to NICE concordant treatment within four weeks remained below target to 89.5% (target 95%) -In May 17 out of 19 urgent cases were seen within 4 weeks. Appointments within timescale were offered to both cases that breached and were either declined or cancelled by the patient.

Quality

Local Quality Indicators

The Trust continues to perform well against the majority of quality indicators; however, the following improving/exceptions and actions being taken should be noted:

Care Planning

Work continues in front line services to adopt collaborative approaches to care planning. The May data is showing an improved position of 85.7% and remains above threshold. The improvement group continue to support operational services and further improvements to compliance are expected during quarter one 23/24.

Risk Assessments

May data shows a slight decline in performance from the previous month within inpatient services (87.7%), however community services (94.6%) have shown a marked improvement. All areas are working to improve performance and quality of risk assessments. Issues with data capture, service pressures and data quality continue to be addressed. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality. A new trajectory for improvement has been set based upon the current and projected performance to allow for sustainable and impactful improvement actions to be implemented.

Waiting Lists

- CAMHS continue to prioritise children with high levels of need and if a child's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period.
- Waiting times and waiting numbers for neurodevelopmental services within CAMHS continue to remain high. As previously reported, waiting list initiatives are in place to work towards stabilising this position. 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.
- Waiting list times continue to be an issue due to staffing/operational pressures in community learning disability services, with 84.3% (against a target of 90%) of Learning Disability referrals where patients have had a completed assessment, care package and commenced service delivery within 18 weeks. People on waiting lists are receiving regular welfare phone calls to ensure they remain well and have not escalated in need due to their wait.
- Adult Attention Deficit Hyperactivity Disorder (ADHD) and autism referrals continue to be at levels higher than pre-pandemic – cases are triaged and prioritised according to need.

Patient Safety Indicators

95% of patient incidents reported in May 2023 resulted in no or low harm or did not occur whilst under the care of the Trust, an overview of key indicators is below:

- The number of restraint incidents has decreased slightly to 186 from 192 in April. Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month is stable, not showing any cause for cause concern and is within expected range. This is described as common cause variation within the report.
- 86.6% of prone restraint incidents were for a duration of three minutes or less which is a deterioration on the previous two months performance, there was one incident over the 3-minute threshold and this was a complex case and appropriate measures were taken and support was given to both the service user and staff involved in the incident.
- There was one pressure ulcer due to a lapse in the Trust's care during May. Further details on the cases are within the main report. The Chief Nurse is ensuring a thorough review of all cases and the outcome will be reported to the Clinical Governance Clinical Safety Committee as part of the Chief Nurse report.
- The number of inpatient falls in May was 53, which is an increase from last month. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are investigated.

Our People

- Our substantive staff in post position continues to remain stable and has increased slightly in May. The number of people joining the Trust outnumbered leavers in May. Year to date, we have had 97 new starters and 74.8 leavers during the first two months of the year and focus remains on recruitment and retention.

- Overall turnover rate in May was 12.2% which is the lowest level it has been over the last 12 months. This is monitored against a revised target of between 12 to 13%.
- Sickness absence in May was 4.6%, which is the lowest it has been in the last 12 months with a rolling 12-month position of 5.3%.
- Rolling appraisal compliance rate for May saw a small increase, from 74.4% to 74.9%. Executive management team (EMT) have agreed an improvement trajectory of 78% for May, the improvement trajectory will be reviewed monthly in EMT to be clear on how the Trust will achieve the 90% target in year. Actions are in place to address hotspot areas in care groups and support services and the focus continues across the Trust to prioritise appraisals.
- Overall mandatory training is at 90.9% compliance which exceeds the Trust target of 80%, this has increased marginally from 90.5% reported in April. However, 2 subjects out 17 reported are below the Trust target, which are cardiopulmonary resuscitation and reducing restrictive practice interventions. Targeted actions are in place and compliance is reported monthly to the Executive Management Team (EMT) with hot spot reports reviewed by the Operational Management Group (OMG).
- The refreshed Trust position for information governance data security training achieved 95.9% at the end of May which is above the 95% threshold. Food safety performance also achieved the 80% threshold during May, reporting at 83.4%.

Care Groups

Staffing vacancies and absence continue to impact on the Trust and our partners resulting in significant challenges across our local places and integrated care systems.

The care group summary section describes the “hotspot” performance areas and mitigating actions for the month of May, these are as follows:

- All care groups, with the exception of inpatients (94.3%) and LD, ADHD, ASD (94.2%) are now achieving the compliance rate for information governance mandatory training. Focus still remains on compliance. Managers are receiving weekly lists of non-compliant staff so that progress can be monitored, and actions can be taken to address compliance. This is monitored at operational management group and executive management team.
- Mental health acute wards have continued to manage high levels of acuity and continued high occupancy levels across mental health wards and capacity to meet demand for beds remains challenging.
- Workforce challenges have continued, with staff absences due to sickness and difficulties sourcing bank and agency staff on top of vacancies leading to staffing shortages across the wards. Workforce challenges are being supported through Trust wide recruitment and retention programme.
- Challenges with demand outstripping capacity in the Single Point of Access (SPA) services remains high with referrals being risk screened to ensure that urgent demand is met. This increases the risk of routine triage and assessment being delated. Work to maintain patient flow continues, with the use of out of area beds being closely managed, however usage continued to be high and remained at a high level in May.

	• During May, there was a slight decrease in the overall number of cases that were clinically ready for discharge, reducing from 2.4% to 2.1%, however this is still identified as a risk due to the availability of options to support people with complex needs on discharge. Work with systems partners at place continues to explore and optimise all community solutions to get people home as soon as they are ready. We continue to work towards the standards in the 100 Day Discharge Challenge and working at Integrated Care Board level to share improvements and collaborative approaches. • The children's eating disorder pathways remain under demand pressure as a consequence of increasing referrals and limited staff capacity. This is consistent with national trends and has contributed to difficulties in achieving national response targets. • Access to tier 4 beds and specialist residential care for children remains a risk and currently more challenging due to pressures within a current provider. Work is taking place across local systems to ensure that care is provided in the best place for children who are waiting for a bed. **Finance** • Although April 2023 continued the positive run rate, the May 2023 position has been significantly impacted by the gap associated with the national Agenda for Change pay award. This will be paid in June 2023. Agency spend in May was £908k. • Actions are in place to address agency spend, which is being overseen by the Trust's agency group. • The Trust cash position remains strong at £77.7m; this is higher than plan. This has always been maximised however the current interest rates provide additional financial incentive. • Pay costs were £20.46m in May, compared to last month which was £19.14m. • Out of area bed costs - Despite acute bed day usage being higher than plan, out of area bed costs for April and May are both below plan at £1609k. This is due to less additional nursing being used than planned and a reduction in bed day rates. • Performance against the Better Payment Practice Code increased to 97%.
Recommendation:	**Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.**

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

May 2023

With **all of us** in mind.

Table of Contents

Click on each section heading to navigate to that section

Introduction

Please find the Trust's Integrated Performance Report (IPR) for May 2023. The development of the IPR will continue to evolve to reflect any changes in the operational environment.

The Trust has developed care group summary reports for inclusion in the IPR. This is to provide an overview of performance against key indicators by care group in order to give assurance regarding the quality and safety of the care we provide. These have been added to the start of the care groups section.

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. Executive directors have reviewed all priority programmes and how they should be reported in the 2023/24 IPR, these will be presented to the Finance, investment and performance committee and implemented on approval. Metrics for 2023/24 have been identified and were reviewed by Trust Board in May and will be implemented from July 2023.

It is worth reminding the reader of the report of the Trust's four strategic objectives against which our performance metrics are designed to measure progress. These are:
- Improving health
- Improving care
- Improving resources
- Making SWYPFT a great place to work

Performance is reported through a number of key performance indicators (KPIs). KPIs provide a high level view of actual performance against target. The report has been categorised into the following areas to enable performance to be discussed and assessed with respect to:
- Executive summary
- Strategic Objectives & Priorities
- Quality
- People
- National metrics
- Care groups
- Finance
- Systemwide monitoring

The Strategic Objectives & Priorities section has been updated to reflect the Trust's priorities and associated metrics for 2023/24. The national metrics section has also been updated to reflect changes in the NHS oversight framework, long-term planning metrics and NHS standard contract metrics. We also need to consider how Trust Board monitors performance against the reset and recovery programme. The Trust is also keen to include performance data related to the West Yorkshire and South Yorkshire Integrated Care Systems (ICSs) – this is an iterative process as work is underway within the ICSs to determine how performance against their key objectives will be assessed and reported. Our Integrated Performance Strategic Overview Report is publicly available on the internet.

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

Strategic Objectives & Priorities

• A key priority for the Trust is to improve the recording and collection of protected characteristics across all services. There is one national indicator which is for ethnicity, the Trust is performing at 96.6% against a target of 90%. For the Trust derived indicators, as at May 2023, disability 43.5%, sexual orientation 43.4% and postcode 99.8% of service users have had their equality data recorded. Whist recording postcode is not technically part of equality data it does help identify referrals from areas with higher levels of deprivation, which could indicate inequalities in relation to healthcare access, experience, and outcomes. Work continues to ensure data capture will be extended to all services, the Trusts Equality, Inclusion and Involvement Committee monitor this work.

• Specific actions the Trust is taking to address inequalities include co-designing services with communities, ensuring representation is reflective of the population and covers all protected groups and carers. Approaches being used include community reporters and researchers to capture patient stories, offering enhanced equality and diversity training and ensuring health assessments for people with a learning disability.

• Timely completion of equality impact assessments (EIA) for service and policy remains a key metric and currently 53.7% of service EIAs have been reviewed within 12 months. 100% of services have an EIA in place and work is taking place to ensure they are reviewed within the 12-month timescale.

• Referral to assessment within 2 weeks for mental health single point of access continues to be impacted by demand and capacity. SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment has been at risk of being delayed in all areas and is below target performance in Barnsley and Calderdale and Kirklees. Rapid improvement work in Single point of access (SPA) together with some progress in recruitment should contribute to an improved performance in the coming month.

Quality

NHS England Indicators (national)

The Trust continues to perform well against the majority of national metrics. The following under-performance should be noted:

• Inappropriate out of area bed days continue to be above trajectory with 574 days in May. This remains high and mainly relates to increased acuity, Covid-19 outbreaks and challenges to timely discharge. Workforce pressures also impact the successful management of acuity. The Trust had 17 people placed in out of area beds at the end of May. The inpatient improvement programme is aiming to address the workforce challenges. Systems are in place to manage and unblock barriers to discharge as well as effective coordination of out of area placements so that people can be repatriated as quickly as possible.

• The percentage of service users seen for a diagnostic appointment within 6 weeks decreased to 53.3% in May from 60.7% reported in the previous month, this continues to remain below the national threshold of 99%. This metric relates to the Trust's Paediatric Audiology service which is a small service and there have been a number of staffing issues that have impacted on clinic availability. Performance is not expected to reach 99% until October 23 with additional pressures related to increased number of referrals also impacting.

• The percentage of children and young people with an eating disorder designated as urgent cases who require access to NICE concordant treatment within one week remained below target at 80% (target 95%). In May 4 out of 5 urgent cases were seen within one week. The case that breached was due to patient declining an appointment that was offered within timescale.

• The percentage of children and young people with an eating disorder designated as routine cases who require access to NICE concordant treatment within four weeks remained below target at 89.5% (target 95%) - In May 17 out of 19 urgent cases were seen within four weeks. Appointments within timescale were offered to both cases that breached and were either declined or cancelled by the patient.

Quality continued

Local Quality Indicators

The Trust continues to perform well against the majority of quality indicators; however, the following improving/exceptions and actions being taken should be noted:

Care Planning

Work continues in front line services to adopt collaborative approaches to care planning. The May data is showing an improved position of 85.7% and remains above threshold. The improvement group continue to support operational services and further improvements to compliance are expected during quarter one 23/24.

Risk Assessments

May data shows a slight decline in performance from the previous month within inpatient services (87.7%), however community services (94.6%) have shown a marked improvement. All areas are working to improve performance and quality of risk assessments. Issues with data capture, service pressures and data quality continue to be addressed. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality. A new trajectory for improvement has been set based upon the current and projected performance to allow for sustainable and impactful improvement actions to be implemented.

Waiting Lists

• Childrens and Adolescent Mental Health Services (CAMHS) continue to prioritise children with high levels of need and if a child's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period.
• Waiting times and waiting numbers for neurodevelopmental services within CAMHS remain high. As previously reported, waiting list initiatives are in place to work towards stabilising this position. 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.
• Waiting list times continue to be an issue due to staffing/operational pressures in community learning disability services, with 84.3% (against a target of 90%) of Learning Disability referrals where patients have had a completed assessment, care package and commenced service delivery within 18 weeks. People on waiting lists are receiving regular welfare phone calls to ensure they remain well and have not escalated in need due to their wait.
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95% of patient incidents reported in May 2023 resulted in no or low harm or did not occur whilst under the care of the Trust, an overview of key indicators is below:

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• 86.6% of prone restraint incidents were for a duration of three minutes or less which is a deterioration on the previous two months performance, there was one incident over the 3-minute threshold and this was a complex case and appropriate measures were taken and support was given to both the service user and staff involved in the incident.

• There was one pressure ulcers due to a lapse in the Trust's care during May. Further details on the cases are within the main report. The Chief Nurse is ensuring a thorough review of all cases and the outcome will be reported to the Clinical Governance Clinical Safety Committee as part of the Chief Nurse report.

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• Our substantive staff in post position continues to remain stable and has increased slightly in May. The number of people joining the Trust outnumbered leavers in May. Year to date, we have had 97 new starters and 74.8 leavers during the first two months of the year and focus remains on recruitment and retention.

• Overall turnover rate in May was 12.2% which is the lowest level it has been over the last 12 months. This is monitored against a revised target of between 12 to 13%.

• Sickness absence in May was 4.6%, which is the lowest it has been in the last 12 months with a rolling 12-month position of 5.3%.

• Rolling appraisal compliance rate for May saw a small increase, from 74.4% to 74.9%. The Executive Management Team (EMT) have agreed an improvement trajectory of 78% for May, the improvement trajectory will be reviewed monthly in EMT to be clear on how the Trust will achieve the 90% target in year. Actions are in place to address hotspot areas in care groups and support services and the focus continues across the Trust to prioritise appraisals.

• Overall mandatory training is at 90.9% compliance which exceeds the Trust target of 80%, this has increased marginally from 90.5% reported in April. However, 2 subjects out 17 reported are below the Trust target, which are cardiopulmonary resuscitation and reducing restrictive practice interventions. Targeted actions are in place and compliance is reported monthly to EMT with hot spot reports reviewed by the Operational Management Group (OMG).

• The refreshed Trust position for information governance data security training achieved 95.9% at the end of May which is above the 95% threshold. Food safety performance also achieved the 80% threshold during May, reporting at 83.4%.

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The care group summary section describes the “hotspot” performance areas and mitigating actions for the month of May, these are as follows:

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• Mental health acute wards have continued to manage high levels of acuity and continued high occupancy levels across mental health wards and capacity to meet demand for beds remains challenging.

• Workforce challenges have continued, with staff absences due to sickness and difficulties sourcing bank and agency staff on top of vacancies leading to staffing shortages across the wards. Workforce challenges are being supported through Trust wide recruitment and retention programme.

• Challenges with demand outstripping capacity in the Single Point of Access (SPA) services remains high with referrals being risk screened to ensure that urgent demand is met. This increases the risk of routine triage and assessment being delated. Work to maintain patient flow continues, with the use of out of area beds being closely managed, however usage continued to be high and remained at a high level in May.

• During May, there was a slight decrease in the overall number of cases that were clinically ready for discharge, reducing from 2.4% to 2.1%, however this is still identified as a risk due to the availability of options to support people with complex needs on discharge. Work with systems partners at place continues to explore and optimise all community solutions to get people home as soon as they are ready. We continue to work towards the standards in the '100 Day Discharge Challenge' and working at Integrated Care Board level to share improvements and collaborative approaches.

• The children’s eating disorder pathways remain under demand pressure as a consequence of increasing referrals and limited staff capacity. This is consistent with national trends and has contributed to difficulties in achieving national response targets.

• Access to tier 4 beds and specialist residential care for children remains a risk and currently more challenging due to pressures within a current provider. Work is taking place across local systems to ensure that care is provided in the best place for children who are waiting for a bed.

Finance

• Although April 2023 continued the positive run rate, the May 2023 position has been significantly impacted by the gap associated with the national Agenda for Change pay award. This will be paid in June 2023. Agency spend in May was £908k.

• Actions are in place to address agency spend, which is being overseen by the Trust’s agency group.

• The Trust cash position remains strong at £77.7m; this is higher than plan. This has always been maximised however the current interest rates provide additional financial incentive.

• Pay costs were £20.46m in May, compared to last month which was £19.14m.

• Out of area bed costs - Despite acute bed day usage being higher than plan, out of area bed costs for April and May are both below plan at £1609k. This is due to less additional nursing being used than planned and a reduction in bed day rates.

• Performance against the Better Payment Practice Code increased to 97%.

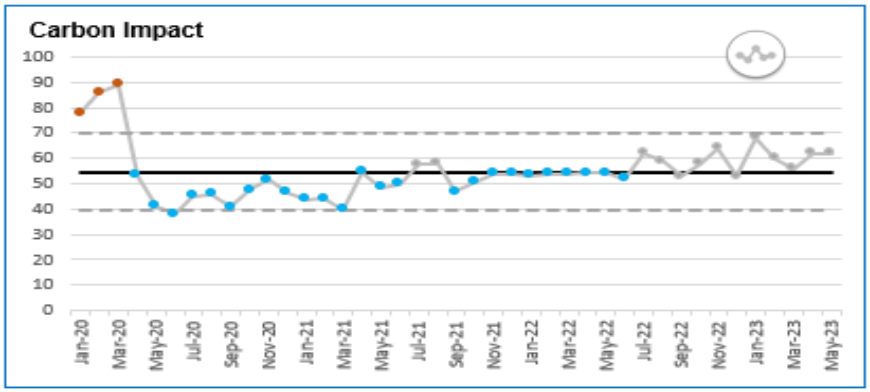
The following section highlights the performance against the Trust's strategic objectives and priority programmes for 2022/23.
For some metrics, we have identified when we anticipate this data to be available. Some of the identified metrics will be reported quarterly.
We will also incorporate statistical process control 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 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

Metrics	Threshold	Mar-23	Apr-23	May-23	Variation/ Assurance	Notes
Percentage of service users who have had their equality data recorded - ethnicity	*90%*	96.3%	96.6%	96.6%		
Percentage of service users who have had their equality data recorded disability	To be determined for 23/24	41.9%	43.2%	43.5%		The threshold for 23/24 is being developed by the equality inclusion and involvement committee and it is expected to be included in the July report.
Percentage of service users who have had their equality data recorded - sexual orientation		42.2%	43.3%	43.4%		
Percentage of service users who have had their equality data recorded - deprivation (postcode)		99.8%	99.8%	99.8%		
Timely completion of equality impact assessments (EIAs) in services and for policies (Quarterly)	95%	77.6% Service 95.3% Policy	53.3% Service 94.6% Policy	53.7% Service 96.1% Policy		EIAs for services are reviewed annually. This means all services have an EIA in place. Work is being undertaken to support services with the reviews within the year.
Completion of equality mandatory training (Quarterly)	>=80%	95.1%	96.0%	96.2%		
Number of people who sustain 26 weeks employment via Trust Individual placement support service	Trend monitor	-	0	1		2023/24 to be used as a baseline
Carbon Impact (tonnes CO2e) - business miles	76	56	62	62		Data showing the carbon impact of staff travel / business miles. In May staff travel contributed 62 tonnes of carbon to the atmosphere.
Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks), by ethnicity, disability, sexual orientation and deprivation	55%	63.3%	Due August 2023			Q4 - 63.3% Reported 6 weeks in arrears. A weighted average is used given there are different targets in different places.

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



The SPC chart shows that as at May 2023 we remain in a period of common cause variation. The drop in mileage figures are a direct consequence of Covid-19 and now that restrictions have been removed 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 a more blended approach to working is expected going forward. The performance against this measure will continue to be monitored.

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

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

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	Phase 1, developing the social responsibility and sustainability action plan, completed by July 2023		The first quarterly update of the strategy was presented into the Equality, Involvement and Inclusion committee in June. This included the metrics for measurement of delivery against the strategy which were agreed. Plans are in place to launch the green team to establish a network of people who can champion this agenda. The eBikes for the staff pilot have been delivered to our partner Barnsley Cycle hub, protocols and user agreement documents have been agreed. Work has commenced on the refurbishment of a garage on the Kendray site. The Social Responsibility and Sustainability Steering group has been established and held its first meeting. EMT supported the proposal for social responsibility and sustainability to become a 'golden thread' throughout all strategic change priority programmes in 2023/24.
Work in partnerships at System & Place to improve the health of our communities	Community Mental Health transformation: Identify actions for SWYPFT to support implementation of next phase. April 2023		EMT supported next steps proposal. Internal steering group for Community Transformation (mental health (MH)) is in process of being established to take forward this work under the improving mental health portfolio of priority programmes for 2023/24
	Community Mental Health transformation: Develop internal and external communication messages to raise awareness and promote understanding of SWYPFT role in next phase of transformation.		This work is being aligned to Place based and ICS messaging via weekly meetings and is a workstream of the newly formed internal Community Transformation (MH) steering group.
	Address inequalities involvement and equality in each of our places with our partners		It has been agreed by EMT that in 23/24 there will be a priority programme of improvement work with the focus on ensure equality, involvement & inclusion are central to all that we do so we reduce inequalities. This programme is currently under rescoping, building on the existing work that has been undertaken and setting an improvement plan for 2023/24. EMT supported the proposal for equality, involvement and addressing inequalities to be a 'golden thread' throughout all strategic change priority programmes in 2023/24.

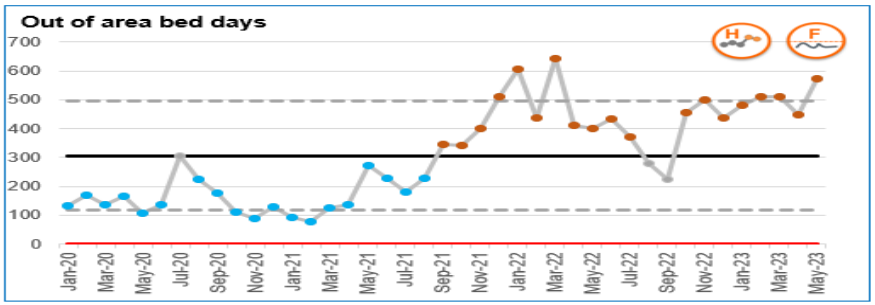
Improve Care

Metrics	Threshold	Mar-23	Apr-23	May-23	Variation/ Assurance	Notes
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95% Improvement trajectory: June 90%, July 92%, Aug 94%, Sept 95%	89.9%	90.6%	*87.7%*		May data shows a slight decline in performance from the previous month within inpatient services, however community services have shown a marked improvement. All areas are working to improve performance and quality of risk assessments. Issues with data capture, service pressures and data quality continue to be addressed but are complex. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality. A new trajectory for improvement has been set based upon the current and projected performance to allow for sustainable and impactful improvement actions to be implemented.
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		79.4%	80.7%	*94.6%*		
% Service users on CPA offered a copy of their care plan	80%	75.1%	85.0%	85.7%		All areas continue working to improve performance and the impact of this can be seen through the data improvements. The May position remains above threshold for the second month. The actions in place at each care group plus the change ideas being tested through the improvement group are supporting continued improvements. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality.
Registered substantive staff in post mental health and learning disabilities services	Establishment	Due July 23 (August report)				
Staff in neighbourhood teams	Establishment					
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	20	23	37		In May the majority of race related incidents against staff were reported in Forensics, reported equally over low and medium secure. In mental health inpatient areas the majority of incidents were recorded in Barnsley, with all incidents in Barnsley reported on Melton PICU. Any increases are monitored by the Patient Safety Team.
Inappropriate out of area bed placements (days)	Q1 - 455, Q2 - 368, Q3 - 276, Q4 - 0	511	457	574		See statistical process chart below for further detail.
% service users clinically ready for discharge	<=3.5%	3.5%	2.4%	2.1%		
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	607	694	296		Average wait in days. Clients are seen in order of need and not by how long they have waited. The longest wait for those seen in the month was 775 days, the shortest was 20 days. Number on waiting list at end of May - 270. The longest waiter on the waiting list had waited 797 days. Waiting list initiatives in place, we will not reach a steady state until Q1 of 2023/24
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	126	495	492	479		Average wait in days. Clients are seen in order of need and not by how long they have waited. The longest wait for those seen in the month was 583 days, the shortest was 44 days. Number on waiting list at end of May - 1573. The longest waiter on the waiting list had waited 807 days. 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%	76.2% 64/84	72.9% 43/59	84.3% 59/70		Barnsley is above target (One speech and language case due to locum focus on dysphagia and urgent communication cases). Calderdale below target but there only one out of six cases in breach (psychology case on waiting list - no welfare call). Wakefield was below target with three of 17 cases in breach (two psychology on waiting list and had welfare calls; one psychiatry case – service offered but patient cancelled/DNA appointments – opt-in being sent). Kirklees – there are a six breaches (four physio cases on waiting lists; 2 psychology, one of which DNA – patient not brought).
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	80%	86.6%	90.3%	88.2%		There has been a slight decrease in May however this is still within acceptable range and this metric remain in special cause improving variation
Community health services two hour urgent response standard	70%	83.8%	87.3%	86.6%		
Referral to assessment within 2 weeks (external referrals)	75%	67.7%	60.4%	68.6%		Demand into the Single Point of Access (SPA) and capacity issues have lead to ongoing pressures in the service, workforce challenges are continuing to compound these problems and have been increasing with a significant number of vacancies despite active recruitment. SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment has been at risk of being delayed in all areas, and is below target performance in Barnsley and Calderdale and Kirklees. Rapid improvement work in SPAs together with some progress in recruitment should contribute to an improved performance in the coming months.

Glossary

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

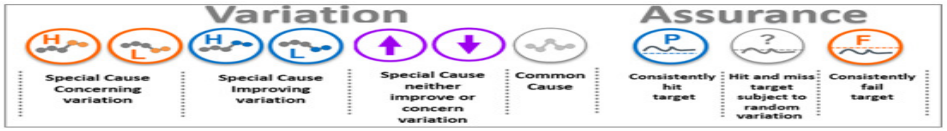
What the data is telling us. Statistical process control charts will be inserted here to alert the reader to metrics that require further work or investigation.
(SPC charts to be included here where relevant)



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 to 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 17 people placed in out of area beds at the end of May 2023.



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 (PSIRF) to analyse our data and intelligence to identify the Trust's patient safety priority areas. Phase one: Orientation by 30/11/2022 completed Phase two: Diagnostic and discovery by 31/5/2023 completed Phase three: governance and quality monitoring by 31/5/2023 Complete/ Under Review Phase four: patient safety response planning by 30/06/2023 Phase five: Curate and agree patient safety policy and plan by 31/8/2023 Go Live: Develop comprehensive improvement plans by Autumn 2023 (NHS England have revised the go live date)		PSIRF Phase four: patient safety response planning by 30/06/2023 All other phases have commenced. It should be noted although dates are given, these are estimates as the phases are not linear and aspects are expected to continue throughout our journey.
	Care Planning and Risk Assessment		It has been agreed by the executive management team (EMT) that in 23/24 there will be a priority programme of improvement work with the focus on Care Planning and Risk Assessments. This programme is currently under rescoping, building on the existing work that has been undertaken and setting an improvement plan for 2023/24.
	Personalised Care (Moving on from CPA)		It has been agreed by EMT that in 23/24 there will be a priority programme of improvement work with the focus on Personalised Care (moving on from CPA). This programme is currently under rescoping, building on the existing work that has been undertaken, alignment to community mental health transformation, and setting an improvement plan for 2023/24.
Continually improve the care we provide, ensuring it is responsive, inclusive & timely	Improving Access to Care (IATC): Update on improvement work to reduce waits		- Community LD services (LD): The design of SystmOne waiting list functionality with the Calderdale team has been approved. Configuration team and training team are aiming to complete build and have this rolled out to wider localities in a collaborative approach and teams using the System by end of July. - The Equality and Involvement and Business Intelligence teams provided an awareness session with Calderdale team to support in data recording and understanding of importance of data capture of protected characteristics to improve data collection. - CAMHS neurodevelopmental services in Kirklees and Calderdale: In the last month, configuration of the agreed standardised referral form on SystmOne to support the transition between children's and adult ADHD service was completed. A workshop has been scheduled to create a set of shared transition principles and expectations. This work links in with the wider work being undertaken by West Yorkshire Mental Health, Learning Disabilities and Autism (MHLDA) Partnership Board transition project group. - Adult community services – Core psychology: SystmOne waiting lists have gone live in all core psychology localities. Service level data analysis work has begun as this will help identify potential areas of improvement. A rescoped project plan and driver diagram have been developed. - SystmOne waiting list project: The project continues to support services in using the functionality correctly, supporting solving of data quality issues, and concentrating on the remaining services trained/setup to begin feeding data from the high-level reporting tool/become "live". - Review of waiting times report: This is a collaborative piece and work continues to develop the report to the agreed plan, in line with the scheduled Clinical Governance and Clinical Safety Committee (CGCSC) meetings. Work has commenced on scoping the programme of work for 2023/24 aligned to other priority programmes under the Improving mental health portfolio.
	Improving Mental Health portfolio		It has been agreed by EMT that in 23/24 there will be four priority programmes of improvement work covering Care Closer to Home, Inpatient Improvement, Community Transformation (Mental Health) and Improving Access to Care. These programmes are currently under rescoping, building on the existing work that has been undertaken and setting improvement plans for 2023/24.
	Out to public consultation on older people inpatient services by Summer 2023		Work continues on finalising the business case and draft consultation documents

Improve resources

Metrics	Threshold	Mar-23	Apr-23	May-23	Variation/ Assurance	Notes
Surplus/(deficit) against plan	Breakeven	(£546k)	£222k	(£326k)		Although April 2023 continued the positive run rate, the May 2023 position has been significantly impacted by the gap associated with the national Agenda For Change pay award. This will be paid in June 2023.
Capital spend against plan	£8.8m	£2721k	£282k	£537k		Capital spend is ahead of plan due to schemes brought forward. These were existing schemes within the plan but an opportunity was taken to complete them earlier than planned. The overall forecast remains that the £8.8m allocation will be fully utilised in year.
Agency spend managed within the overall workforce (Monthly)	3.5% £8.7m	£1073k	£939k	£908k		Agency run rate continues higher than planned and exceeds the capped rate with spend of £908k in month.
Financial sustainability and efficiencies delivered over time	£12m	£471k	£568k	£1,497k		Savings in ahead of plan for the year to May 2023. Risks remain in overall deliverability and schemes, with mitigations, are being progressed.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	7	Due July 23			
Estates Urgent Response Times - SLA	95%	95.6%	93.8%	96.8%		SLA 1 & 2 are the priorities given to Emergency and Urgent work which has a 2 day response time
Premise Assurance Model (PAM)	Good	Good	Good	Good		PAM is a report measuring how well the Trust is run and includes Estates, Facilities, Governance, Patient Safety, Efficiency &
Statutory Compliance	100%	100.0%	100.0%	100.0%		Includes Water, Gas, Electricity, Refrigeration, Pressure, Lower and Asbestos
% of ligature jobs completed within timeframe	100%	-	50.0%	76.0%		All jobs that pertain to a ligature risk

What the data is telling us. 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	Financial Improvement plan		Financial improvement plan established and scope of plan, including non-recurrent funding for project management resource, agreed by executive management team (EMT).
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 mid- June 2023		The go-live for launch of Patient Knows Best has been postponed by a few weeks as NHS England work through some technical details with the NHS App which are also impacting existing users of Patient Knows Best in other areas of the country.
	Implementation of a Trustwide approach to digital dictation submission for Board approval July 2023.		Tender submissions evaluated and decision making in progress.

We have added some additional metrics from November 2022 to allow the board to review and monitor performance against a number of key estates metrics. These can be seen in the table below.

Make SWYPFT a great place to work

Metrics	Threshold	Mar-23	Apr-23	May-23	Variation/ Assurance	Notes
Turnover external (12 month rolling)	>12% - 13%<	13.5%	13.0%	12.2%		Rolling turnover continues to decrease and has dropped by 0.8% to 12.2%
Registered workforce growth	3% (by March 23)		0.6%			
Sickness absence - rolling 12 months	<=4.8%	5.3%	5.3%	5.3%		Absence rate in month decreased by 0.4% to 4.6%.
Workpal appraisals - rolling 12 months	>=78%	71.8%	74.4%	74.9%		For the month of May, the % rate increased by 0.5.% to 74.9%.
% staff recommending the Trust as a place to work	65%	Due Aug 23				Quarterly reported, next survey July '23.
% staff recommending the Trust as a place to receive care and treatment	65%	Due Aug 23				Quarterly reported, next survey July '23.
Staff supervision rate	80%					Supervision data is currently excluded due to a review of the supervision policy, recording and reporting. An improvement approach is being taken to this work. The supervision database will be live from end June and it is anticipated reporting will be available from August with planned trajectory for improvements.
Complaints - Number of responses provided within six months of the date a complaint received	100%	29% (4/14)	27% (4/15)	38% (3/8)		
Mandatory training - Cardiopulmonary resuscitation	80%	75.0%	75.5%	79.2%		
Mandatory training - Reducing restrictive practice interventions	80%	74.6%	73.8%	73.8%		
Mandatory training - Fire	80%	89.4%	90.2%	91.2%		
Mandatory training - Information governance	95%	86.5%	90.6%	95.9%		

What the data is telling us. 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	People Directorate work plan has been finalised. The Great Place to Work priority programmes are under development.		A series of metrics and measurements for the Great Place to Work programme have been devised and will be used as a baseline and developed further to provide an ongoing mechanism for reporting impact during 2023/24. Inclusive recruitment, retention and wellbeing and living our values programmes of work have been agreed and the improvement work plans for these is currently being scoped. EMT supported the proposal for recovery focused and becoming a trauma informed organisation to be a 'golden thread' throughout all strategic change priority programmes in 2023/24.

Reducing Inequalities

Addressing inequalities and demonstrating we meet the requirements of the Public Sector Equality Duty and our legal obligations under the Equality Act 2010 and NHS Constitution is a Trust priority. We know there are differential impacts on protected groups and carers and we use the joint needs assessment (JNA) data in each of our places as a baseline so we can understood the local population and meet the needs of local people:

- Every service in the Trust, and every strategy and policy have an Equality Impact Assessment (EIA)
- We have a Trust dashboard in line with NHSE and CORE20PLUS5 to track out progress for workforce and people in our services
- We are using the King's Fund approach to address inequalities and are testing this model out in service areas
- We continue to co-design services with our communities ensuring representation is reflective of the population and covers all protected groups and carers.
- We work proactively with the voluntary and community sector to reach grass roots communities
- We have started to roll out enhanced equality and diversity training to create the right conditions and culture

Key actions the Trust are taking to address inequalities are:

- Data - improving data collection gaps – addressed using the 'All of You' campaign, and staff development.
- Information - literature bank for equality and diversity and community films to support insight and understanding of diverse groups.
- Monitoring – the use of translation services at a service level against patient profile, and ensuring service information is in the right format and accessible
- Improving access - Identifying digital access as part of initial assessment via SystmOne.
- Involving - capturing patient and staff feedback, and equality monitoring responses to highlight specific issues.
- Development – through mandatory and enhanced training and lunch time talks we are developing our staff
- Our People - ensuring reflective and representative workforce and leadership. Removing the requirement for Maths and English qualifications.
- Stories - Using tools to capture patient stories, and approaches such as community reporters and researchers.
- Creative approaches - developed through 'Recovery Colleges' and 'Creative Minds'.
- Faith - spiritual support through 'Spirit in Mind'.

Specific examples include:

- Creative Minds worked with 'Lead the Way's Art Group' to develop a piece of work that helped people with learning disabilities share their own experiences of the pandemic
- Staff at Kirklees NHS Talking Therapies (formerly Improving Access to Psychological Therapy (IAPT)) services received training on delivering 'Transcultural Therapy' combined with a focus on providing culturally sensitive supervision.
- NHS Talking Therapies are working in partnership with the voluntary organisation 'Solace' in Calderdale to better understand the psychological needs of asylum seekers to ensure we can improve access to services
- Recovery College Kirklees is working with the south Asian community for people with lived experience to become partners and co-facilitators delivering culturally informed groups.

Reducing Inequalities

Specific examples continued:

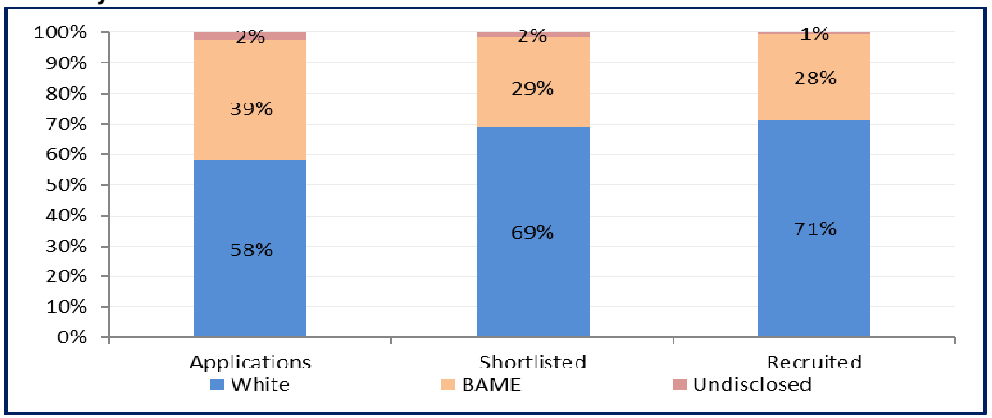
• Perinatal pathways include peer support workers as key members of staff within the new pathway design
• The Trust has an updated Transgender policy and Accessible Information Policy. Both policies have been co-designed with the voice and views of staff, lead managers, staff side, staff networks and service users, carers, and families.
• The Trust delivered a 'Disability Matters' event in August 2022.
• Wakefield CAMHS Mental Health Support Team have developed leaflets in a variety of languages based on their target audience.
• Young people were involved in the co-creation, design and development of a choose well campaign
• Kirklees carers of people with a learning disability project (funded by SWYPFT) have mapped what support is available to carers of people with a Learning Disability so people can access the support they need to continue their caring role
• In Barnsley mental health services, a gender specific role works specifically with women to focus on physical health in the recovery college and support them to access community services.
• Paediatric SALT has established a Facebook page, You Tube and Twitter feed where parents can send messages via social media, this is proving popular with service users as they can access peers and the support they need.
• The Trust increased the take up of health checks in Calderdale for people with severe mental illness by creating letters that were beautifully illustrated and less formal, so people felt engaged as soon as the letter arrived
• The Trust has developed a consent to care, treatment, and discharge tool within SystmOne to ensure the child's voice is captured in decisions around their care
• A 'Respect Project' was set up to tackle trends in negative language and behaviours relating to ethnicity, sexual orientation, and gender. The project ran an art competition across the wards to promote positive identity and celebrate diversity

This section of the report will continue to be developed 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.

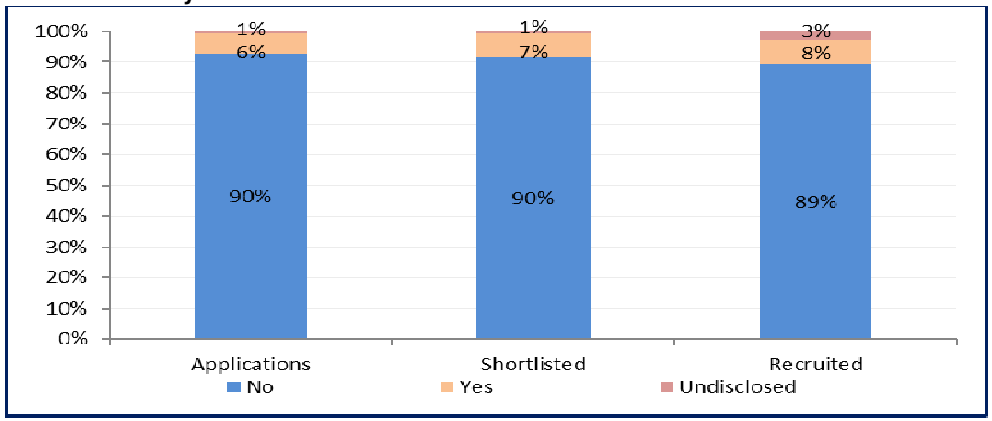
Reducing Inequalities

Recruitment - rolling 12 months to end of Quarter 4 2022-2023

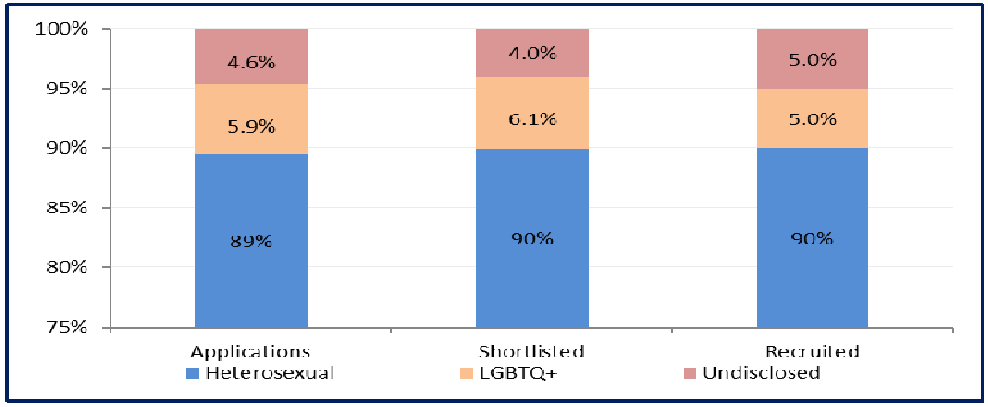
Ethnicity



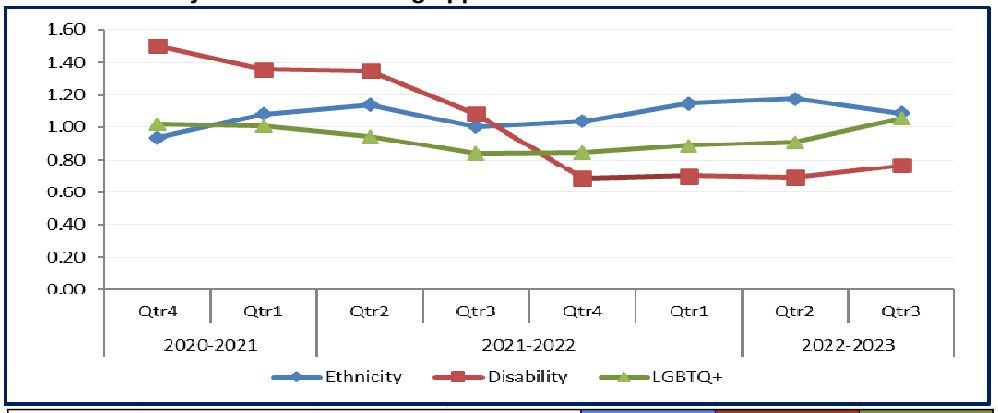
Disability



Sexual Orientation



Relatively likelihood of being appointed



Relative Likelihood YTD Quarter 4 2022-2023:	BAME:	Disability:	LGBTQ+:
	1.08	0.92	1.22

Reducing Inequalities

Recruitment - rolling 12 months to end of Quarter 4 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 Trust catchment area.

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

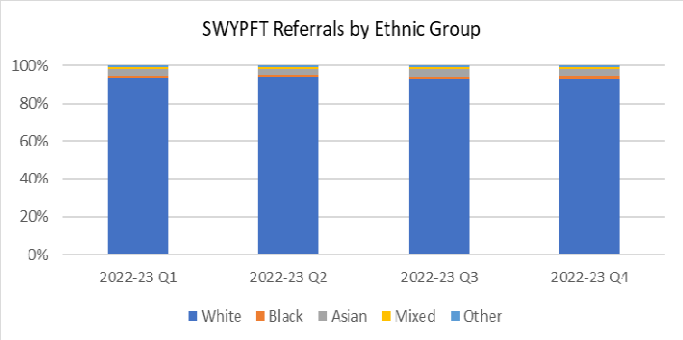
BAME - relative likelihood of being appointed compared to white applicants this quarter = 1.08
Disability - relative likelihood of being appointed compared to non-disabled applicants this quarter = 0.92
LGBTQ+ - relative likelihood of being appointed compared to heterosexual applicants this quarter = 1.22
NB Relatively large proportions of undisclosed could unintentionally skew the data

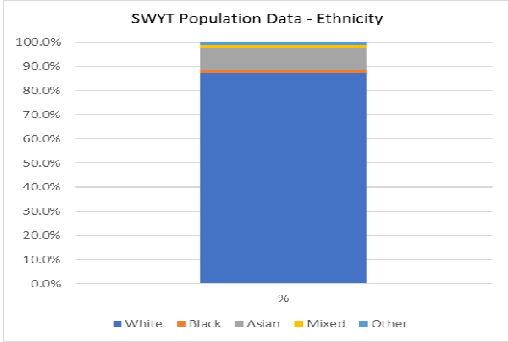
Relative likelihood key
1.00 = target figure, equally as likely to be appointed.
Greater than 1.00 = less likely to be appointed
Lower than 1.00 = more likely to be appointed

Action
Recruitment & Selection policy in the process of being reviewed
Review Recruitment & Selection training
Work with staff networks around action planning

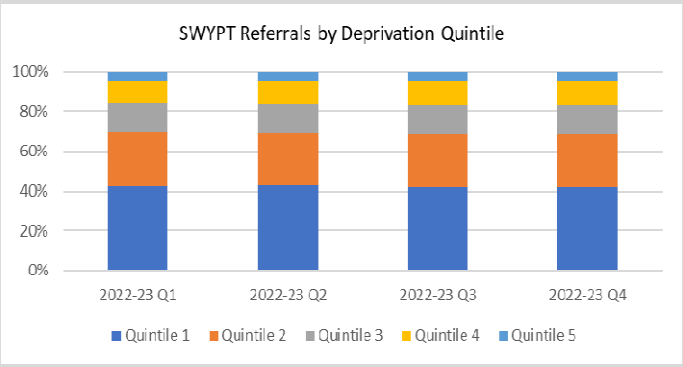
Reducing Inequalities

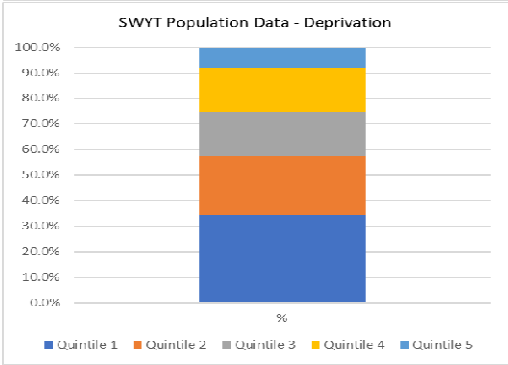
Referrals - (Includes physical health, mental heath, learning disability and forensics)





Ethnic Group	2022-23 Q1	2022-23 Q2	2022-23 Q3	2022-23 Q4	Local Population
White	97.5%	97.7%	93.1%	93.2%	87.1%
Black	1.2%	1.1%	1.0%	1.2%	1.4%
Asian	3.3%	3.3%	3.8%	3.5%	8.9%
Mixed	1.2%	1.0%	1.1%	1.2%	1.6%
Other	0.9%	0.9%	0.9%	0.9%	1.1%





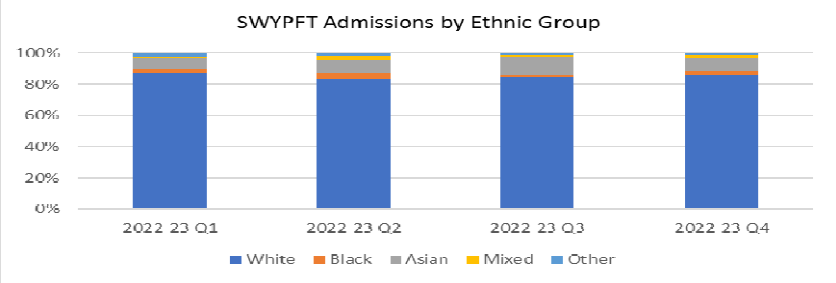
Quintile	2022-23 Q1	2022-23 Q2	2022-23 Q3	2022-23 Q4	Local Population
Quintile 1	42.3%	42.7%	41.7%	41.8%	34.1%
Quintile 2	26.9%	26.4%	26.5%	26.6%	23.4%
Quintile 3	15.5%	15.2%	15.6%	15.2%	17.0%
Quintile 4	10.9%	11.0%	11.5%	11.6%	17.8%
Quintile 5	4.4%	4.7%	4.7%	4.8%	7.8%

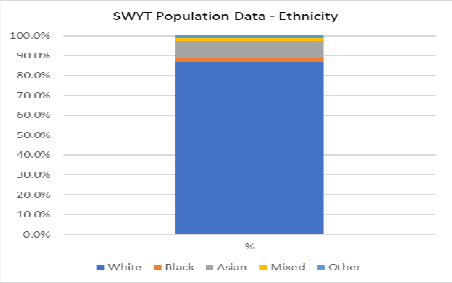
Notes:

- 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
- The Trust continues to receive more referrals for people from a white ethnic background.
- When comparing the referrals to the Trust against the ethnic make up of the local population, the proportion of people from a white ethnic background in the local population is lower that the proportion of referrals to the Trust for people from a white ethnic background.

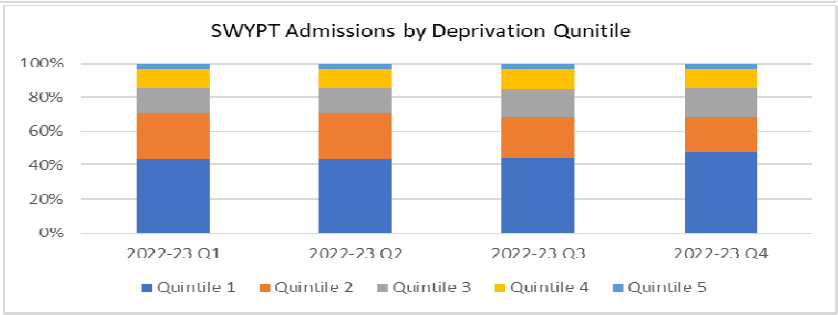
Reducing Inequalities

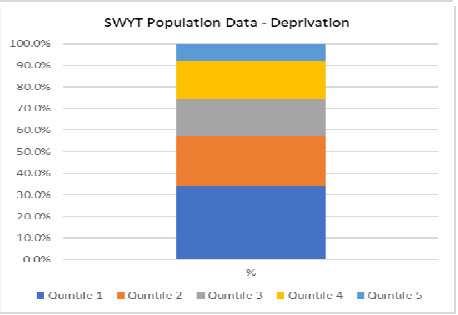
Admissions - (Includes physical health, mental heath, learning disability and forensics)





Ethnic Group	2022-23 Q1	2022-23 Q2	2022-23 Q3	2022-23 Q4	Local Population
White	87.6%	83.6%	84.4%	86.1%	87.1%
Black	2.2%	3.2%	1.7%	2.5%	1.4%
Asian	6.2%	8.6%	11.1%	7.6%	8.9%
Mixed	1.8%	2.7%	1.5%	2.7%	1.6%
Other	2.2%	1.8%	1.3%	1.1%	1.1%





Quintile	2022-23 Q1	2022-23 Q2	2022-23 Q3	2022-23 Q4	Local Population
Quintile 1	43.6%	43.6%	44.4%	47.8%	34.1%
Quintile 2	27.4%	27.4%	23.8%	20.5%	23.4%
Quintile 3	14.5%	14.5%	16.1%	17.3%	17.0%
Quintile 4	10.7%	10.7%	12.1%	10.5%	17.8%
Quintile 5	3.8%	3.8%	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
- Admissions during quarter 3 for people from a white ethnic group were at a lower proportion than that of the population the Trust serves.
- Admissions for people with a mixed ethnic group were slightly lower than the mixed population of the population the Trust serves - these are small numbers and so can impact on the overall percentage.
- There were a significantly greater number of admissions from the quintile 1 (most deprived) compared to the proportion of the Trust's population that are in quintile 1. 44.8% of the Trust's admissions were for people from the most deprived areas of the population the Trust serves.
- There has been a decrease in the number of admissions from the least deprived areas (quintile 5) compared to the last 2 quarters.

Work is taking place through the Adults and Older People Mental Health Equality, Inclusion and Involvement Care Group to interpret data and identify actions to address any health inequalities using the health inequalities improvement report. The initial focus has been on service users admitted and detained under the Mental Health Act where nationally a disproportionately high number of people from BAME populations are detained. A framework to support improvements in data capture and reduce health Inequalities has also been developed with the focus initially being placed on the perinatal service - where the UK has one of the highest rate of maternal mortality in Europe - and learning disability services, where the median age of death for people with a learning disability is 20 years younger than the general population and where 49% of deaths were classified as "avoidable" compared with 22% for the general population. This framework has started to identify areas where there may be gaps in our data such as digital poverty, or where improvements to care could be made such as completion of physical health screenings.

Quality Headlines

Section	KPI	Target	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 5	TBC	61.3%	57.2%	60.0%	53.0%	66.0%	68.0%	70.0%	72.0%	74.0%	78.0%	76.0%	81.0%	N/A
Complaints	% of feedback with staff attitude as an issue 12	< 20%	19% 4/21	18% 4/22	20% 4/20	25% 5/20	15% 4/26	9% 2/22	20% 4/20	0% 0/16	11% 2/18	0% 0/21	17% 4/23	11% 2/17	1
Service User Experience	Friends and Family Test - Mental Health	84%	85%	88%	85%	85%	84%	86%	85%	83%	85%	83%	82%	85%	1
	Friends and Family Test - Community	95%	93%	93%	92%	93%	93%	93%	94%	93%	95%	97%	94%	97%	1
Quality	Number of compliments received	N/A	25	31	10	13	5	28	39	83	22	26	50	66	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) 4	Trend monitor	26	31	19	35	32	33	31	40	30	37	23	21	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions 4	Trend monitor	3	0	0	0	2	2	2	3	2	1	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches 4	0	0	0	1	2	1	0	0	0	2	0	0	0	1
	% Service users on CPA offered a copy of their care plan	80%	33.5%	36.1%	38.2%	42.8%	44.3%	43.8%	44.1%	50.5%	58.6%	75.1%	85.0%	85.7%	4
	Number of Information Governance breaches 3	<12	19	10	9	13	11	13	8	12	8	13	12	9	2
	% of inpatients clinically ready for discharge	3.5%	2.1%	2.6%	3.0%	2.8%	3.3%	2.7%	3.8%	4.3%	4.5%	3.5%	2.4%	2.1%	3
	The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95%	72.1%	78.0%	82.0%	71.3%	71.3%	79.1%	76.6%	83.6%	87.8%	89.9%	90.6%	*87.7%*	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	95%	72.2%	54.2%	81.7%	62.9%	68.0%	69.5%	74.3%	68.2%	67.0%	79.4%	80.7%	*94.6%*	4
	Total number of reported incidents	Trend monitor	1130	1179	1254	1168	1242	1307	1187	1245	1196	1243	1172	1253	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	24	27	11	32	26	30	24	34	26	35	18	26	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	1	4	3	3	3	7	7	3	3	2	2	1	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	1	0	5	2	3	0	3	3	1	2	3	1	
	Safer staff fill rates	90%	116.6%	115.8%	115.6%	118.4%	117.4%	119.1%	118.1%	122.1%	121.4%	119.3%	123.5%	123.5%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	85.0%	84.7%	83.1%	87.5%	91.0%	90.8%	85.6%	90.5%	89.1%	89.7%	94.4%	95.7%	1
	Number of pressure ulcers which developed under SWYPFT care (1)	Trend monitor	44	50	26	43	49	48	39	55	46	37	26	35	
	Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care (2)	0	0	3	0	1	1	1	4	0	2	1	1	1	1
	Eliminating Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	% of prone restraint with duration of 3 minutes or less 8	90%	87.5%	80.0%	91.0%	100%	100%	92.0%	100.0%	95.2%	87.0%	100.0%	90.0%	86.6%	1
	Number of Falls (inpatients)	Trend monitor	37	70	63	58	68	63	59	51	49	39	34	53	
	Number of restraint incidents	Trend monitor	152	171	161	160	169	223	189	212	223	203	192	186	
	Potential under-reporting of patient safety incidents														
	% people dying in a place of their choosing 14	80%	85.7%	100.0%	85.3%	85.7%	91.7%	93.3%	78.1%	93.8%	83.3%	100.0%	87.5%	89.4%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	6	0	0	0	0	0	0	0	0	0	0	0	0	1
	C Diff avoidable cases	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	E. Coli bloodstream infection rate	0													
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0													
	No of wards with Covid-19 outbreaks	Trend monitor													
	No of Service users Covid-19 positive and now recovered	Trend monitor													
	No of Service users Covid-19 positive and still within 28 days, monitoring not completed	Trend monitor													
	No of Service users Covid-19 positive and deceased within 28 days of positive test	Trend monitor													
Improving Resource	NHS England Systems Oversight framework segmentation	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	Overall CQC rating														
	CQC well - led rating														

Quality Headlines

Quality Headlines cont…

1 - Attributable - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. There is evidence in care records of all interventions put in place to prevent patients developing pressure ulcers, including risk assessment, skin inspection, an equipment assessment and ordering if required, advice given and consequences of not following advice, repositioning if the patient cannot do this independently off-loading if necessary
2 – Lapses in care - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. Evidence is not available as above, one component may be missing, e.g.: failure to perform a risk assessment or not ordering appropriate equipment to prevent pressure damage
3 - The 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. Excludes autistic spectrum disorder waits and neurodevelopmental teams.
8 - The threshold has been locally identified and it is recognised that this is a challenge. The monthly data reported is a rolling 3 month position.
9 - Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed. Trend reviewed in risk panel and clinical governance and clinical safety group. Initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report.
9 - Patient safety incidents resulting in death (subject to change as more information comes available). All incident data is reviewed using SPC charts to identify any special cause variation, if this occurs this will be reported by exception. Otherwise reporting rates remain within normal variation.
11 - Number of records with up to date risk assessment - 'Older people and working age adult inpatients' - we are counting how many staying safe care plans were completed within 24 hours and for 'community services for service users on care programme approach' - we are counting from first contact then 7 working days from this point.
12 - This is the count of written complaints/count of whole time equivalent staff as reported via the Trusts national complaints return.
13 - The NHSE Oversight Framework was updated in June 22 . Further detail regarding the framework and the metrics monitored can be seen in the national metrics section of the report.
14 - This metric relates to the Macmillan service, end of life pathway

Quality Headlines

• Number of restraint incidents - during April decreased to 186 from 192 reported in the previous month. Further detail is provided in the relevant section of this report.
• % of prone restraint with duration of 3 minutes or less dropped below the 90% threshold for May 23. Further detail can be seen in the following section of the report.
• Performance for CAMHS Referral to Treatment - services have highlighted that sustained increases in referrals will negatively impact on the length of wait. A review of support for people on waiting lists is being monitored through the Trustwide Clinical Governance Group.
• Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care - 1 in May. Lapse in care identified. There is a lapse in care identified due to appropriate risk assessment and prevention of pressure ulcers not being in place
• The number of people with a risk assessment/staying safe plan in place within timescale has improved again this month for community services but has seen a slight decrease in inpatient services further improvement is expected to continue. See the Strategic Objectives & Priorities section for further details.
• The percentage of service users on care programme approach offered a copy of their care plan has improved again this month, and remains above threshold. See Strategic Objectives & Priorities section for further details.
• Clinically ready for discharge (previously delayed transfers of care) - This remains below threshold in April 2023. We are continuing to experience pressures linked to patients being medically fit for discharge but who are subsequently delayed. We are working with systems partners at place to develop crisis provision including safe places to stay away from home, and exploring and optimising all community solutions to get people home as soon as they are ready – utilising roles such as discharge coordinators, and improving links with homeless services and housing providers.
• 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 is available. 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 SPC to explore any potential higher or lower rates than would usually be considered acceptable. Where there are outlying areas, these will be reported on by exception.
• Number of Falls (inpatients) - All falls incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required . In May, there have been fewer service users who repeatedly fall. However, on one ward there has been a service user with complex physical and mental health needs, this service users accounts for 50% of the falls. 100% of the service user falls were linked with a diagnosis of dementia, which is associated with agitation and wandering, often this is further complicated by postural instability and hypotension, muscle weakness, delirium, urinary frequency or incontinence, effects of medication, and visuospatial impairment, this makes it harder to reduce falls risks. People with dementia are twice more prone to falls than their peers.

Patient Safety Incident Response Framework (PSIRF)
As reported in the previous Integrated performance report, NHS England launched the new Patient Safety Incident Response Framework on 16 August 2022. The transition work commenced in September 2022. We are in a 12 month transition period working towards going live in Autumn 2023. We are progressing through various phases of work, including discussions with our ICB and provider collaborative colleagues, mapping our services, data analysis and improvement activity, writing our draft PSIRF policy and plan. Our intranet page has been updated with an overview of PSIRF
https://swyt.sharepoint.com/sites/Intranet/Patientsafetystrategy/Pages/Patient-Safety-Incident-Response-Framework.aspx

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)
NHS England have recently extended the transition timescales as below:
A) By 31/03/2023 - to have our Datix test system updated with the LFPSE functions - Achieved
B) By 30/09/2023 - to go live with Datix LFPSE recording - this will be implemented following thorough testing of (A) above.
As with all NHS Trusts using Datix, we are now awaiting an upgrade to Datix around June/July to activate further system enhancements before further work can continue and promote changes with staff.

Patient Safety Training
We have developed a proposal to seek agreement and funding for level 3 patient safety training to be essential to job role.
It sets out the national requirement for level 3 patient safety training (levels 1 and 2 are already agreed and underway in the trust). This supports the NHS Patient Safety Strategy and standards set out in the Patient Safety Incident Response Framework
The training will include:
a) Investigation training for lead investigators
b) Oversight of investigation training
c) Engagement and involvement of those affected by patient safety incidents
The paper has been agreed by the Education and Training governance group and Executive Management Team and training is planned between July and December 2023.

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).

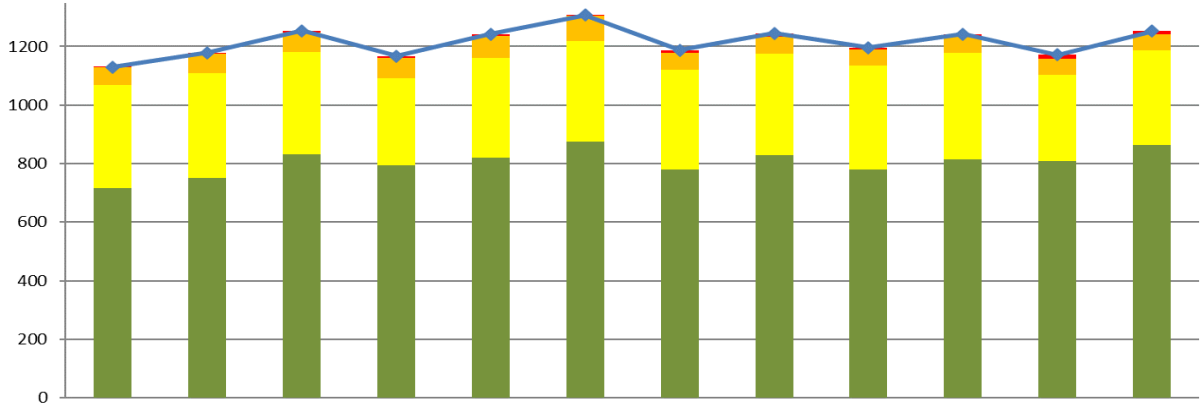
A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (National Patient Safety Agency, 2004: Seven Steps to Patient Safety).

95% of incidents reported in May 2023 resulted in no harm or low harm or were not under the care of the Trust. 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



	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Red (should not be compared with SIs)	2	5	6	8	6	3	8	11	6	9	14	10
Amber	60	65	66	68	76	85	58	59	56	57	55	57
Yellow	351	358	350	299	339	345	340	347	353	363	295	323
Green	717	751	832	793	821	874	781	828	781	814	808	863
Total	1130	1179	1254	1168	1242	1307	1187	1245	1196	1243	1172	1253

The Trusts risk panel meets weekly and scans for themes that require further review or enquiry. The Operational Management Group continues to receive a monthly report, the format and content are regularly reviewed.

No never events reported in May 2023

Safety First cont…

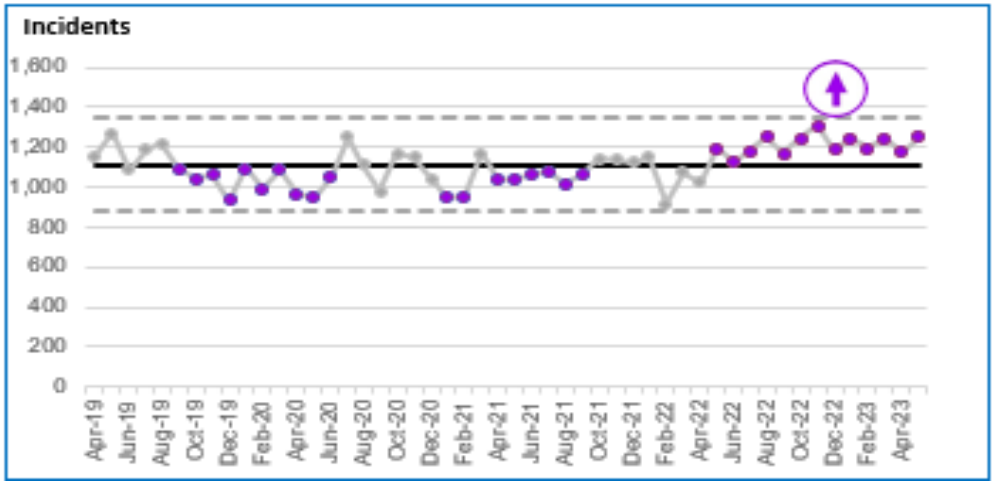
Summary of Patient Safety Incidents resulting in moderate or severe harm or death

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 May 2023:
26 moderate harm incidents
1 severe harm incident
1 patient safety related death

Incidents



We remain in a period of special cause concerning variation, though it should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. We encourage reporting of incidents and near misses. An increase in reporting is a positive where the percentage of no/low harm incidents remains high as it does which is evidenced on the previous page. All incidents are reviewed by the care group management team and then by the Patient Safety Datix team to review the actual degree of harm to ensure consistency with national reporting. All Amber and Red incidents are monitored through the weekly Trust Clinical Risk Panel and all serious incidents are investigated using systems analysis techniques. Learning is shared via a number of routes; care group learning events following a Serious Incident, specialist advisor forums, quarterly trust wide learning events, briefing papers and the production of Situation Background Assessment Recommendation (SBARs).

Learning Library

The learning library has been developed as a way to gather and share examples of learning from experience.
Click the following link for further details of the examples which include information around sexual safety, learning from a serious incident/deaths, recording escapes and inappropriate use of 'toaster bags': https://swyt.sharepoint.com/sites/Intranet/learning-from-experiences/Pages/Learning-library.aspx

On 3 May 2023, a Trustwide learning forum was held to share learning between care groups and specialist advisors. The virtual event was very well attended and many positive examples of learning were shared.

Content, including presentations, is available on the intranet.

The next event is on Wednesday 9th August at 1:30pm - 3:30pm. If you would like to attend or share your learning from experience, please email learninglibrary@swyt.nhs.uk.

Bluelight alerts

Bluelight alert 68 - 16 May 2023 - potential to create an anchor point for a fixed ligature within doorframe

Bluelight alert 67 - 9 May 2023 - Identification of incorrect hypodermic needles for drawing from glass ampules

Bluelight alert 66 - 3 May 2023 - Tampering of seclusion, bedroom and bathroom environments

Bluelight alert 65 - 6 April 2023 - UK emergency alert

Bluelight alert 64 - 5 April 2023 - concealed blades in pens

Bluelight alert 63 - 21 March 2023 - suspended ligature from door closure within a corridor area

Bluelight alert 62 - 27 February 2023 - F-size oxygen safety incidents

Bluelight alert 61 - 27 February 2023 - Oxygen concentrators and emergency cylinders

Bluelight alert 60 - 17 February 2023 - Countersigning of medicines administration

Patient Safety Alerts

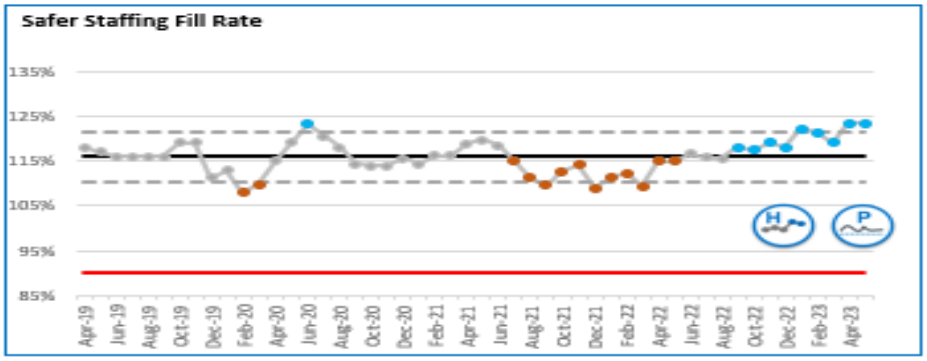
Patient safety alerts issued in May 2023

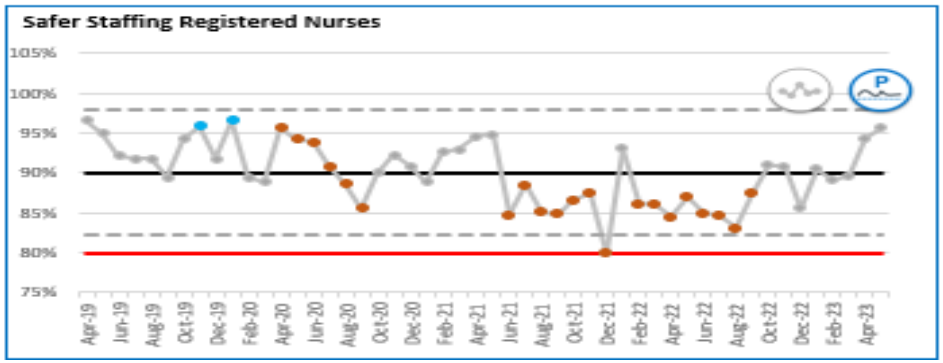
Alerts are issued by the Central Alerting System (CAS) which is a national web-based cascading system for issuing patient safety alerts. Once received into the Trust, patient safety alerts are fully reviewed for understanding and action, sent to identified Trust clinical leads for review and for a decision 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.

There were no patient safety alerts not completed by the deadline of May 2023.

Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
NatPSA/2023/004/MHRA	Recall of Emerade 500 micrograms and Emerade 300 micrograms auto-injectors, due to the potential for device failure	09/05/2023	Yes - circulated for information	12/05/2023	09/05/2023
NatPSA/2023/005/MHRA	Removal of Philips Health SystemsV60 and V60 Plus ventilators from service – potential unexpected shutdown leading to complete loss of ventilation.	18/05/2023	Yes - circulated for information	02/10/2023	
NatPSA/2023/006/DHSC	Shortage of pyridostigmine 60mg tablets	24/05/2023	Yes - circulated for information	26/05/2023	26/05/2023

Safer Staffing Inpatients





The chart above shows that as at May 2023 we remain in a period of special cause improving 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 May 2023 we remain in a period of common cause variation. Further information about staffing levels can be found on the previous page.

There has been a slight increased demand in April on the flexible staffing pool with a total of 68 additional shift requests. The number of shifts filled has increased including on inpatient areas. This is due to availability of substantive and flexible staff and the flexible approach to finding staff solutions from operational colleagues and support services. We continue to monitor staffing related Datix, in May there were 18 incidents recorded. Incident data is reviewed to look for hotspots and trend analysis of staffing deficits. Escalation and continuity plans are followed and are supported by the flexible staffing resource to ensure the delivery of safe and effective care. We continue to monitor the hours that staff work, and any working time directive breeches, to support staff wellbeing.

Although there has been an overall improvement, we continue to fall short of the registered nurse fill rate for day shifts and will continue to look at ways of improving this. This has meant that 18 wards, have fallen below the 90% first fill rate. The overall fill rate describes the acuity on inpatient areas when looked at in conjunction with the unfilled shifts. Teams continue to aim for the delivery of high quality care, as well as being safe, however staffing levels have impacted on Section 17 leave being facilitated and other interventions being delayed. 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).

For the fourth month running one ward fell below the 90% overall fill rate threshold (Lyndhurst, 89%). Inpatient areas continue to experience high acuity as identified above. There are ongoing interventions, projects, and support in place when a ward has been identified as having ongoing and sustained staffing issues to improve the situation. Consistent with the previous month, there were 26 (83.2%) of the 31 inpatient areas who achieved 100% or more overall fill rate. Of those 26 wards, 12 achieved greater than 120% fill rate. The main reason for this being cited as increased acuity, observation, and external escorts.

Both bespoke adverts and centralised recruitment continues and there were four assessment centres throughout May/June which resulted in 18 registered nurse (RN) and 14 health care assistant (HCA) substantive job offers, as well as HCA bank band 2 and band 5 job offers being made.

Within band 5 RN recruitment, bespoke adverts as well as the international recruitment continues. To date we have had 64 internationally recruited band 5 nurses with 54 being on the inpatient wards throughout the Trust. We have received financial support from NHSE until quarter 3 2023/24 and are awaiting the outcome of the new NHSE funding bid.

The first agency scrutiny group, to look at our agency usage and plans for reduction is due to meet at the end of June. There will be a second group which will be looking at actual usage and reasons for this to ensure that we have robust processes in place, monitoring agency usage and understanding the reasons why this has happened.

Project plans for the continued roll out of SafeCare and getting all teams onto the health roster system have been agreed by the executive management team and are ongoing.

Safer Staffing Inpatients cont…

Although safe and effective staffing remains a priority in all our teams, the focus for the flexible staffing resources has been Horizon Centre in Wakefield and across other areas as required. 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.

Registered Nurses Days: Overall registered day fill rates have increased by 0.2% to 88.7% in May compared with the previous month.
Registered Nurses Nights: Overall registered night fill rates have increased by 2.5% in April to 102.7% compared with the previous month.
Overall Registered Rate: 95.7% (increased by 1.35% on the previous month)
Overall Fill Rate: 123.5% (consistent with the previous month): Health care assistants showed a decrease in the day fill rate of 1.1% to 142.1% and the night fill rate increased by 0.2% to 151.2%.

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	Unfilled Percentage		
Registered	338	(-24)	3593.67	28.58%	(-1.95%)	**834**	**(-19)**
Unregistered	332	(-6)	3668.5	7.98%	(-0.33%)	**4174**	**(+117)**
Grand Total	**670**	**(-30)**	**7262.17**	**11.75%**	**(-0.92%)**		

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 increased request on the flexible staffing resource and look at what appropriate resources are required from the trust bank flexible staffing resource.

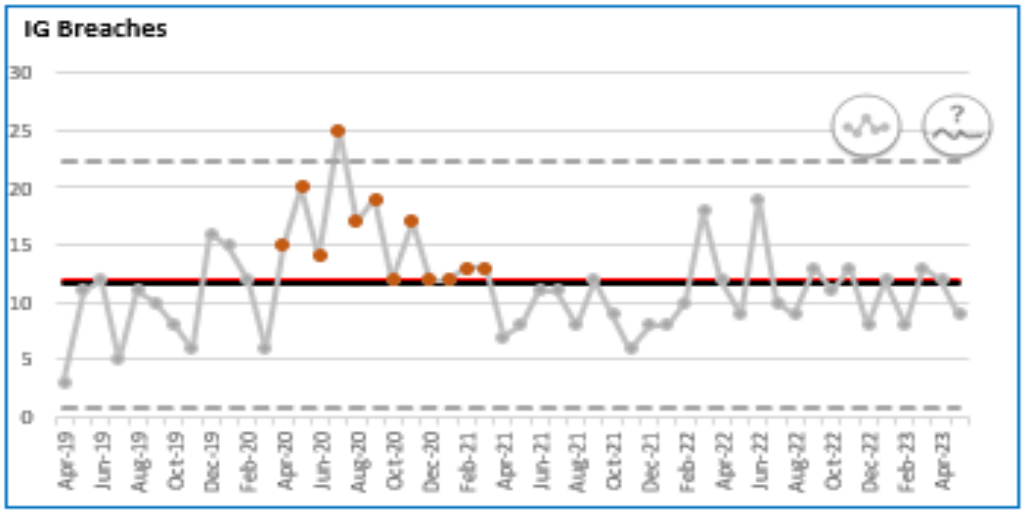
Information Governance (IG)

9 personal data breaches were reported during May. An improvement plan continues to be implemented to reduce the higher numbers of incidents, which includes training, communications and some data quality activity.

5 breaches involved information being disclosed in error. They were largely due to correspondence being sent to the wrong recipient or address, emails being sent with the wrong attachment and letters being sent with the wrong content.

Two amber incidents were reported. One involved a sensitive report intended for a patient's carer being sent to the wrong address, where it was opened, resealed and redirected to the carer. The duty of candour process has been followed and a manager's investigation completed. The other occured when a bundle of post items was found unsecured in a publicly accessible part of the Trust. Estates & Facilities have changed their process in response to the incident to prevent recurrence.

The Trust does not currently have any open cases with the Information Commissioner's Office.



This SPC chart shows that as at May 2023 we remain in a period of common cause variation.

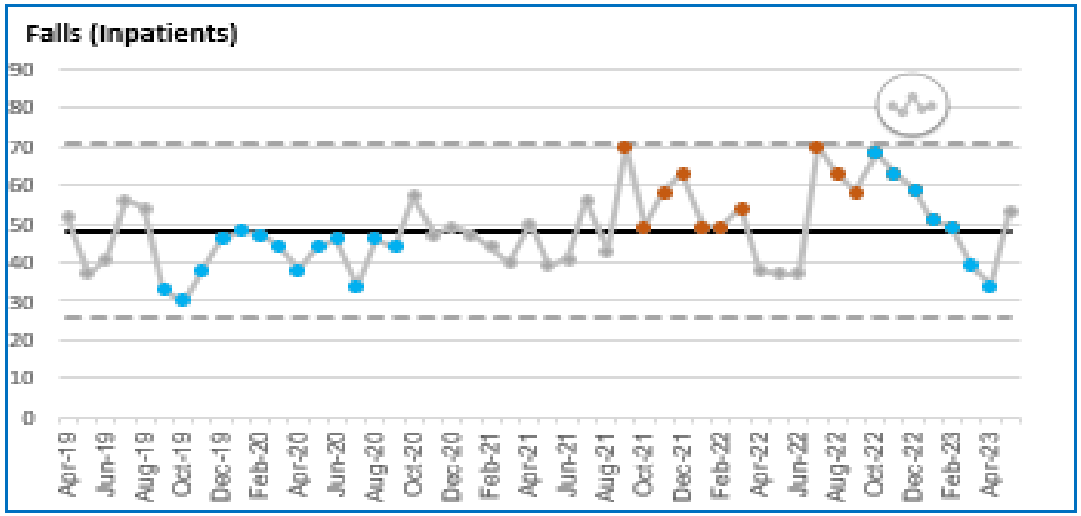
Commissioning for Quality and Innovation (CQUIN)

CQUIN schemes are now in place for 2023/24 contracts. These mainly relate to the Trust's contracts with our Place-based commissioners in each integrated care system (ICS). The overall financial value of CQUIN is 1.25% of total contract value.

There are some new indicators in this years scheme and the Trust's CQUIN leads group are monitoring progress against the thresholds as we come towards the end of quarter 1. Further update around associated risks can be expected next month.

Falls (Inpatient)

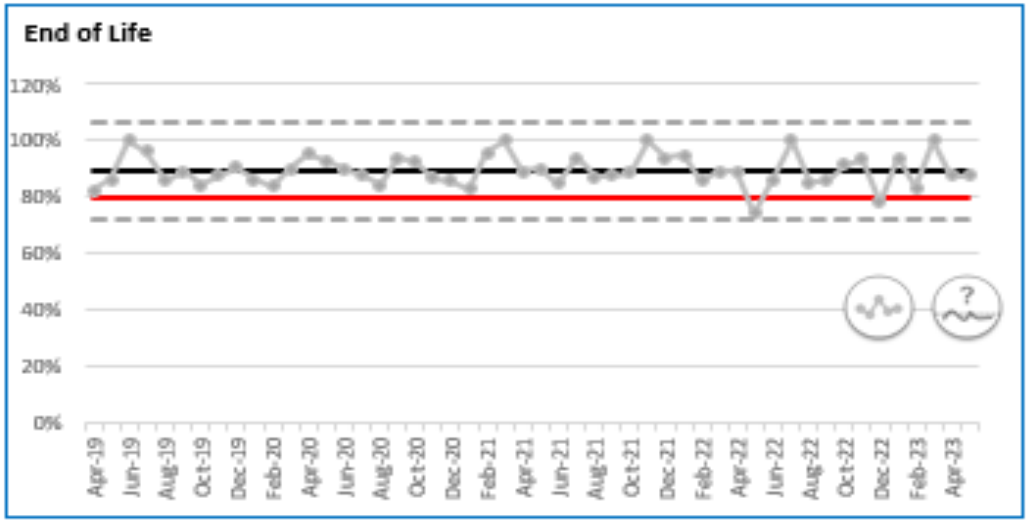
The total number of falls was 53 in May. A new falls coordinator commenced in February 2023, part of the role is to advise, review and support the clinical teams/ staff through education, policy, awareness raising, environmental reviews that may contribute to falls. This will increase staff confidence and will enhance the falls reduction work.



The SPC chart above shows that in May 2023, due to the slight increase in the number of falls, we have entered a period of common cause variation. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation.

End of Life

The total percentage of people dying in a place of their choosing was 89.4% in May.



The chart above shows that in May 2023 the performance against the metric remains in common cause variation and therefore within an acceptable range. Due to fluctuation in the performance whether we will meet the target cannot be determined.

Patient Experience

Friends and family test shows

- 97% would recommend community services
- 85% would recommend mental health services

Mental Health Friends and Family Test Results

	Target	Mar-23	Apr-23	May-23
Community Services	85%	85%	83%	88%
Acute	85%	86%	93%	80%
Secure & Forensics	60%	71%	100%	72%
Other*	85%	93%	82%	82%
Total	**84%*** **	**83%**	**82%**	85%

Specialist Services Friends and Family Test Results

	Target	Mar-23	Apr-23	May-23
ADHD	85%	50%	44%	50%
CAMHS	75%	83%	76%	85%
Learning Disability	85%	100%	100%	100%

Community Services Friends and Family Test Results

	Target	Mar-23	Apr-23	May-23
Children & Families	95%	98%	93%	96%
Inpatient	95%	100%	100%	100%
Nursing	95%	91%	100%	100%
Other	95%	91%	100%	100%
Rehabilitation & Therapy	95%	98%	94%	97%
Specialist**	95%	94%	95%	93%
Total	**95%**	**95%**	**94%**	97%

*includes Insight team, perinatal, friends and family team

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

*** weighted for 2023/24

Patient Experience

The satisfaction target figures for each service have been agreed and set by the Trust and these vary depending on the service type. There is a new weighted target figure for mental health services which is 84%. Community services target remains at 95%, with ADHD, CAMHS and learning disability services being 85%, 75% and 85% respectively.

Overall satisfaction across the Trust has increased. The number of responses had declined across the Trust, this is due to the recent change in the text message. This is an expected decline, and work is ongoing to raise awareness of the new text message, supporting services using other feedback methods and identifying services who have not received Friends and Family Test feedback.

Where there are services that have not met the expected threshold of performance, there has been analysis undertaken of the feedback received and there are no themes or trends in the feedback which would indicate concerns. Numbers are too small to determine any learning. An accumulation of feedback over a longer period of time will be reviewed to ascertain themes and trends to ensure feedback is used effectively to inform change.

	Top three positive themes	Top three negative themes
Trustwide	1. Staff	1. Staff
	2. Communication	2. Access and waiting times
	3. Clinical Treatment	3. Patient Care
Community	1. Staff	1. Staff
	2. Clinical Treatment	2. Communication
	3. Patient Care	3. Clinical Treatment
Mental Health	1. Staff	1. Staff
	2. Communication	2. Access and Waiting Times
	3. Access and Waiting Times	3. Patient Care

The themes from Friends and Family Test feedback are in the table to the left.

Themes can be both positive and negative in nature.

Safeguarding

Safeguarding Adults:
In May 2023, there were 47 Datix incidents categorised as Safeguarding Adults. No incidents were graded red, six were graded amber, 13 were graded yellow and 28 were graded green.
The incidents were categorised as follows: there were 12 emotional abuse, seven financial abuse, six sexual abuse, five physical abuse, five self-neglect, four domestic abuse, four neglect, one hate crime, one, radicalisation, one organisational and one failure in the safeguarding process.
All incidents were managed appropriately and safeguarding measures were put in place.
In addition to the safeguarding adults incidents, there were also 14 sexual safety Datix incidents where service users were the affected person. All of these incidents were graded as green or yellow.

Safeguarding Children:
In May there were 13 Datix incidents completed in relation to child safeguarding concerns. Four were classed as amber, medium risk and nine were classed as green, low risk. Three of the amber concerns identified were related to neglect, with the other case being classified as emotional abuse. All of the incidents were responded to appropriately and staff clearly demonstrated professional curiosity, considered the 'Think Family' approach, sought advice and shared information appropriately.

There has been an increase in compliance across most services. Childrens and adolescent mental health services staff are 100% compliant in both level 1 and level 2 safeguarding children training.

Infection Prevention Control (IPC)

The National Infection Prevention and Control (IPC) board assurance framework (BAF) is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The framework is for use by all those involved in care provision in England and can be used to provide assurance in NHS settings or settings where NHS services are delivered. The Trust is complaint with 9 criteria and partially compliant with 1 criteria, for which there are mitigation actions in place. The IPC BAF will be reviewed quarterly.

There have been zero cases of E.coli bacteraemia, C difficile, MRSA bacteraemia and MSSA bacteraemia.

Mandatory training figures are healthy: Hand Hygiene-Trust wide Total – 91%,
Infection Prevention and Control- Trustwide Total – 90%

A 12-month extension request for policies due for review in 2023, this is to accommodate implementation of the National IPC Manual, which has a target date of March 2024. The current policies and procedures remain compliant, and there are no identified risks to note.

Change in Covid-19 Guidance:
Mask Wearing
From Monday 22 May 2023, staff were informed that they no longer need to routinely wear face masks. This applies to clinical and non-clinical areas.
There will be instances where masks will still be required. These include:

- When caring for patients with suspected or confirmed Covid-19.
- Covid-19 outbreaks.
- When dealing with clinically vulnerable service users - the decision for this will be based on the outcome of an individual risk assessment for a patient.
- Staff members returning to work who have been symptomatic with Covid-19 symptoms and/or been positive for Covid-19. Depending on the outcome of a risk assessment they may be required to temporarily wear a face mask.
- Staff are welcome to continue wearing a face mask if they wish. Our Trust will continue to provide face masks in main reception areas.

Covid-19 Testing
There were also changes to patient and staff testing requirement. This was in line with NHS guidance and local risk factor.
The decision was agreed by our Trust's operational management group (OMG) on the basis that the prevalence of Covid-19 has significantly improved.

Complaints

• Acknowledgement and receipt of the complaint within three working days – 79% for formal complaints.
• Number of responses provided within six months of the date a complaint received – 3 (38%)
• Number of complaints waiting to be allocated to a customer service officer – 30
• Number of cases who breach the six months target who have not had a conversation to agree a new timeframe for completion 0% – all complainants are updated and have either received the monthly delay/update letter apologising for the delay (for those waiting to be allocated to a case handler), or for those allocated a case handler are updated regarding the progression of their complaint throughout the complaint process/journey.
• Longest waiting complainant to be allocated to a customer service officer – 9 weeks average.
• There were 19 new formal complaints in May 2023
• Of these 1 has a timescales start date, 13 are awaiting consent and 5 are awaiting allocation.
• 11% of new formal complaints (n=2) have staff attitude as a primary subject.
• 66 compliments were received.
• Customer services closed 8 formal complaints in May 2023.
• Number of concerns (informal issues) raised and closed in May 2023 – 30
• Number of enquiries responded to in March 2023 - 176
• Number of complaints referred to the Parliamentary Health Service Ombudsman this financial year to date - 0

Reducing Restrictive Physical Intervention (RRPI)

There were 186 reported incidents of RRPI used in May 2023 this is within acceptable range.

86.6% of prone restraints in May 2023 lasted under three minutes.

In May 2023 prone restraint (those remaining in prone position and not rolled immediately) was reported 15 times of 283 (5.3%) of total restraint positions, this is a reduction of 5 from last month that stood at 20 of 291.

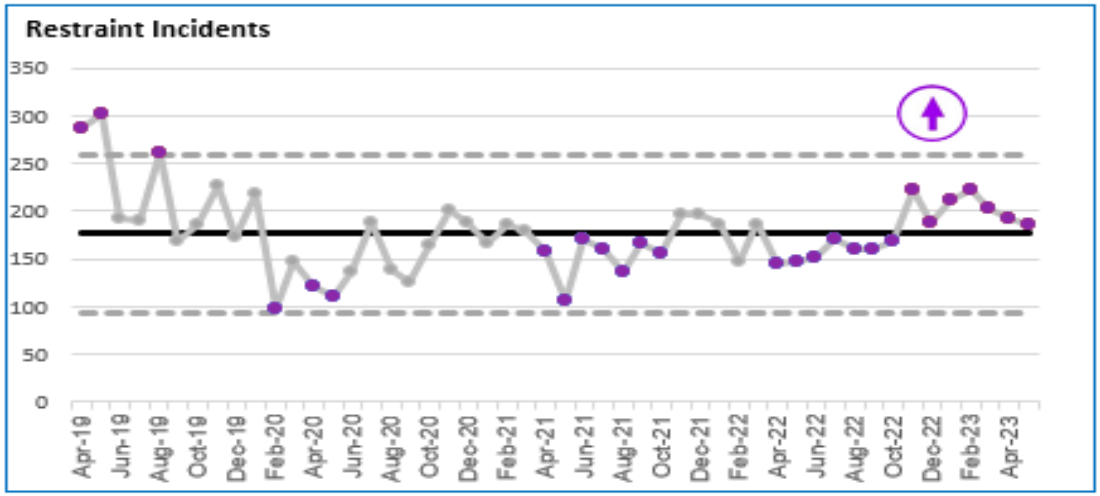
The prone restraint incident with a duration between 13-14 minutes was due to the service user requiring restraint in level 3 holds in a prone position to prevent further risk to self. The service user placed themselves on their front and was attempting to swallow a foreign object to choke. The cogent reason to remain in prone was to minimise the risk of choking. Medical and nursing colleagues were present throughout. The incident was discussed in a professionals meeting which was attended by RRPI specialist advisors and appropriate referral to speech and language therapy (SALT) services had been actioned. All actions taken were appropriate and support was given to both the service user and staff involved in the incident.

Restraint Position Used	Number of restraint Positions Used	Percentage of the Type of Restraint Position Used of Total
Standing	107	37.8%
Seated	56	19.7%
Supine	38	13.4%
Safety Pod	32	11.3%
Prone	15	5.3%
Restricted escort	11	3.5%
Prone then rolled	10	3.8%
Side	8	2.8%
Kneeling	6	2.1%
Total	283	

Team Using Prone Restraint	Total
Beamshaw Ward - Barnsley	2
Horizon Centre Assessment and	2
Newhaven Forensic Learning Disabilities	2
Sandal Ward (Bretton Centre)	2
Stanley Ward, Wakefield	2
Walton PICU	2
Bronte Ward, Newton Lodge, Forensic	1
Elmdale Ward	1
Melton PICU, Barnsley	1
Total	15

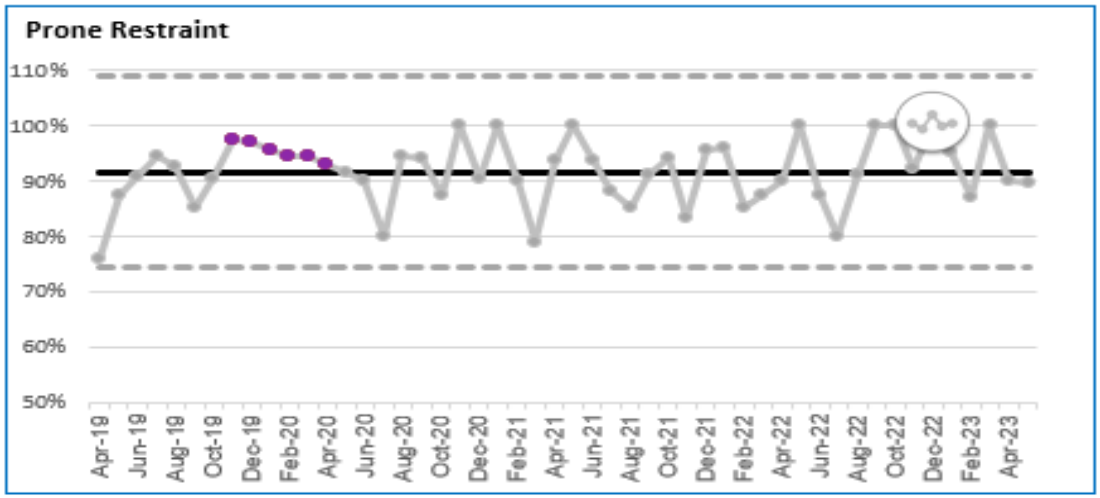
Duration of Prone Restraint Position	Total
0 - 1 minute	8
1 - 2 minutes	4
4 - 5 minutes	1
2 - 3 minutes	1
13 - 14 minutes	1
Total	15

Reducing Restrictive Physical Intervention (RRPI)



This SPC chart shows that in May 2023 we have entered a period of special cause variation (purple markers).

It should be noted that an increase in restraint incidents does not always indicate a deterioration in performance.



This SPC chart shows that due to the continued variation in prone restraint incidents in May 2023 means that we remain in a period of common cause variation.

People - Performance Wall

Trust Performance Wall

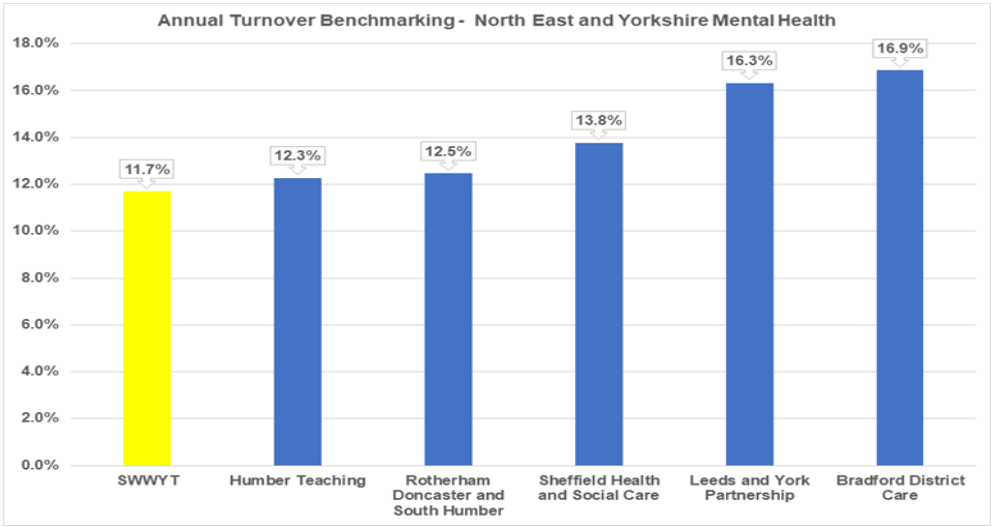
	Objective	CQC Domain	Threshold	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Establishment	Improving Resources	Well Led	-	4,960.2	4,933.5	5,011.2	5,039.4	5,145.9	5,156.5	5,197.9	5,237.9	5,246.6	5,267.2	5,157.4	5,174.0
Employed Staff (ESR last day in the month)			-	4,136.2	4,134.6	4,130.2	4,169.2	4,174.6	4,169.9	4,173.4	4,186.0	4,229.7	4,241.0	4,257.0	4,266.2
Vacancies			-	756.2	723.1	795.3	816.5	881.8	895.2	942.0	936.8	944.8	926.9	818.9	822.0
Vacancy rate			<10%	15.2%	14.7%	15.9%	16.2%	17.1%	17.4%	18.1%	17.9%	18.0%	17.6%	15.9%	15.9%
Turnover external (12 month rolling)			>12% - <13%	15.4%	15.5%	15.2%	14.8%	14.4%	14.4%	14.2%	14.3%	13.7%	13.5%	13.0%	12.2%
Starters			-	56.5	46.4	58.1	69.5	56.9	50.5	26.6	65.4	70.2	58.1	42.9	54.1
Leavers			-	37.0	56.9	56.3	51.6	48.2	40.6	27.5	60.1	38.5	43.1	39.6	35.2
Sickness absence - Rolling 12 month			<=4.8%	4.6%	4.9%	4.8%	4.9%	5.0%	5.1%	5.3%	5.3%	5.2%	5.3%	5.3%	5.3%
Sickness absence - Month			<=4.8%	4.8%	5.5%	4.7%	4.8%	5.7%	5.9%	6.3%	5.3%	5.3%	5.1%	5.0%	4.6%
Employees with long term sickness over 12 months			-	-	-	0	2	2	2	2	4	2	2	1	0
Appraisals - rolling 12 months			May Trajectory>=78% Overall threshold: >=90%	59.7%	55.8%	61.3%	57.3%	56.0%	60.7%	62.9%	69.8%	71.5%	71.8%	74.4%	74.9%
Employee Relations - Suspensions (over 90 days)			-	1	1	2	2	2	2	3	3	1	1	0	0
Mandatory Training - TOTAL	Improving Care		>=80%	86.9%	87.2%	90.7%	89.8%	89.5%	89.5%	89.2%	89.4%	90.1%	90.2%	90.5%	90.9%
Mandatory Training - Reducing Restrictive Practice Interventions				73.6%	73.8%	73.8%	72.0%	70.3%	68.4%	66.4%	71.9%	74.5%	74.6%	73.8%	73.8%
Mandatory Training - Cardiopulmonary Resuscitation				74.2%	74.6%	75.7%	75.0%	72.5%	72.1%	72.0%	73.0%	75.1%	75.0%	75.5%	79.2%
Mandatory Training - Clinical Risk				96.2%	96.2%	96.4%	96.6%	96.3%	96.2%	96.0%	95.7%	94.9%	95.9%	95.6%	95.4%
Mandatory Training - Display Screen Equipment				93.9%	94.3%	94.9%	95.5%	95.1%	95.4%	95.8%	96.0%	96.3%	96.4%	96.5%	96.8%
Mandatory Training - Equality & Diversity				93.9%	94.1%	93.9%	94.3%	93.8%	94.2%	94.1%	94.6%	95.1%	95.8%	96.0%	96.2%
Mandatory Training - Fire Safety				87.1%	87.4%	87.1%	86.4%	87.3%	87.7%	87.5%	88.3%	88.4%	89.4%	90.2%	91.2%
Mandatory Training - Food Safety				79.4%	79.3%	79.8%	79.2%	78.6%	79.9%	79.5%	79.6%	79.8%	79.4%	78.0%	83.4%
Mandatory Training - Freedom To Speak Up (FTSU)				85.5%	86.8%	88.2%	89.8%	90.5%	91.3%	91.7%	92.0%	92.4%	92.5%	93.2%	93.7%
Mandatory Training - Infection Control & Hand Hygiene				87.0%	87.3%	87.7%	88.2%	88.4%	88.6%	88.4%	88.4%	88.6%	90.2%	91.5%	92.4%
Mandatory Training - Information Governance (Data Security)			>=95%	92.9%	92.9%	92.5%	92.2%	91.2%	89.8%	87.6%	87.3%	84.8%	86.5%	90.6%	95.9%
Mandatory Training - Moving & Handling			>=80%	95.6%	95.7%	95.3%	95.2%	95.3%	95.8%	95.6%	93.0%	93.4%	95.5%	95.5%	94.9%
Mandatory Training - Nat Early Warning Score 2 (New S2)				82.6%	84.3%	85.6%	86.3%	87.4%	88.1%	89.6%	91.1%	92.0%	92.4%	92.5%	92.1%
Mandatory Training - Mental Capacity Act/Dols				93.4%	93.3%	93.5%	93.8%	93.5%	93.4%	93.3%	95.6%	95.3%	94.0%	91.6%	93.6%
Mandatory Training - Mental Health Act				89.4%	89.5%	90.4%	90.9%	90.7%	91.0%	91.2%	90.4%	91.6%	92.2%	91.6%	91.3%
Mandatory Training - Prevent				94.4%	94.6%	95.1%	95.3%	95.0%	94.6%	94.4%	94.7%	95.2%	95.6%	95.4%	95.5%
Mandatory Training - Safeguarding Adults				88.8%	89.1%	89.7%	89.5%	89.4%	89.5%	89.0%	89.1%	89.9%	90.0%	90.0%	89.7%
Mandatory Training - Safeguarding Children				89.9%	89.9%	89.7%	90.2%	88.7%	88.9%	88.6%	88.8%	89.3%	89.8%	90.0%	90.7%

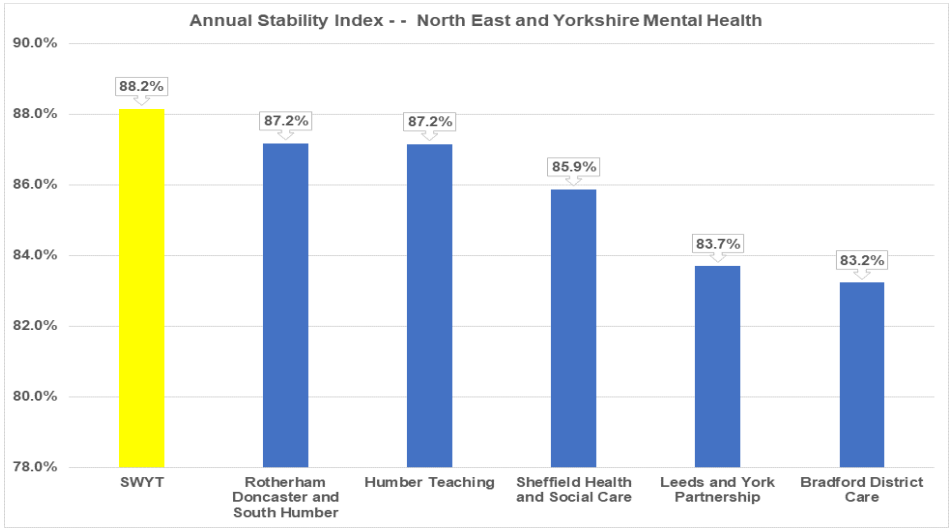
Notes:

- Employed Staff (Electronic Staff Record - (ESR) last day in the month) - Employed staff in post are staff on temporary or permanent contracts within ESR. This does not include staff on secondments or other recharges such as local authority staff and junior doctors.
- The figures reported here differ to the figures included in the finance appendix 'WTE (whole time equivalent) worked' as this reflects contracted employment and therefore does not include overtime, additional hours worked or agency.
- Starters/Leavers - variation in alignment to establishment exists due to a number of factors such as, data taken as a snapshot so will not reflect any changes made on the system after the extraction date as well as changes in contractual hours that cannot be retrospectively applied.
- Turnover - Quarterly reports from feedback of leavers are being appraised in the Trust's operational management group with reporting and actions from quarterly reports to care groups.
- Sickness absence - from April 23 - the reported figure is rolling 12 month. For earlier months this was year to date.

Stability of the Workforce

- Substantive staff in post has increased by 9.2 whole time equivalents (WTE) in May.
- Staff in post workforce growrth since April stands at 0.59% against a target of 3% for the year (on target)
- Rolling and year to date turnover is 12.2%. When benchmarked against the latest workforce statistics published by NHS England on digital.nhs.uk (Jan 2023) the Trust has one of the lowest rates in our region and the highest for the staff stability index (staff in post over 1 year).





Keep Fit & Well

Absence

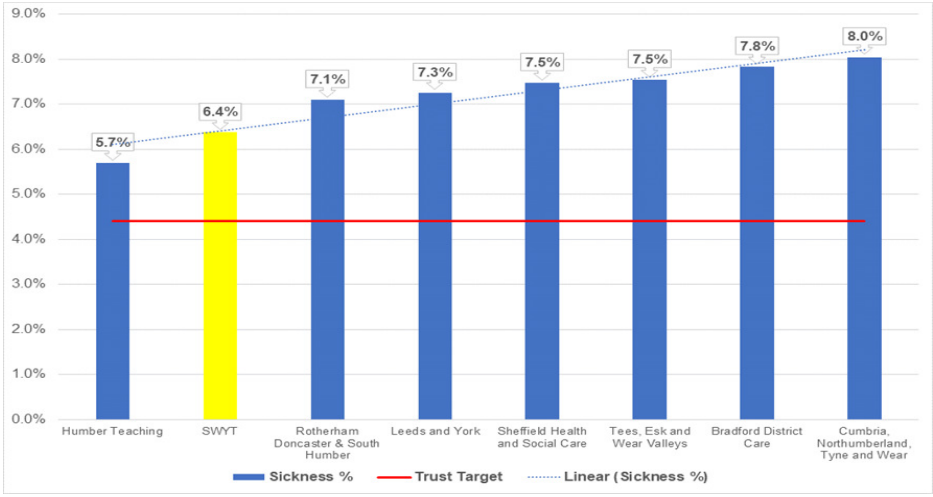
• 12 month rolling absence rate remains at 5.3%.

• Forensics absence saw an increase in month to 6.9% making the year to date position 6.6%. Focused support with managers on long term sickness, has been undertaken in the care group which has previously had a positive effect on the absence rate.

• Estates and Facilities absence increased during May to 6.5% (6.0% year to date) - focus remains on sickness meetings, monthly reports to individual managers and increased personal development support to address this increase.

• Stress related absences still accounts for the largest reason increasing to 37%.

• When compared to the latest figures published by NHS England via digital.nhs.uk (Dec 2022) we have the second lowest percentage in the region.



Supportive Teams

Appraisals

• For the month of May, the percentage rate increased by 0.5% to 74.9%.

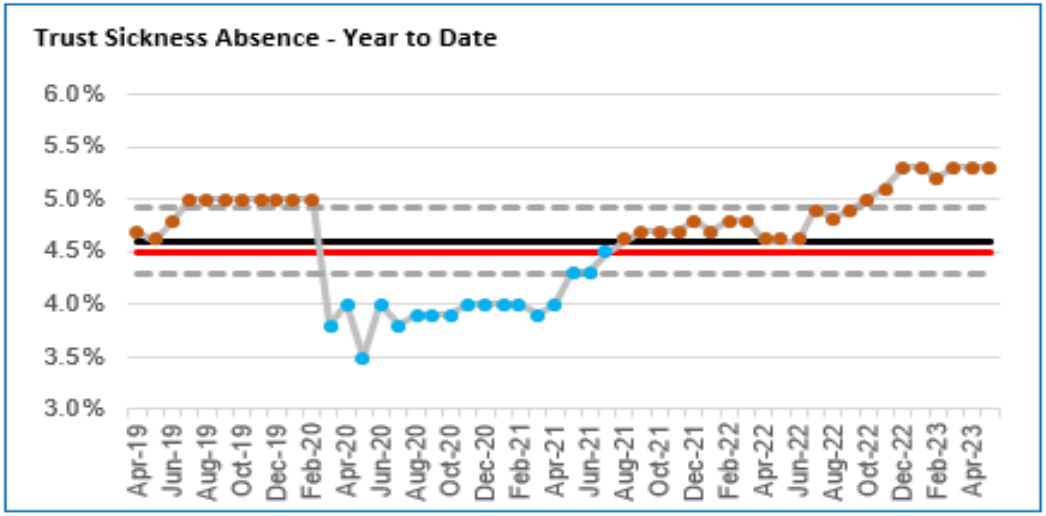
Mandatory Training

• Overall mandatory training reports 90.9% which remains above Trust target. Compliance by care group is reported monthly to the executive management team with hot spot reports reviewed by operational management group.

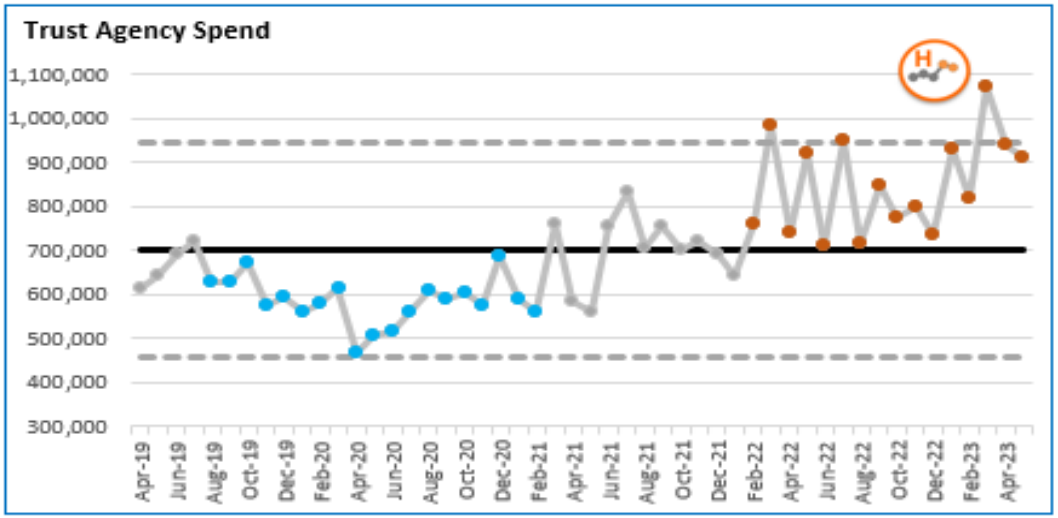
• Two subjects out of 17 reported are below the Trust's 80% target - these are resuscitation and reducing restrictive practice interventions. Actions being taken to address these areas include use of third-party providers to increase capacity to deliver, the introduction of an e-learning suite to increase accessibility and reduce the need for face-to-face training and a project plan being delivered in close partnership with the Nursing, Quality & Professions directorate.

• The Trust has exceeded its 95% target for Information Governance training for substantive staff. The Trust has also achieved the standard for food safety this has been achieved by improving the learning offer.

Analysis



The SPC chart shows that as at May 2023 we remain in a period of special cause concerning variation (orange markers). From July 2022 this also includes absence due to Covid-19.



The SPC chart shows that in May 2023 we remain in a period of special cause concerning variation (orange markers). This is being monitored in workforce/finance. Actions being taken include:

- The re-introduction of agency scrutiny group who are leading on agency spend reduction plan to meet 23-24 agency cap (£7.8m) – Targeting reduction of high cost individual long term areas of agency spend with bespoke plans to reduce (medical roles). Monthly agency performance group established to commence in June for all care groups.
- Alternative marketing campaigns to engage wider markets.
- Significant increase in assessment centre recruitment events – 8 since April (usually 1 per month) over 370 potential candidates into bank and substantive healthcare support worker and nurse posts. This will have a positive impact upon agency provision in future months.
- We are reviewing our three main staff group agency contracts to maximise financial efficiency and we have commenced an external review (Liaison workforce) of our bank, agency and e-rostering efficiency (report due July).

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) were established with the general statutory function of arranging health services for their population and will be responsible for performance and oversight of NHS services within their integrated care system (ICS). NHS England will work with ICBs as they take on their new responsibilities, the ambition being to empower local health and care leaders to build strong and effective systems for their communities. 2022/23 was a year of transition as Integrated Care Boards ICBs were formally established and new collaborative arrangements are developed at system level. ICBs are now lead for the oversight of NHS providers, assessing delivery against these domains, working through provider collaboratives where appropriate. No further update has been provided for 2023/24 to date. The Trust will continue to monitor for any changes.
• This table only includes operational metrics, there are a number of other workforce, quality and finance metrics that are reported in the relevant section of the IPR.
• 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 reflect metrics included in the contracts for 22/23 work continues across provider and commissioner to conform contracts for 23/24 and once this process has been completed, metrics may be amended to ensure they reflect current year. 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 - NHS England systems oversight framework, NHS long term plan, NHS standard contract

KPI	Objective	CQC Domain	Owner	Source	Target	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	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	Improving Care	Responsive	CH	SOF/LTP	Q1 - 455	1245	874	1359	1504	439	482	511	511	457	574		
Community health services two hour urgent response standard	Improving Health	Responsive	CH	SOF/LTP	70%	Reporting to commence January 2023					87.5%	85.0%	83.8%	87.3%	86.6%		
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	LTP	60%	85.5%	90.1%	91.5%	89.5%	84.8%	92.6%	94.4%	81.3%	96.7%	94.4%		
NHS Talking Therapies (formerly IAPT) - proportion of people completing treatment who move to recovery	Improving Health	Responsive	CH	LTP/SC	50%	53.4%	53.9%	47.1%	54.8%	52.6%	57.1%	53.9%	53.6%	52.7%	*53.6%*		
NHS Talking Therapies (formerly IAPT) - Number of people who first receive recognised advice and signposting or start a course of psychological therapy within the reporting period - Barnsley	Improving Health	Responsive	CH	LTP	Per Quarter - 1563	1379	1202	1224	1441	377	500	461	480	456	500		
NHS Talking Therapies (formerly IAPT) - Number of people who first receive recognised advice and signposting or start a course of psychological therapy within the reporting period - Kirklees	Improving Health	Responsive	CH	LTP	No Target Set	2437	2383	2457	2656	698	978	792	886	724	929		
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	LTP	92%	98.5%	88.5%	93.5%	97.5%	93.5%	95.1%	95.7%	97.5%	97.9%	98.9%		
Number of people accessing Individual Placement Support (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				18 Calderdale 33 Kirklees	40 Calderdale 37 Kirklees 31 Wakefield			Due July 2023			
Number of individuals accessing specialist community perinatal and maternity mental health services	Improving Care	Responsive	CH	LTP	Q1 - 316	480	285	225	222	84	81	57	84	342	130		
Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)	Improving Care	Responsive	CH	SC	99%	91.7%	95.9%	86.2%	79.8%	86.2%	88.0%	91.6%	79.8%	60.7%	53.3%		
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	Improving Health	Responsive	CH	SC	80%	84.6%	89.0%	88.1%	87.8%	88.9%	87.9%	89.6%	86.6%	90.3%	88.2%		
NHS Talking Therapies (formerly IAPT) - Treatment within 6 weeks of referral	Improving Health	Responsive	CH	SC	75%	94.7%	97.5%	98.4%	97.8%	98.5%	97.7%	97.6%	98.1%	97.7%	*98.6%*		
NHS Talking Therapies (formerly IAPT) - Treatment within 18 weeks of referral	Improving Health	Responsive	CH	SC	95%	100.0%	100.0%	99.8%	99.9%	99.5%	99.8%	100.0%	99.8%	*99.8%*	*99.8%*		
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%	95.5%	78.6%	95.2%	84.6%	100.0%	87.5%	80.0%	87.5%	33.3%	80.0%		
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%	90.1%	77.7%	80.2%	95.2%	88.2%	88.6%	100.0%	100.0%	75.0%	89.5%		
Data Quality Maturity Index	Improving Health	Responsive	CH	SC	95%	98.5%	99.5%	99.4%	98.6%	99.1%	99.4%	98.2%	98.2%	98.0%	*97.6%*		

KPI	Objective	CQC Domain	Owner	Source	Target	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	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	0	16	44	23	52	0	8	31	44	15	11		
Total number of children and younger people under 18 in adult inpatient wards	Improving Care	Safe	CH	O	0	1	2	4	3	0	2	2	2	3	1		
Number of detentions under the Mental Health Act (MHA)	Improving Care	Safe	CH	O	Trend Monitor	183	179	161	184	161	184			Due July 2023			
Proportion of people detained under the MHA who are BAME	Improving Care	Safe	CH	O	Trend Monitor	18.0%	21.2%	22.4%	19.6%	22.4%	19.6%						
% Admissions gate kept by crisis resolution teams	Improving Care	Responsive	CH	O	95%	96.2%	99.3%	99.6%	98.7%	100.0%	98.9%	99.0%	98.2%	100.0%	99.0%		
% Service users on care programme approach (CPA) having formal review within 12 months	Health & Wellbeing	Safe	SR/KT	O	95%	96.1%	94.3%	96.9%	96.2%	96.9%	95.8%	95.4%	97.6%	97.1%	97.4%		
% clients in settled accommodation	Improving Health	Responsive	CH	O	60%	88.3%	87.2%	85.7%	84.5%	85.2%	84.4%	84.4%	84.6%	84.4%	*84.1%*	⚠	
% clients in employment	Improving Health	Responsive	CH	O	10%	11.1%	11.8%	11.7%	11.4%	11.4%	11.6%	11.4%	11.2%	11.1%	*11.5%*	⚠	
Completion of improving access to psychological therapies (NHS Talking Therapies (formerly 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%	98.1%	98.1%	98.7%	98.5%	98.1%	99.1%	98.9%	98.9%	*95.4%*		
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%	100.0%	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%	99.1%	99.3%	99.3%	99.4%	99.3%	99.4%	99.4%	99.4%	99.5%	*99.4%*		
The number of completed non-admitted RTT pathways in the reporting period	Improving Care	Responsive	CH	LTP	18000 (1500 per month)	Reporting from 23/24								1523	1719		
The number of incomplete Referral to Treatment (RTT) pathways	Improving Care	Responsive	CH	LTP	27900 (split 2500 p/m A-J; 2400 J-S; 2300 O-D; 2200 J; 2100 F; 2000 M	Reporting from 23/24								1933	1835		
Count of 2-hour urgent community response first care contacts delivered within reporting quarter	Improving Health	Responsive	CH	SOF/LTP	Q1 2800, Q2 2500, Q3 3700, Q4 3100	Reporting from 23/24								Due July 2023			
Virtual ward occupancy	Improving Care	Responsive	CH	LTP	80%	Reporting from 23/24								82.9%	44.3%		
Community services waiting list (report split by 0-17; 18+)	Improving Health	Responsive	CH	LTP	Q1 5652, Q2 5430, Q3 5469, Q4 5198	Reporting from 23/24								Due July 2023			
Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses	Improving Health	Responsive	CH	LTP	Plan per Place/ Trust level	Reporting from 23/24								Due July 2023			
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Improving Health	Responsive	CH	LTP	Plan per Place/ Trust level	Reporting from 23/24								Due July 2023			

Glossary			
SOF	NHSE System Oversight Framework	O	Other National Metric
SC	NHS Standard Contract	SU	Service User
LTP	NHS Long Term Plan	CPA	Care Programme Approach

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 from point of referral to treatment remains above the target threshold at 98.9%

• 72 hour follow up remains above the threshold at 88.2%. We remain in a period of special cause improving variation due to continued (more than 6 months) performance above the mean.

• The percentage of service users seen for a diagnostic appointment within 6 weeks in the paediatric audiology service has decreased to 53.3% in May. This remains below threshold and has now entered a period of special cause concerning variation (please see SPC chart on the next page). This is a small service and there have been a number of staffing issues that have impacted clinic availability. Due to the continued increase in referrals from January 2023, it is unlikely we will have any capacity to run additional clinics over spring and summer and therefore we do not anticipate we will hit the 99% target until October 2023. The service are also reporting a number of appointments being cancelled by their parents/carers, or children not being brought to their appointments. The Was Not Brought (WNB) figures are high and the service are taking steps to try to address this. This includes sending an additional appointment text message reminder closer to the appointment date, and also changing the wording within appointment letters that are sent out to parents/carers. When an appointment is cancelled by a parent/carer or a child is not brought, the service often have to book another appointment that breaches the 6 week wait.

• 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 May 4 out of 5 urgent cases were seen within 1 week, this has taken the performance below threshold at 80%.

• During May 2023, there was one service user aged under 18 years placed in an adult inpatient ward with a total length of stay in the month of 11 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.

• The percentage of clients in employment and percentage of clients in settled accommodation - there are some data completeness issues that may be impacting on the reported position of these indicators however both are above their respective thresholds.

• Data quality maturity index - the Trust has been consistently achieving this target. This metric is in common cause variation and we are expected to meet the threshold.

• NHS Talking Therapies - proportion of people completing treatment who move to recovery remains above the 50% target at 53.6% for May. This metric remains in common cause variation however fluctuations in the performance mean that achievement of the threshold cannot be estimated.

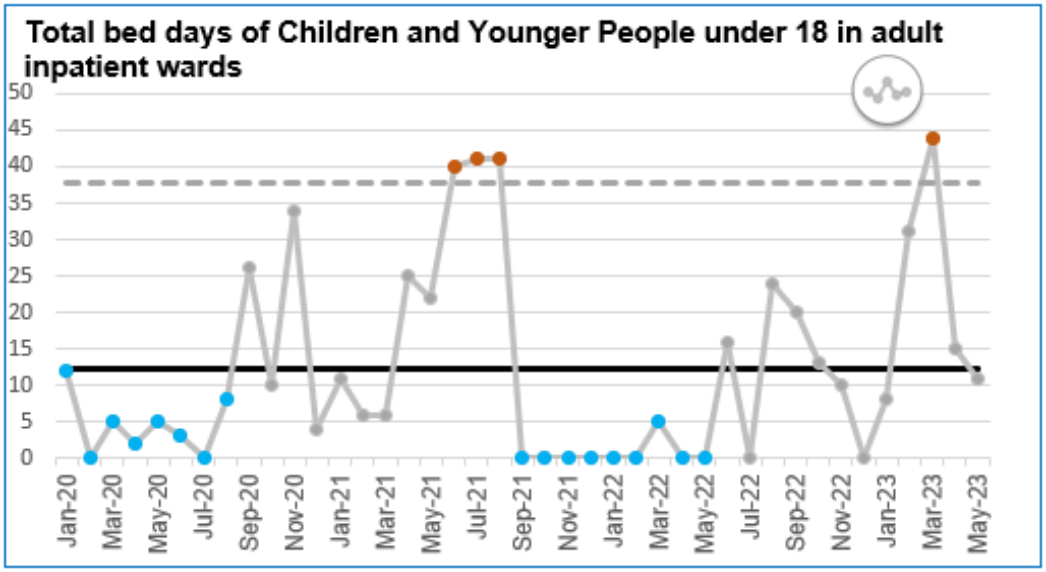
• Percentage of service users on the care programme approach (CPA) having formal review within 12 months remains above threshold during the month of May. This metric has entered a period of special cause improving variation due to continued (more than 6 months) performance above the mean. Fluctuations in the performance mean that achievement of the threshold cannot be estimated.

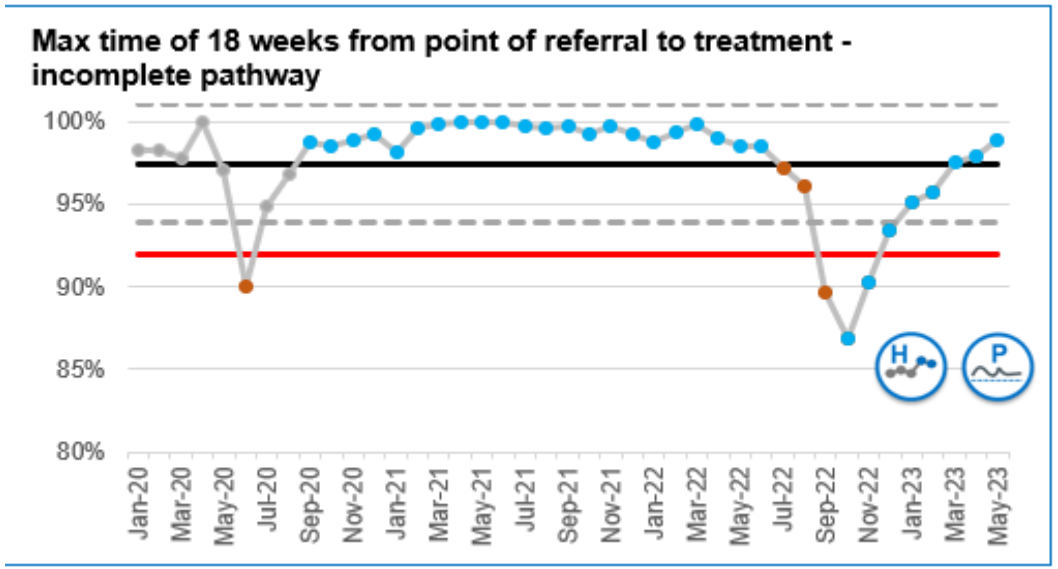
Data quality:
An additional column has been added to the tables on the previous pages to identify where there are any known data quality issues that may be impacting on the reported performance. This is identified by a warning triangle and where this occurs, further detail is included.

For the month of May the following data quality issue has been identified in the reporting:

- The reporting for employment and accommodation shows 14.7% of records have an unknown or missing employment and/or accommodation status. This has been flagged as a data quality issue and work is taking place within care groups to review this data and improve completeness.

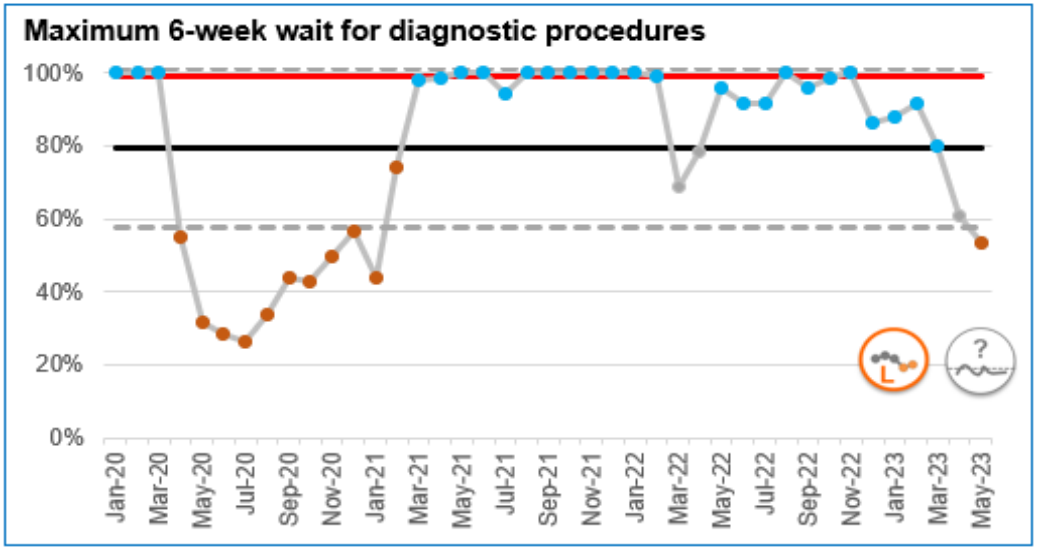
Analysis

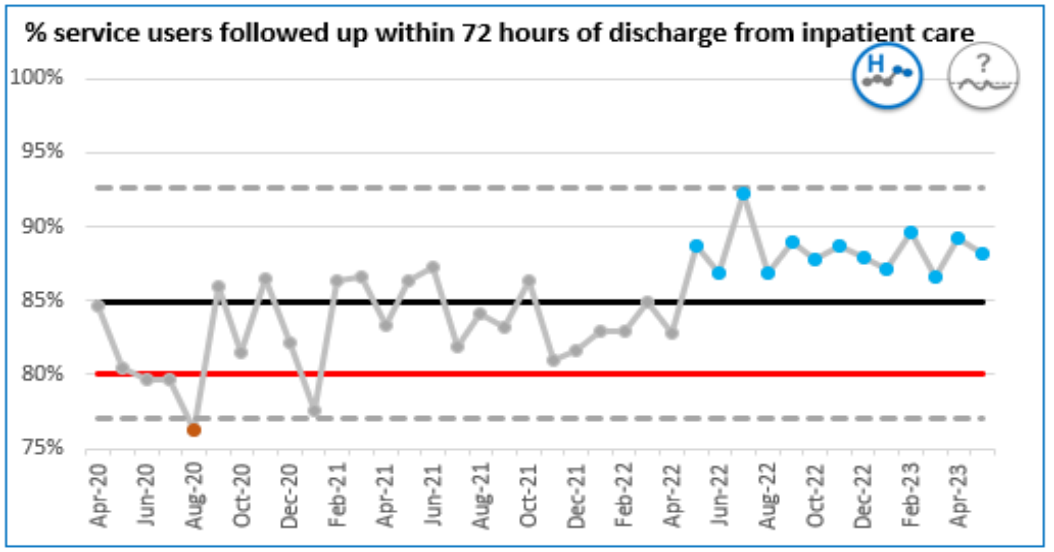




The statistical process control charts (SPC) above show that in May 2023 we remain in a period of common cause variation regarding the number of beds days for children and young people in adult wards. After consecutive periods of improvement against the referral to treatment metric we remain in a period of special cause improving variation in May 2023 and we are expected to meet the target.

Analysis





The SPC charts above show that for May 2023 for clients waiting for a diagnostic procedure we have entered a period of special cause concerning variation and due to the fluctuating nature of this metric, whether we will meet or fail the target cannot be estimated. We are currently in a period of improving variation for clients discharged from inpatient care being followed up within appropriate timescales but again due to the fluctuating nature of this metric, whether we will meet or fail the target cannot be estimated.

The following section of the report has been created to give assurance regarding the quality and safety of the care we provide. A number of key metrics have been identified for each care group and performance for the reporting month is stated along with variation/assurance for each metric where applicable. Figures in bold and italics are provisional and will be refreshed next month.

Current average OPEL level

2.78

Key

- OPEL Level 1
- OPEL Level 2
- OPEL Level 3
- OPEL Level 4

Mental Health Community (Including Barnsley Mental Health Services)

Metrics	Threshold	Apr-23	May-23	Variation/ Assurance
% Appraisal rate	>=90%	76.8%	75.1%	
% Assessed within 14 days of referral (Routine)	75%	60.4%	68.6%	
% Assessed within 4 hours (Crisis)	90%	97.4%	97.5%	
% Complaints with staff attitude as an issue	< 20%	9% (1/11)	0% (0/5)	
% service users followed up within 72 hours of discharge from inpatient care	80%	90.3%	88.2%	
% Service Users on CPA with a formal review within the previous 12 months	95%	97.4%	98.5%	
% Treated within 6 weeks of assessment (routine)	70%	97.6%	98.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	72.2%	78.1%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	80.7%	*94.6%*	
Information Governance training compliance	>=95%	86.9%	97.1%	
Reducing restrictive practice interventions training compliance	>=80%	69.5%	69.5%	
Sickness rate (Monthly)	4.5%	5.5%	5.0%	
% rosters locked down in 6 weeks				

Barnsley General Community Services

Metrics	Threshold	Apr-23	May-23	Variation/ Assurance
% Appraisal rate	>=90%	77.7%	79.6%	
% Complaints with staff attitude as an issue	< 20%	0% (0/1)	33% (1/3)	
% people dying in a place of their choosing	80%	87.5%	87.5%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.5%	82.7%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	
Information Governance training compliance	>=95%	91.9%	95.3%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	97.9%	98.9%	
Maximum 6 week wait for diagnostic procedures	99%	60.7%	53.3%	
Reducing restrictive practice interventions training compliance	>=80%	33.3%	50.0%	
Safer staffing (inpatient)	90%	110.7%	114.0%	
Sickness rate (Monthly)	4.5%	4.6%	4.3%	
% rosters locked down in 6 weeks				

Mental Health Inpatient

Metrics	Threshold	Apr-23	May-23	Variation/ Assurance
% Appraisal rate	>=90%	42.9%	52.3%	
% Bed occupancy	85%	86.3%	88.7%	
% Complaints with staff attitude as an issue	< 20%	40% (2/5)	20% (1/5)	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	72.5%	74.7%	
% of clients clinically ready for discharge	3.5%	3.3%	2.9%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	90.6%	*87.7%*	
Inappropriate Out of Area Bed days	152	457	574	
Information Governance training compliance	>=95%	90.6%	94.3%	
Physical Violence (Patient on Patient)	Trend Monitor	18	23	
Physical Violence (Patient on Staff)	Trend Monitor	66	42	
Reducing restrictive practice interventions training compliance	>=80%	79.2%	79.9%	
Restraint incidents	Trend Monitor	123	***110***	
Safer staffing	90%	126.9%	128.1%	
Sickness rate (Monthly)	4.5%	4.8%	4.2%	
% rosters locked down in 6 weeks				

Forensic

Metrics	Threshold	Apr-23	May-23	Variation/ Assurance
% Appraisal rate	>=90%	67.2%	69.3%	
% Bed occupancy	90%	88.5%	87.8%	
% Complaints with staff attitude as an issue	< 20%	0% (0/1)	0% (0/0)	
% Service Users on CPA with a formal review within the previous 12 months	95%	92.6%	96.3%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.4%	83.1%	
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	N/A	N/A	
Information Governance training compliance	>=95%	88.6%	95.2%	
Physical Violence (Patient on Patient)	Trend Monitor	0	3	
Physical Violence (Patient on Staff)	Trend Monitor	8	18	
Reducing restrictive practice interventions training compliance	>=80%	83.0%	83.6%	
Restraint incidents	Trend Monitor	18	***37***	
Safer staffing	90%	116.9%	113.5%	
Sickness rate (Monthly)	5.4%	6.5%	6.9%	
% rosters locked down in 6 weeks				

LD, ADHD & ASD

Metrics	Threshold	Apr-23	May-23	Variation/ Assurance
% Appraisal rate	>=90%	69.3%	72.1%	
% Complaints with staff attitude as an issue	< 20%	100% (1/1)	0% (0/3)	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	50.0%	50.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.1%	82.6%	
% of clients clinically ready for discharge	3.5%	25.0%	25.0%	
Information Governance training compliance	>=95%	86.3%	94.2%	
LD – First face to face contact within 18 weeks	90%	72.9%	78.5%	
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	42	33	
Reducing restrictive practice interventions training compliance	>=80%	75.1%	78.6%	
Safer staffing	90%	140.7%	143.2%	
Sickness rate (Monthly)	4.5%	4.6%	5.2%	
Restraint incidents	Trend Monitor	43	***31***	
% rosters locked down in 6 weeks				

CAMHS

Metrics	Threshold	Apr-23	May-23	Variation/ Assurance
% Appraisal rate	>=90%	80.4%	80.5%	
% Complaints with staff attitude as an issue	< 20%	0% (0/3)	0% (0/3)	
CAMHS - Crisis Response 4 hours	N/A	93.9%	98.5%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.7%	80.3%	
Eating Disorder - Routine clock stops	95%	75.0%	89.5%	
Eating Disorder - Urgent/Emergency clock stops	95%	33.3%	80.0%	
Information Governance training compliance	>=95%	90.4%	96.7%	
Reducing restrictive practice interventions training compliance	>=80%	69.8%	72.2%	
Sickness rate (Monthly)	4.5%	3.8%	3.2%	
% rosters locked down in 6 weeks				

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

Child and adolescent mental health services (CAMHS):

Alert/Action

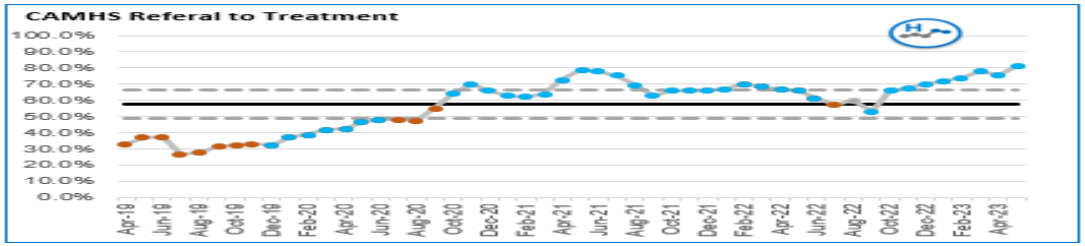
• Waiting numbers for Autistic Spectrum Conditions (ASC)/Attention Deficit Hyperactivity Disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees remain problematic. Robust action plans in place (with Transformation Programme support) – but a shortfall between commissioned capacity and demand remains:
  • Kirklees waiting list now 1,568 with referrals 160+ per month and commissioned capacity of 64 assessments per month.
  • Calderdale waiting list now 260. Referrals reduced significantly since introduction of any qualified provider arrangement (average 10 per month) – but some concern regarding delays/blockage at the point of screening/choice (as facilitated by Northpoint).
• Eating disorder routine clock stops under threshold (89.5%) – 2 cases breached 1 Barnsley, 1 Kirklees and urgent clock stops also under threshold (80%) – 1 breach Kirklees. Eating disorder caseloads remain under pressure due to case acuity/complexity.
• Ongoing issue with shortage of specialist residential and Tier 4 places – reduced capacity nationally and ongoing capacity issues at Red Kite View - leading to inappropriate stays for young people on acute hospital wards, in Trust inpatient beds and on section 136 suites. This is noted on the Trust risk register and subject of a number of recent MP enquiries. Work continues with the provider collaboratives to improve patient flow.
•The focus on maintaining staffing levels in Wetherby Young Offenders Institution (YOI) and Adel Beck secure children's home continues. Specific issues in relation to recruitment of band 6 nursing staff.
• Self-harm incidents/risk a key focus of improvement work at Wetherby young offenders institute

Advise

• Waiting times from referral to treatment in Wakefield remain an outlier. Referral rates remain a key factor. Brief intervention and group work service offer strengthened and medium term improvement anticipated. Additional mental health support team investment confirmed – enabling further strengthening of schools-based offer.
• Work in Kirklees continues - as part of a Kirklees 'Keep in Mind' programme – to develop the mental health support team offer across all local schools/colleges.
• Business case being developed in Barnsley with respect to specialist support offer for children with learning disabilities/special educational needs. Recognised gap and supported in principle by commissioners.
• A number of environmental issues have been escalated with respect to staff working conditions at Wetherby YOI. Progress being made in implementing action plan.
• Work programme underway to ensure more seamless transition to adult ADHD/ASC pathway.

Assure

• Staff wellbeing remains a focus. Each CAMHS team has an agreed action place in place as a direct response to the staff survey. Staff survey results generally positive across all teams. Sickness rates remain low.
• Clinical lead and service manager posts recruited to (and in post) across Wetherby young offenders institute and Adel Beck
• Proactively engaged with provider collaboratives in South and West Yorkshire to strengthen interface with inpatient providers and improve access to specialist beds.



As you can see in May 2023, we remain in a period of special cause improving variation. For further information see narrative above.

Barnsley general community services:

Alert/Action

Health Integration Team Urban House:
• The Band 7 Nurse Prescriber left the service in November 2022 and leaves only one Nurse Prescriber (Lead Nurse who is currently working from home due to their clinical vulnerability). This creates pressure and some risk within the service. To date we have been unable to recruit through bank/agency on a temporary basis or to cover period of recruitment. We are currently working with pharmacy and the Walk in Centre in Wakefield, to provide cover for the service as necessary.
• The service has a high level of sickness absence which is causing additional pressures in the team. We have been unsuccessful in attempts to cover this through bank/agency, but the team has been supported by staff within general community services.
• Following a recent visit by the Integrated Care Board (ICB) quality team, the feedback has been very positive, however they have suggested a resilience review with regard to staffing levels.

Advise

• Live Well Wakefield - awaiting outcome for bid submitted for the tender of service is association with NOVA.
• South Yorkshire Integrated Care Board (ICB) are expected to publish the virtual ward technology procurement documents later this month. The aim is to procure a single remote monitoring technology provider across the region with each provider organisation holding an individual contract. SWYPFT were given a 'one off' funding allocation to fund this contract; it is expected that the technology will be deployed from late August 2023. Therefore it is unlikely that SWYPFT will utilise the full funding within the 2023/2024 financial year. Discussions may be required around the potential option to accrue the funding to the 2024/2025 year.
• The paediatric epilepsy nursing service is experiencing staffing pressures due to existing staff secondments and a member of staff who was providing backfill now leaving the Trust for a permanent position elsewhere. This is being managed internally within the team.

Health Integration Team Urban House (UH):
• The commissioner is reviewing current health provision for the 6 resettlement programmes in Wakefield including UH. Following the meeting with the commissioners in January 2023, a discussion paper was submitted as to how we can work collaboratively with primary care to ensure the delivery of equitable services for all those clients within the resettlement programmes in Wakefield. We have since met with the commissioner and discussed a potential collaborative approach to service delivery with Primary Care and the commissioner will now arrange further meetings with partner organisations as to next steps. To date we have not received any further update.
• There is currently a chicken pox outbreak in Urban House; this is being managed with key partners.

Barnsley general community services continued:

Assure

• Excellence Awards May 2023:
Winners in Leader of the Year and Unsung Hero awards.
Highly commended for Excellence in Improving Health (School Age Immunisation Service), Partnership Working Excellence (Virtual Ward pathway), and Social Responsibility and Sustainability Excellence (Live Well Wakefield Social Prescribing Model).
• Successful recruitment process for permanent appointment to Associate Director of Operations post.
• Yorkshire Smokefree Sheffield - successfully procured a supplier to supply the service with vapes.
• ReSPECT – SWYPFT go live date was 5 June with a graduated introduction. Communication has been updated on intranet in terms of training, standard operating procedures etc.
• Regional stroke conference took place in May and our team won best poster for the BP@Home work. The team also led on two workshops (vocational rehabilitation and stroke drop in cafes). We also had a further poster display on the Life After Stroke Group which is held at Tesco in Barnsley.
• A piece of development work is to commence later this month with Adult Social Care colleagues to develop enhanced collaborative working between SWYPFT community nursing staff and Barnsley metropolitan borough council adult social care teams. This will enable greater synergies to occur between both teams across all neighbourhood areas. This work will commence in the North-East neighbourhood before being rolled out across the other five neighbourhood areas.
• A task action group is being developed in collaboration with the GP federation and the local authority to look at out of hours provision and more co-ordinated integrated working. A presentation on this work stream is to be delivery at the Urgent Care Board and the Barnsley Place Delivery Group.
• Increased interest in vacancies advertised on NHS jobs – Vacancy factor reducing in Neighbourhood Nursing Service (NNS).
• The Paediatric Epilepsy Nursing Service have commenced a trial of the HAMHA (Huddersfield Application for Mental Health Assessment) mental health risk assessment for non-mental health professionals. The service is working with SWYPFT quality improvement team and the University of Huddersfield (Mike Doyle) on this project and trial.

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) services:

Alert/Action

• AQP (Any Qualified Provider) - Calderdale AQP (Any Qualified Provider) for Neurodiversity officially launched on 1st May 2023. The service is still working through the detail with commissioners.
• Friend & Family Test – Friends and family test is 50%. The service is continuing to explore different methods of collating and using feedback to improve services.

Advise

ADHD
• For ADHD the Calderdale AQP makes no change to the offer, all complete referrals that meet the service criteria are accepted. There are currently 776 people on the waiting list for ADHD assessment. The Service receives circa 64 referrals each month. Waiting lists are monitored through the normal governance mechanisms within the service.
Autism
• In line with other AQP's specification the service is working to understand any potential risks with respect to costs, clinical care and waiting list and explore risk management options that may need to be put in place to mitigate its impact.

Collaboration with Bradford
• This work continues to progress really positively and learning from this piece of work is being shared across all commissioners across the Trust.

Assure

• All KPI targets met.
• All training is above the threshold.
• Relationship with Bradford working very well.
• Excellent levels of supervision and appraisal across the team (100%).

Learning disability services:

Alert/Action

Community Services
• Work on the reduction of waiting times continues. During this phase of the work Calderdale has been the focus with the intention to role out the improvements across all localities. The work should enable teams to intervene sooner. Training sessions planned for staff.
• Locality TRIOs are now in place.
• Focus on sickness absence with support provided by the People Directorate.

ATU (Assessment & Treatment Unit)
• Horizon improvement programme continues to make progress. Improvements continue to embed and staff involvement and engagement remains a priority.
• Recruitment to posts which were previously shared posts (with Bradford) is underway.
• People who are clinically ready for discharge (previously delayed transfers of care) is currently 25% and reflects system challenges in provision of bespoke packages of care to meet complex needs.

Advise

Community & ATU (Assessment & Treatment Unit)

- Service is working with the executive sponsor (Dr Thiyagesh) with the priority set as collaborative working across the Trust re Green Light Toolkit.
- Community improvement programme is planned and will follow the same format as the Horizon plan.
- Robust plans in all localities to celebrate LD week.
- Horizon environment continues to improve with clear evidence of personalised care.
- Appraisal currently 67.9%↑
- Potential service gap for people with an LD who require and ADHD assessment. The service will liaise with colleagues and commissioners to work towards a solution.
- Out of hours service currently being mobilised.

Assure

ATU (Assessment & Treatment Unit)

- Recruitment continues to progress. A senior Occupational Therapist has been appointed at Horizon and this has been a gap for a considerable period of time.
- Robust plans in place to address mandatory training, supervision, and appraisal shortfall and progress is being monitored closely.
- Benchmarking against CQC 'Outstanding' rated services has been undertaken and will be presented to the improvement group.

Community

- Waiting List mitigation includes more frequent data cleansing and the establishment of an early alert system which will help teams to potentially avoid delays in appointments.
- Annual health checks across all 4 localities are continuing to improve.
- Wellbeing plans in place for both Horizon and community services.

Forensic services:

Alert/Action

• Bed Occupancy – Newton Lodge 84.62, Bretton 95.33%, Newhaven 87.5%. Occupancy in Newhaven is impacted by recent discharges and occupancy in Newton Lodge is impacted by empty beds at the rehabilitation part of the pathway.
• Sickness absence/Covid absence – remains above the care group target but has reduced to 6.7%.
• Vacancies & Turnover – Turnover remains high 14.9%. Recruitment & Retention remains a priority.
• Care programme approach reviews within 12 months - under target at 96.30% though represents a significant improvement.
• QNFMHS (Quality Network Forensic Mental Health Services) – Developmental review has taken place in early May. The service awaits the report.
• CQC – 9 out of 11 wards were visited in the full inspection in May. Work has been undertaken to address the issues identified throughout the visit which includes significant improvements made to the way that ligature risk assessments are managed.

Advise

• Regular meetings continue to assimilate Forensic Child and Adolescent Mental Health Services (FCAMHS) into the West Yorkshire Provider Collaborative.
• Mandatory training overall compliance:
  Newton Lodge – 90.9%
  Bretton – 89.6%
  Newhaven –89.8
The above figures represent the overall position for each service.
• The roll out of Trauma Informed Care is going well and training sessions for staff have commenced with some staff having completed all four modules.
• Appraisal (69.4%) & supervision remain a priority.
• The wellbeing of staff also remains a priority within the service. The wellbeing group have reviewed the NHS survey results and developed an action plan identifying three key areas to focus on. There is a strong level of engagement within the care group.

Assure

• High levels of data quality across the Care Group (100%).
• 100% compliance for HCR20 (historical clinical risk management – relating to the risk of violence) being completed within 3 months of admission.
• All Equality Impact Assessments (EIA) across Forensic Services have been completed for 2023/24.
• Positive feedback received from the commissioning hub relating to the quarterly submissions and presentations at contract meetings.

Adults and Older People mental health:

Alert/Action

• Acute wards have continued to manage high levels of acuity.
• We have had high occupancy levels across wards and capacity to meet demand for beds remains difficult.
• Workforce challenges have continued with increased use of agency staff.
• The work to maintain effective patient flow continues, with the use of out of area beds being closely managed.
• We are working actively with partners to reduce the length of time people who are clinically ready for discharge spend in hospital and to explore all options for discharge, solutions/alternatives to hospital, underpinned by the work on the '100 Day Discharge Challenge'.
• Demand into the Single Point of Access (SPA) and capacity issues have lead to ongoing pressures in the service, workforce challenges are continuing to compound these problems and have been increasing with a significant number of vacancies despite active recruitment.
• SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment has been at risk of being delayed in all areas and is below target performance in Barnsley, and Calderdale and Kirklees, although the latter has seen significant improvement this month.
• Rapid improvement work in SPAs together with some progress in recruitment should contribute to an improved performance in the coming months.
• Intensive Home Based Treatment (IHBT) teams in Calderdale and Kirklees are experiencing additional workforce challenges and are looking at innovative remedial and improvement approaches as part of a rapid action plan.
• 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 with action plans in place for certain teams and continue to be proactive and innovative in approaches to recruitment and workforce modelling.
• All areas are focussing on continuing to improve performance for FIRM risk assessments, and performance is showing good progress 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.
• Progress has been made in all areas on ensuring care plans are produced collaboratively and shared with service users.
• Care Programme Approach (CPA) review performance is above target in all Calderdale, Kirklees and Wakefield, with Barnsley sustaining significant improvement, action plans and support from Quality and Governance leads remain in place.

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.
• Intensive work to consider how we maintain quality and safety on our wards and improve the wellbeing of staff and service users and encourage recruitment and retention is underway.
• We are actively expanding creative approaches to enhance service user experience and the general ward environments. We are building identified challenges and priorities into the workforce strategy and the inpatient improvement priority programme.
• Work continues in front line community services to adopt collaborative approaches to care planning, build community resilience, and to offer care at home including providing robust gatekeeping, trauma informed care and effective intensive home treatment.
• We are participating in the Trustwide 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 community mental health transformation.
• We recognise the key role of supervision and appraisal in staff wellbeing and are ensuring time is prioritised for these activities and for acute inpatient wards we are committed to a trajectory of all appraisals being completed by mid July.
• We are looking at our performance regarding Friends and Family Tests, both in the content of responses and numbers completed and developing actions to improve.
• 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.
• We are working closely with specialist advisors and we also have plans in place across inpatient services to ensure appropriately trained staff are on duty across all shifts at all times.

Assure

• Calderdale memory service has been successful in its reaccreditation with Memory Services National Accreditation Programme which is a quality improvement and accreditation network for services that assess, diagnose and treat dementia in the UK. As part of this process they were awarded the Sustainable Mental Health Service Commendation, in recognition of their work towards achieving a sustainable mental health service and meeting 90% of the College Centre for Quality Improvement (CCQI) sustainability standards.
• We are performing well in gatekeeping admissions to our inpatient beds.
• We are performing well in 72 hour follow up for all people discharged into the community.

Overall Financial Performance 2023/24

Executive Summary / Key Performance Indicators

Performance Indicator		Target	Year to Date	Forecast 2023/24	Narrative
1	Surplus / (Deficit)	Breakeven	£0m	£0m	In May 2023 the financial position is a deficit of £0.2m which is lower than plan. Year to date there is a surplus of £44k. The main driver in this movement from month 1 is the estimated impact of the national Agenda For Change pay award with estimated expenditure being higher than estimated income. The forecast position will be assessed by the end of the first quarter. The target is breakeven.
2	Agency Spend	£8.7m	£1.8m	£9.8m	Agency spend for 2023 / 24 is planned to reduce from £10.0m to £8.7m. This is in line with national, and ICB, reduction targets and caps. Spend in May is £908k and year to date is 13% above the plan trajectory.
3	Financial sustainability and efficiencies	£12.0m	£1.5m	£11.1m	The Trust financial plan includes a sustainability programme totalling £12.0m and is directly linked to the Trust priority of spending money wisely. Individual performance is provided within the report. Scheme realisation is required in year to ensure that this target is met.
4	Cash		£77.7m	£76.9m	The Trust cash position remains strong at £77.7m; this is higher than plan. This has always been maximised however the current interest rates provide additional financial incentive.
5	Capital	£8.8m	£0.8m	£8.8m	The capital programme is made up of 2 elements. Key performance is monitored against the ICB capital allocation and excludes the impact of IFRS 16 (leases). The detail is shown within the full report. To date expenditure is £0.8m with significant progress made on the door replacement programme.
6	Better Payment Practice Code	95%	97%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 95% of all invoices have been paid within 30 days of receipt.

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

System-wide monitoring

The Trust works in partnership with health economies predominantly in Barnsley, Calderdale, Kirklees, Wakefield, and the Integrated Care Systems (ICS) of South Yorkshire and West Yorkshire. Progress against delivery of the ICS five year strategies can be found by following the links below:

West Yorkshire Health and Care Partnership -

https://www.westyorkshire.icb.nhs.uk/meetings/finance-investment-and-performance-committee

South Yorkshire ICS -

ICB Board meeting and minutes :: South Yorkshire ICB

The Trust is trying to establish a feed of data of applicable key performance indicators for each of the integrated care boards.

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 2 (2023 / 24)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0 Executive Summary / Key Performance Indicators

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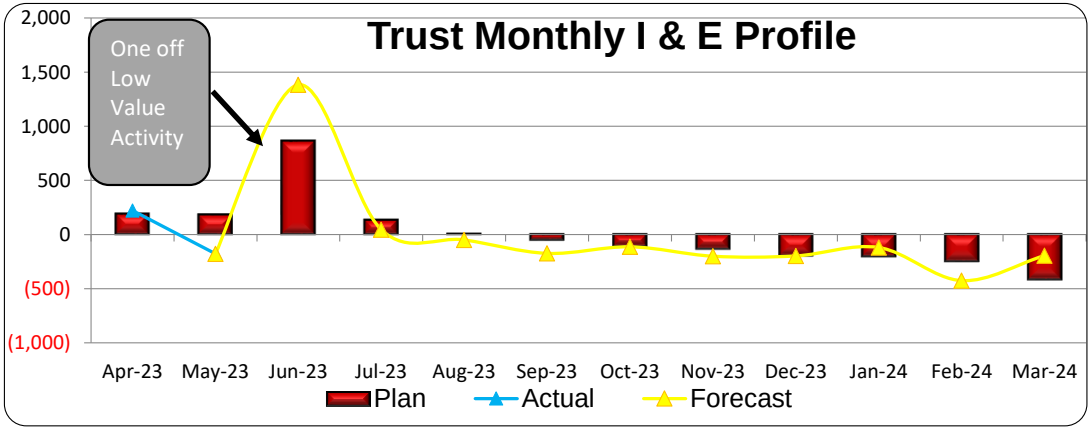
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

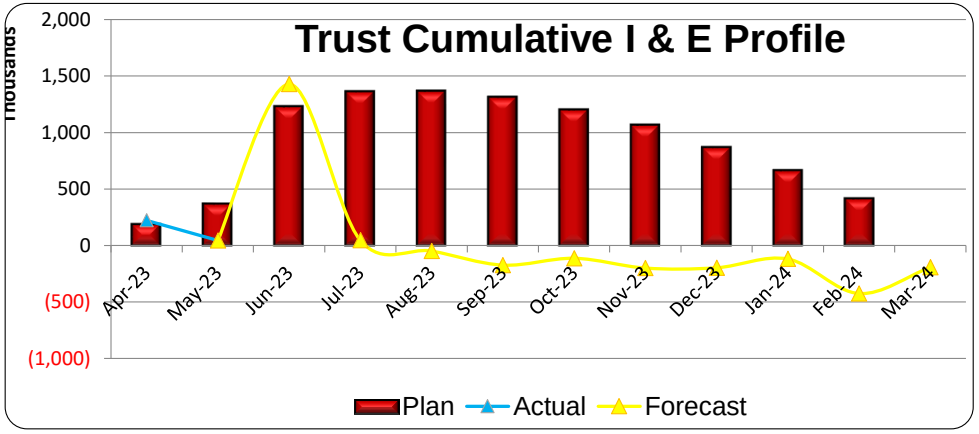
2.0 Income & Expenditure Position 2023 / 24

The table below presents the total consolidated financial position for South West Yorkshire Partnership NHS Foundation Trust. This incorporates it's role as co-ordinating provider for a number of Mental Health Provider Collaboratives but excludes it's linked charities which are consolidated into the Trust's group annual accounts. The impact of the Provider Collaboratives is highlighted separately within this report.

Total Financial Position

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Healthcare contracts					31,887	32,127	239	63,689	63,912	223	386,741	387,897	1,156
Other Operating Revenue					1,093	1,032	(61)	2,069	2,113	44	12,295	11,831	(464)
Total Revenue					**32,981**	**33,159**	**178**	**65,758**	**66,025**	**267**	**399,036**	**399,728**	**692**
Pay Costs	4,802	4,804	2	0.0%	(20,540)	(20,462)	78	(39,867)	(39,606)	261	(242,186)	(242,465)	(279)
Non Pay Costs					(11,821)	(12,478)	(657)	(24,640)	(25,584)	(944)	(151,823)	(152,776)	(953)
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**4,802**	**4,804**	**2**	**0.0%**	**(32,361)**	**(32,940)**	**(579)**	**(64,507)**	**(65,190)**	**(683)**	**(394,009)**	**(395,241)**	**(1,231)**
EBITDA	**4,802**	**4,804**	**2**	**0.0%**	**620**	**219**	**(401)**	**1,251**	**835**	**(416)**	**5,027**	**4,487**	**(539)**
Depreciation					(518)	(517)	1	(1,035)	(1,034)	1	(5,949)	(5,940)	8
PDC Paid					(179)	(179)	0	(358)	(358)	0	(2,148)	(2,148)	0
Interest Received					258	300	42	512	601	89	3,070	3,601	531
Surplus / (Deficit) - ICB performance measure	**4,802**	**4,804**	**2**	**0.0%**	**181**	**(177)**	**(358)**	**370**	**44**	**(326)**	**(0)**	**0**	**0**
Depn Peppercorn Leases (IFRS16)					0	0	0	0	0	0	0	0	0
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,802**	**4,804**	**2**	**0.0%**	**181**	**(177)**	**(358)**	**370**	**44**	**(326)**	**(0)**	**0**	**0**





2.0 Income & Expenditure Position 2023 / 24

The position of South West Yorkshire Partnership NHS Foundation Trust, excluding the financial impact of Provider Collaboratives, is shown below. The movement between the total financial position and the total excluding the collaboratives is reconciled below for ease.

Total Financial Position

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Healthcare contracts					23,658	23,590	(68)	47,231	47,076	(154)	287,992	288,244	252
Other Operating Revenue					1,093	1,032	(61)	2,069	2,113	44	12,295	11,831	(464)
Total Revenue					**24,752**	**24,623**	**(129)**	**49,300**	**49,189**	**(111)**	**300,287**	**300,075**	**(212)**
Pay Costs	4,782	4,773	(10)	0.2%	(20,407)	(20,306)	102	(39,614)	(39,253)	361	(240,703)	(240,254)	450
Non Pay Costs					(3,691)	(4,148)	(457)	(8,401)	(9,233)	(832)	(54,390)	(55,465)	(1,076)
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**4,782**	**4,773**	**(10)**	**0.2%**	**(24,098)**	**(24,453)**	**(355)**	**(48,015)**	**(48,485)**	**(471)**	**(295,093)**	**(295,719)**	**(626)**
EBITDA	**4,782**	**4,773**	**(10)**	**0.2%**	**654**	**169**	**(484)**	**1,285**	**704**	**(581)**	**5,194**	**4,356**	**(838)**
Depreciation					(518)	(517)	1	(1,035)	(1,034)	1	(5,949)	(5,940)	8
PDC Paid					(179)	(179)	0	(358)	(358)	0	(2,148)	(2,148)	0
Interest Received					258	300	42	512	601	89	3,070	3,601	531
Surplus / (Deficit) - ICB performance measure	**4,782**	**4,773**	**(10)**	**0.2%**	**215**	**(227)**	**(442)**	**404**	**(87)**	**(491)**	**168**	**(131)**	**(299)**
Depn Peppercorn Leases (IFRS16)					0	0	0	0	0	0	0	0	0
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,782**	**4,773**	**(10)**	**0.2%**	**215**	**(227)**	**(442)**	**404**	**(87)**	**(491)**	**168**	**(131)**	**(299)**

To help with clarity on the position of the provider collaboratives a summary between the two tables is shown below. The individual analysis within the remainder of this report highlights the Trust only values. The collaborative financial performance is reported separately.

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Total Trust Position	4,802	4,804	2	0.0%	181	(177)	(358)	370	44	(326)	(0)	0	0
Provider Collaboratives	20	31	11	56.7%	(34)	50	83	(34)	131	165	(168)	131	299
Total excluding Collaboratives (as shown above)	**4,782**	**4,773**	**(10)**	**0**	**215**	**(227)**	**(442)**	**404**	**(87)**	**(491)**	**168**	**(131)**	**(299)**

Income & Expenditure Position 2022 / 23

The impact of the 2023 / 24 Agenda For Change pay award has been incorporated in month. Estimated expenditure is greater than estimated income. This, including any arrears, will be paid in June 2023.

The Trust revised financial plan, submitted May 2023, is a breakeven position. This is profiled with a surplus in the first months of the year which reduces in line with Trust workforce, recruitment and retention assumptions. Cost reductions are profiled also later in the year which help to reduce the impact of cost increases. The plan included an assumed pay award at 2% and related uplifts to commissioner tariff. The revised pay offer presents a significant financial pressure to this plan position.

NHS England - monthly submission

The financial performance reported here is consistent with the monthly return made to NHS England and also to that reported into the West Yorkshire Integrated Care Board (ICB). The corresponding declaration is made within the return itself.

Income

The majority of income continues to be received through block payment arrangements with any variances to plan agreed by exception. Budgets and actual income have been uplifted for expected increases for Agenda For Change pay award funding which will be paid by commissioners in June 2023.

Pay

In line with national guidance relevant pay expenditure has been uplifted by 5%, with effect from 1st April 2023, to take account of the Agenda For Change pay award. This is an increase from the 2% estimated in April 2023 which was the assumption included within the financial plan. This will be paid in June 2023 including any arrears. Budgets have been increased as well.

Overall the trend of increased worked WTE has continued in May. The main increase is in bank WTE; returning inpatient levels to previous levels with April being lower than normal. Substantive staff, including payment for additional hours worked, has reduced by 14 in month and this will continue to be monitored.

Recruitment and retention workstreams continue, including continued overseas recruitment for nursing and other professions.

Non Pay

The presentation of non pay expenditure has been updated to separate out the significant value associated with the provider collaboratives. Budgets have also been reset for 2023 / 24 based upon historical trends and estimates of inflationary pressures.

Variances are explained within the non pay analysis section with a number of categories spending more than planned at the start of the year. Analysis will continue to highlight if this is increased usage or inflationary price increases causing the pressure.

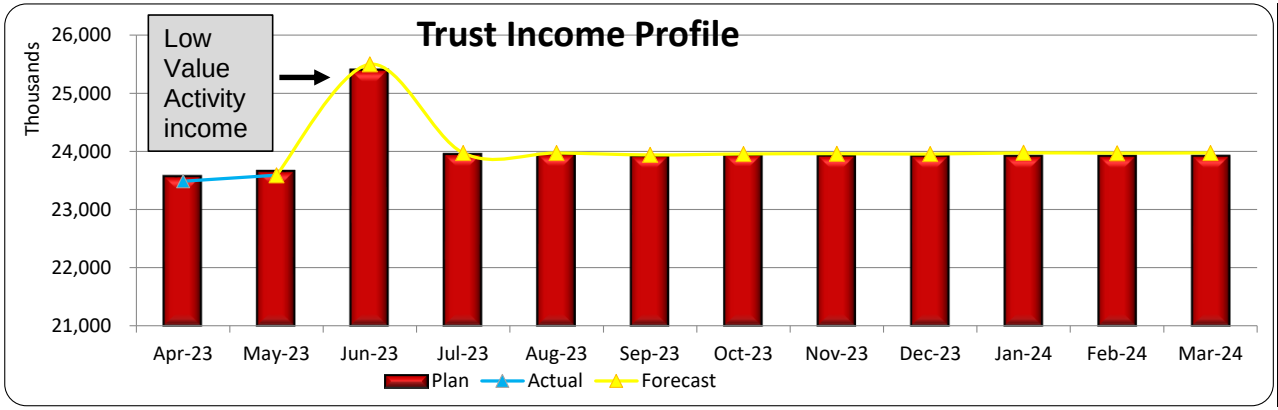
2.1 Income Information

The Trust Income and Expenditure position separately identifies clinical revenue, and other revenue received as part of these significant contracts as a result of the post covid-19 financial architecture. These contracts are historically those to provide healthcare services as the purpose of this Trust. This does not include other income which the Trust receives such as contributions to training, staff recharges and catering income. This is reported as other operating income.

This excludes the income received for the commissioning role as co-ordinating provider. This is reported separately as well.

The vast majority of income continues to be received from local commissioners (formerly CCGs, now Integrated Care Boards (ICBs)) and NHS England.

Income source	Apr-23 £k	May-23 £k	Jun-23 £k	Jul-23 £k	Aug-23 £k	Sep-23 £k	Oct-23 £k	Nov-23 £k	Dec-23 £k	Jan-24 £k	Feb-24 £k	Mar-24 £k	Total £k	Total 22/23 £k
NHS Commissioners	19,533	19,642	21,461	19,935	19,935	19,935	19,935	19,935	19,935	19,935	19,935	19,935	**240,054**	
ICS / System / Covid	0	0	0	0	0	0	0	0	0	0	0	0	**0**	
Specialist Commissioner	2,752	2,753	2,751	2,752	2,752	2,719	2,719	2,719	2,719	2,719	2,719	2,718	**32,791**	
Pay Award	0	0	0	0	0	0	0	0	0	0	0	0	**0**	
Local Authority	490	516	514	515	514	514	506	511	506	527	521	526	**6,160**	
Partnerships	514	584	628	626	626	626	651	651	651	651	651	651	**7,511**	
Other Contract Income	197	96	144	144	144	144	144	144	143	143	143	143	**1,728**	
Total	**23,486**	**23,590**	**25,498**	**23,972**	**23,972**	**23,939**	**23,955**	**23,960**	**23,954**	**23,975**	**23,969**	**23,974**	**288,244**	**0**
2022 / 23													**0**	



As at 31st May 2023 contracts with main commissioners were progressing to signature. These, including the financial elements, will be updated to incorporate the revised Agenda For Change pay award. For 2023 / 24 this will flow as an uplift to commissioner tariff. Arrears relating to 2022 / 23 will be paid directly by NHS England.

Additional income is forecast in June 2023 relating to the one off payment for low value activity. These values are calculated nationally.

Overall income is in line with plan. Financial, and operational, risks will continue to be assessed including CQUIN performance.

2.2 Pay Information

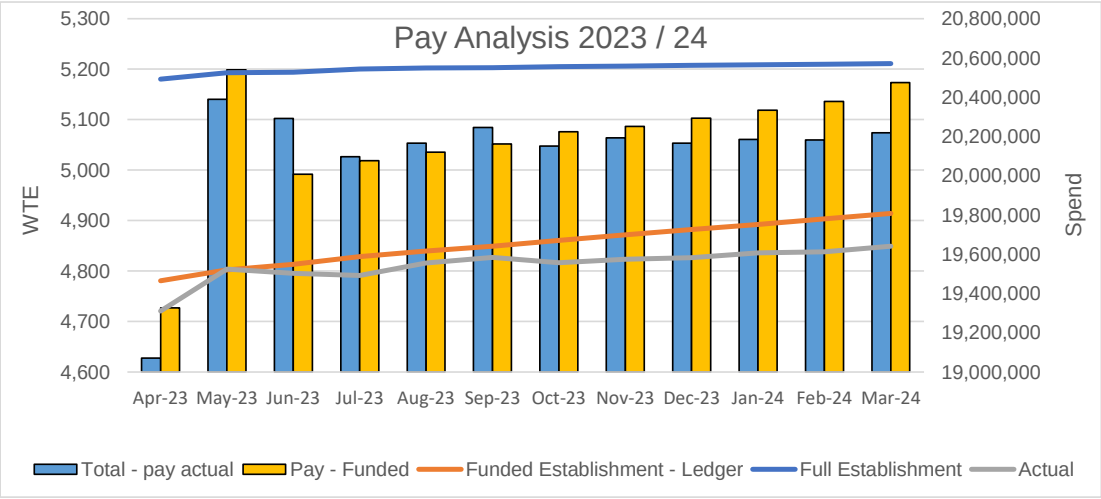
Our workforce is our greatest asset, and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). Trust priorities include a focus on the health and wellbeing of this workforce.

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

Staff type	Apr-23 £k	May-23 £k	Jun-23 £k	Jul-23 £k	Aug-23 £k	Sep-23 £k	Oct-23 £k	Nov-23 £k	Dec-23 £k	Jan-24 £k	Feb-24 £k	Mar-24 £k	Total £k
Substantive	17,160	18,043	18,197	18,052	18,086	18,195	18,125	18,167	18,157	18,176	18,179	18,198	**216,736**
Bank & Locum	849	1,355	1,142	1,121	1,181	1,158	1,154	1,157	1,149	1,148	1,150	1,162	**13,724**
Agency	939	908	864	834	809	803	782	780	770	772	764	769	**9,794**
Total	**18,947**	**20,306**	**20,204**	**20,008**	**20,076**	**20,156**	**20,061**	**20,104**	**20,076**	**20,095**	**20,093**	**20,129**	**240,254**
22/23	17,397	18,201	17,728	18,510	17,937	20,464	18,972	18,425	17,828	16,905	19,719	18,889	**220,976**

Bank as % (in month)	4.5%	6.7%	5.7%	5.6%	5.9%	5.7%	5.8%	5.8%	5.7%	5.7%	5.7%	5.8%	5.7%
Agency as % (in month)	5.0%	4.5%	4.3%	4.2%	4.0%	4.0%	3.9%	3.9%	3.8%	3.8%	3.8%	3.8%	4.1%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,343	4,329	4,360	4,372	4,387	4,401	4,397	4,404	4,408	4,419	4,421	4,429	**4,389**
Bank & Locum	222	314	272	262	275	271	271	271	270	270	270	273	**270**
Agency	157	161	164	157	154	154	148	148	148	147	147	147	**153**
Total	**4,721**	**4,804**	**4,796**	**4,791**	**4,816**	**4,827**	**4,817**	**4,824**	**4,826**	**4,836**	**4,838**	**4,849**	**4,812**
22/23	4,461	4,455	4,396	4,447	4,494	4,494	4,489	4,450	4,482	4,559	4,532	4,591	**4,488**



The original Trust financial plan included an assumed 2% pay award for Agenda for Change staff in line with national guidance. This has been revised to 5% in May 2023 and an estimate of costs to date has been made. This will be paid in June (with appropriate arrears). Budgets have been increased as well.

As a result it's difficult to identify any trend from the initial two months of 2023 / 24.

WTE, however, are an indication as they are not directly affected by this. In May there has been a reduction in substantive staff worked (this includes Trust staff doing additional hours) although this has been more than offset by the increase in bank worked WTE in month.

Average bank worked WTE in Quarter 4 2022 / 23 was 312 WTE and therefore May usage is in line with run rate. April usage was lower than normal in inpatient areas in line with service needs.

2.2 Agency Expenditure Focus

Agency spend is £908k in May. Spend in 2022 / 23 was £10.0m with an average run rate of £834k.

Agency costs have a continued focus for the NHS nationally and for the Trust. As such separate headline analysis of agency trends, pressure areas and actions are presented below.

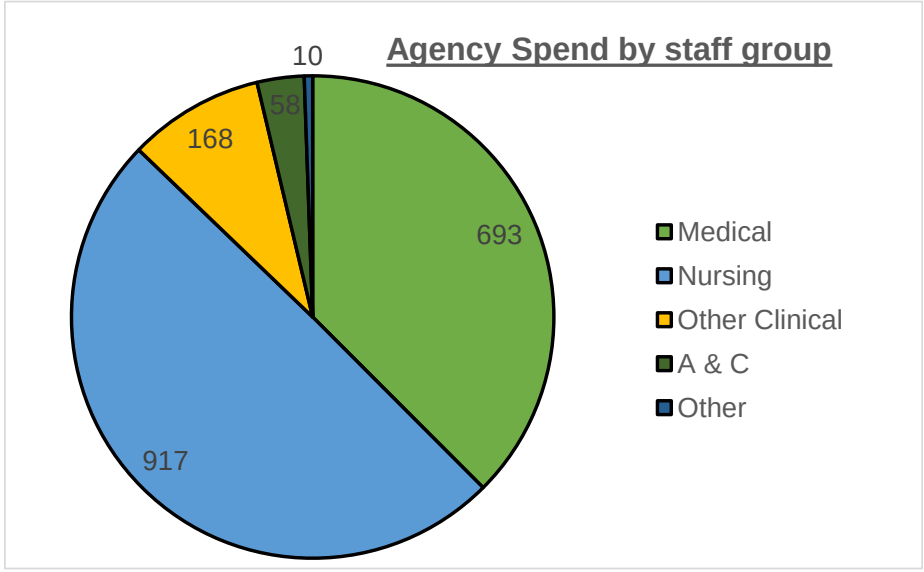
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible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

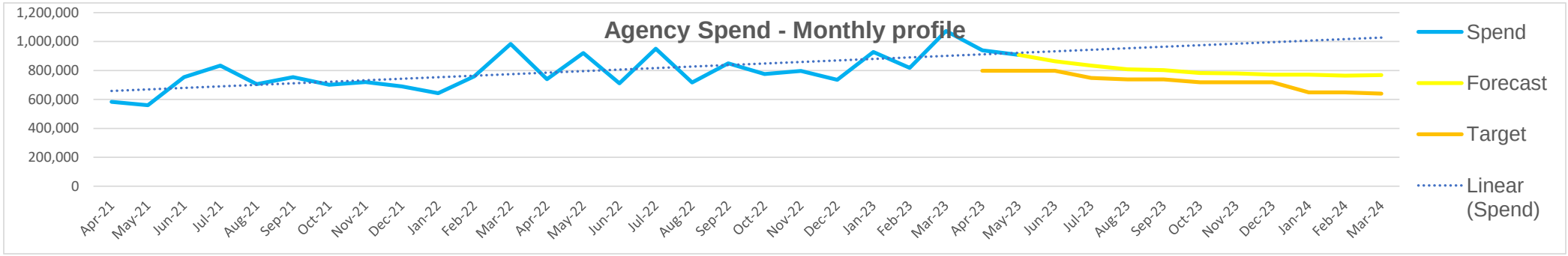
Under the NHS Single Oversight Framework expected maximum agency levels have been set for 2023 / 24. The Trust planned for delivery of this target at £8.7m. This represents a £1.3m reduction from expenditure incurred in 2022 / 23.

The Trust agency scrutiny and management group continues to provide oversight ensuring that Trust processes are followed and agency spend is appropriate and minimised.

May 2023 spend is £908k which, as shown by the graph below, is higher than target. Currently only small reductions are forecast for the rest of the year. The Trust will continue to assess need based upon safety, quality and the financial implications.

As shown by the pie chart nursing staff (registered and unregistered) is the largest single category. This remains focussed in inpatient (both adult acute and older peoples) and Forensic services.



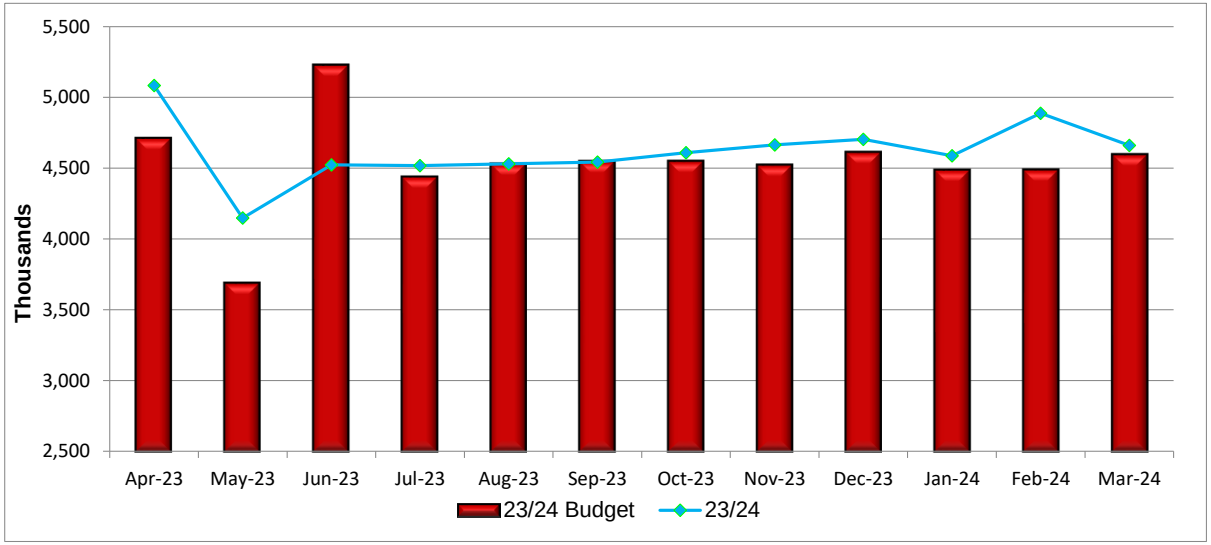


2.3 Non Pay Expenditure

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

Non pay spend	Apr-23 £k	May-23 £k	Jun-23 £k	Jul-23 £k	Aug-23 £k	Sep-23 £k	Oct-23 £k	Nov-23 £k	Dec-23 £k	Jan-24 £k	Feb-24 £k	Mar-24 £k	Total £k
2023/24	5,085	4,148	4,523	4,518	4,531	4,544	4,609	4,665	4,704	4,587	4,889	4,662	**55,465**
2022/23													**0**

Non Pay Category (per accounts)	Budget Year to date £k	Actual Year to date £k	Variance £k
Drugs	690	625	(65)
Establishment	1,459	1,564	105
Lease & Property Rental	1,452	1,449	(3)
Premises (inc. rates)	895	950	54
Utilities	380	378	(3)
Purchase of Healthcare	1,601	1,609	8
Travel & vehicles	759	827	67
Supplies & Services	1,108	1,152	44
Training & Education	281	297	16
Clinical Negligence & Insurance	131	131	(0)
Other non pay	(357)	252	608
Total	**8,401**	**9,233**	**832**
Total Excl OOA and Drugs	**6,110**	**6,998**	**888**



Key Messages

Non pay expenditure budgets were reset for 2023 / 24 based on historical trends and estimates of inflationary price increases. The negative other non pay budget is based on currently identified efficiency requirements; these will be aligned in years as schemes progress.

Overall the purchase of healthcare, which is traditionally an area of financial pressure and continues to be reported separately, is broadly in line with plan. There is however a planned reduction in spend over the course of the year which presents an operational and financial risk.

Current areas of overspend include establishment. For May this is due to the timing of costs, when compared to the budget profile, relating to Trust mobile access (VPN's). As this is timing this overspend is expected to reduce in coming months.

Other non pay includes all other items not categorised into the above headings and allocation continues to ensure spend is correctly coded and as much separately reported as possible. As such this covers a wide range of items and budgets held centrally.

2.3 Out of Area Beds Expenditure Focus

The heading of purchase of healthcare within the non pay analysis includes a number of different services; both the purchase of services from other NHS trusts or organisations for services which we do not provide (mental health locked rehab, pathology tests) or to provide additional capacity for services which we do. In this analysis this is Trust costs only and therefore excludes provider collaboratives.

The largest value relates to out of area bed placements (split acute and PICU and the focus of this analysis) which can be volatile and expensive. The reasons for taking this action can be varied but can include:

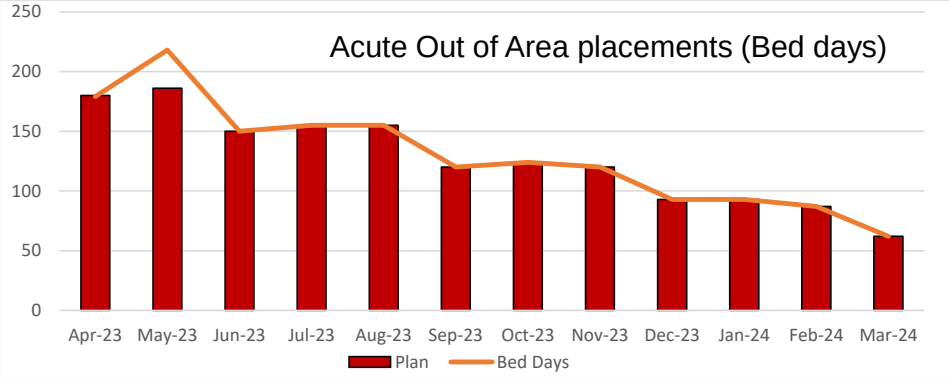
* Specialist health care requirements of the service user not directly available / commissioned within the Trust
* No current bed capacity to provide appropriate care

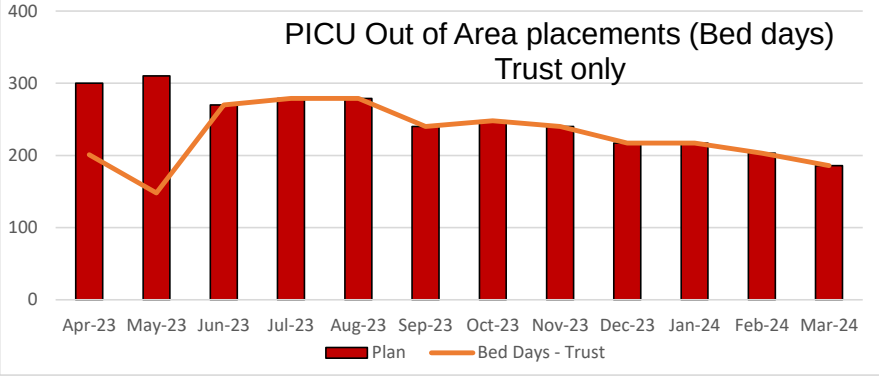
On such occassions a clinical decision is made that the best possible care option is to utilise non-Trust resources. Where possible service users are placed within the Trust geographical footprint.

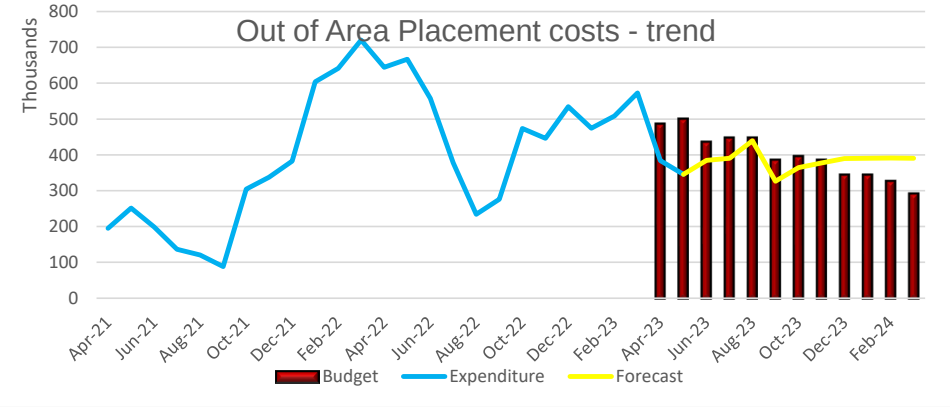
There are an additional 285 PICU bed days in April - May 2023 which are paid directly by the commissioner.

Breakdown - Purchase of Healthcare

Heading	Budget Year to date £k	Actual Year to date £k	Variance £k
Out of Area			
Acute	279	208	(70)
PICU	683	518	(166)
Locked Rehab	380	450	69
Services - NHS	117	103	(14)
IAPT	29	135	106
Yorkshire Smokefree	14	4	(10)
Other	98	191	93
Total	**1,601**	**1,609**	**8**







Out of area bed placements continues to be a Trust priority programme to address the operational and financial pressures that this causes.

The graph to the left highlights the volatility of expenditure as the demand, and require for placements, has changed over months. There can be periods of significant, and sustained, increases.

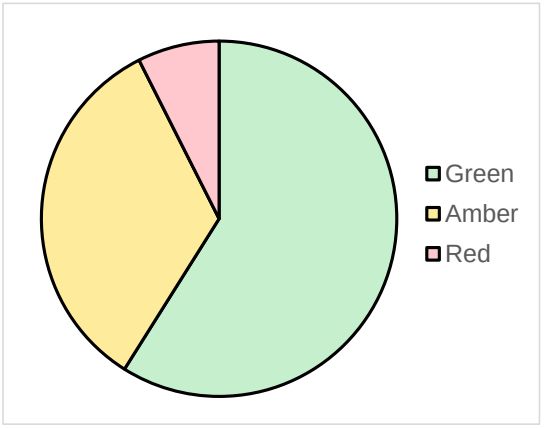
Expenditure wise both acute and PICU are less than plan for April - May 2023. This is despite acute bed day usage being higher than plan. This is due to less than plan addititonal nursing and the bed day rates are lower than the historical average used to calculate the plan.

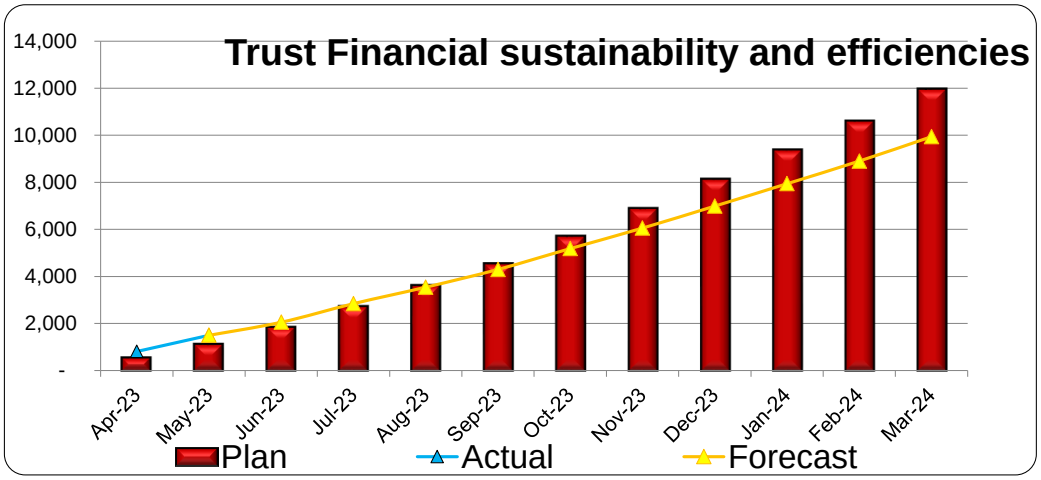
2.4 Value for Money, Financial sustainability and efficiency

The Trust financial plan includes a requirement to demonstrate financial sustainability and efficiency in order to achieve the financial target. This is both the current financial year and as part of the longer term financial plan where continual savings are required to safeguard long term financial sustainability. For 2023 / 24 a target of £11.96m has been identified and included within the plan.

This links closely with the Trust priority to improve the use of resources with a continual strive to ensure that services provide value for money and the best possible use of resources.

		Year to Date				Forecast			
Workstream Categorisation	**Breakdown**	**Target**	**Achieved Recurrent**	**Achieved Non Recurrent**	**Unachieved / Shortfall**	**Target**	**Green**	**Amber**	**Red**
Out of Area Placements	Pg. 10	259	511			3,197	511	2,888	0
Agency & Workforce	Pg.	200		426		4,380	3,502		144
Medicines optimisation		67	65			400	65	335	0
Non Pay Review		209	0			1,548	0	802	746
Interest Receivable	Pg. 4	233	322			1,400	1,931		0
Provider Collaborative	Pg.	173	173			1,044	1,044		0
Total		**1,141**	**1,071**	**426**	**0**	**11,969**	**7,054**	**4,024**	**890**
Recurrent		1,057	1,071			10,943	3,551	2,888	
Non Recurrent		83		426		1,026	426		





Overall the Trust value for money programme has realised more than originally planned for April and May 2023. However future delivery remains a challenge with c. 41% highlighted as amber or red.

The tables above show that out of area placements (with additional information on out of area focus page) is ahead of plan along with workforce costs although these are currently showing as non-recurrent. Work will continue to move these to recurrent if possible.

Interest receivable is also ahead of plan with continued positive rates of interest recevied. This is forecast to continue for the remainder of the year with this line generating an additional £0.5m of income in year. This will help to mitigate slippage on other schemes; at the moment shown as a reduction of the agency and workforce workstream.

3.0 Statement of Financial Position (SOFP) 2023 / 24

Balance Sheet / Statement of Financial Position (SOFP)	2022 / 2023 £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	165,175	170,614	1
Current Assets			
Inventories & Work in Progress	231	231	
NHS Trade Receivables (Debtors)	1,574	1,321	
Non NHS Trade Receivables (Debtors)	2,853	1,689	
Prepayments	3,482	3,672	
Accrued Income	9,372	11,392	2
Cash and Cash Equivalents	74,585	77,736	Pg 15
Total Current Assets	**92,097**	**96,040**	
Current Liabilities			
Trade Payables (Creditors)	(6,524)	(11,113)	3
Capital Payables (Creditors)	(739)	(569)	
Tax, NI, Pension Payables, PDC	(7,696)	(7,984)	
Accruals	(32,952)	(33,252)	4
Deferred Income	(4,172)	(1,604)	
Other Liabilities (IFRS 16 / leases)	(51,979)	(58,944)	1
Total Current Liabilities	**(104,062)**	**(113,465)**	
Net Current Assets/Liabilities	**(11,965)**	**(17,425)**	
Total Assets less Current Liabilities	**153,210**	**153,189**	
Provisions for Liabilities	(4,319)	(4,254)	
Total Net Assets/(Liabilities)	**148,891**	**148,935**	
Taxpayers' Equity			
Public Dividend Capital	45,657	45,657	
Revaluation Reserve	14,026	14,026	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	83,988	84,032	
Total Taxpayers' Equity	**148,891**	**148,935**	

The Balance Sheet analysis compares the current month end position to that at 31st March 2023.

1. Increase in lease / rental costs with effect from 1st April 2023 were higher than expected (and relatively large increases had been included in the plan). This results in an increases in both assets and liabilities.

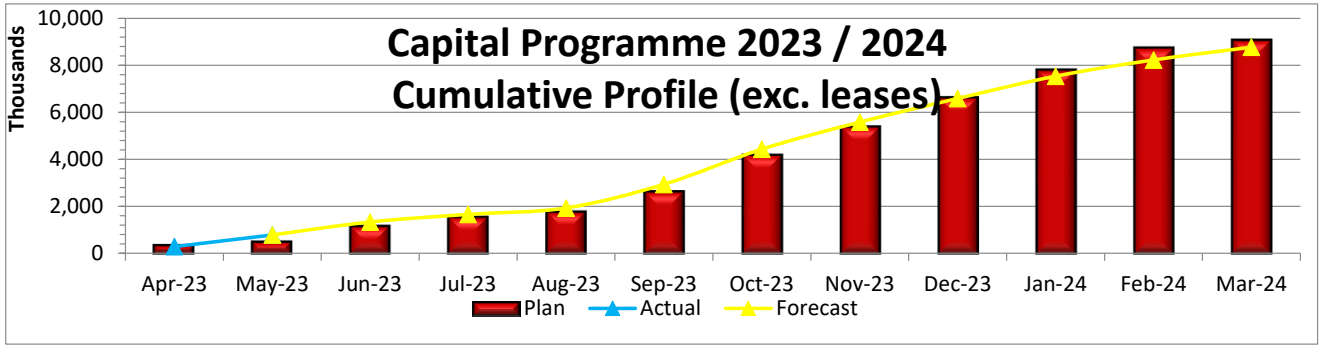
2. Accrued income includes £9m owed by NHS England in respect of funding for the central 2022 / 23 pay award, this is due to be paid in June 2023.

3. Trade payables are currently high due to a delay in April invoicing from some of our partners leading to two months outstanding in May. This is expected to reduce by the end of the quarter.

4. Accruals remain, as they were at year end, with the largest factor relating to estimated pay award payments to be made June 2023. This includes the centrally funded 2022 / 23 and also April and May 2023 relating to the 2023 / 24 pay award. This is expected to significantly reduce in June which will have an impact on the Trust cash position.

3.1 Capital Programme 2023 / 2024

Capital schemes	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k
Major Capital Schemes						
Site Infrastructure	1,475	0	0	0	1,475	0
Seclusion rooms	750	0	0	0	750	0
Maintenance (Minor) Capital						
Clinical Improvement	285	0	0	0	713	428
Safety inc. ligature & IPC	990	50	165	115	1,445	455
Compliance	430	150	0	(150)	200	(230)
Backlog maintenance	510	0	0	0	75	(435)
Sustainability	300	0	0	0	225	(75)
Plant & Equipment	40	0	0	0	45	5
Other	1,223	0	608	608	1,075	(148)
IM & T						
Digital Infrastructure	1,100	0	0	0	1,200	100
Digital Care Records	180	0	0	0	70	(110)
Digitally Enabled Workforce	815	35	0	(35)	815	1
Digitally Enabling Service Users & Carers	400	0	0	0	400	0
IM&T Other	270	0	0	0	280	10
TOTALS	**8,768**	**235**	**772**	**537**	**8,768**	**0**
Lease Impact (IFRS 16)	5,203	5,203	7,097	1,894	7,097	1,894
New lease	303	273	0	(273)	6	(297)
TOTALS	**14,274**	**5,711**	**7,870**	**2,159**	**15,871**	**1,598**



Capital Expenditure 2023 / 24

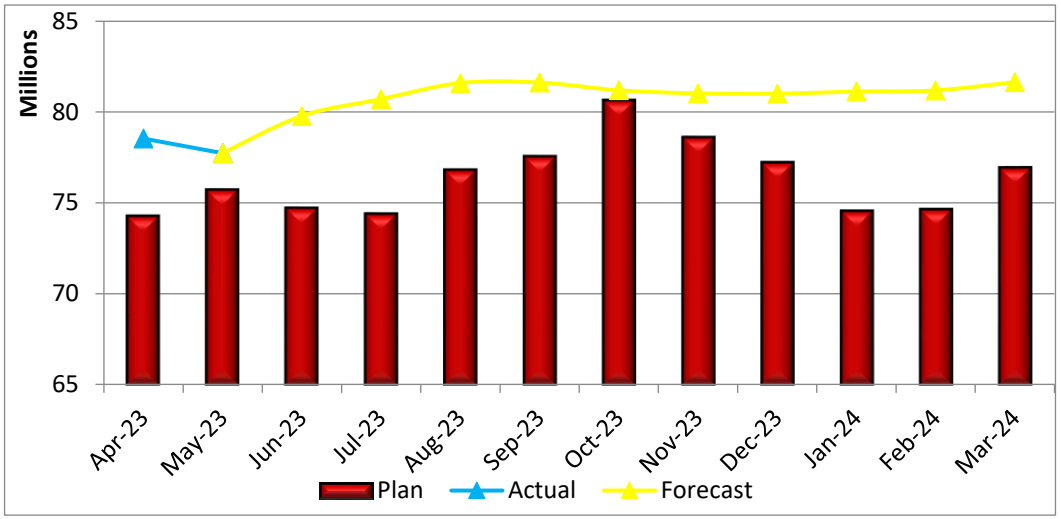
The Trust has continued to work within the West Yorkshire Integrated Care Board capital allocation in establishing it's capital programme for 2023 / 24. This totals £8,768k.

Changes, implemented under IFRS 16 (leases), mean that these costs are now included within the NHS England Capital Departmental Expenditure Limits (CDEL) but is separate from the ICB capital allocation so is presented below the line here.

Spend to date is ahead of plan. This relates to significant progress made on the door replacement programme and continued costs on 2022 / 23 schemes.

Major scheme and IM & T spend is profiled to commence later in the year.

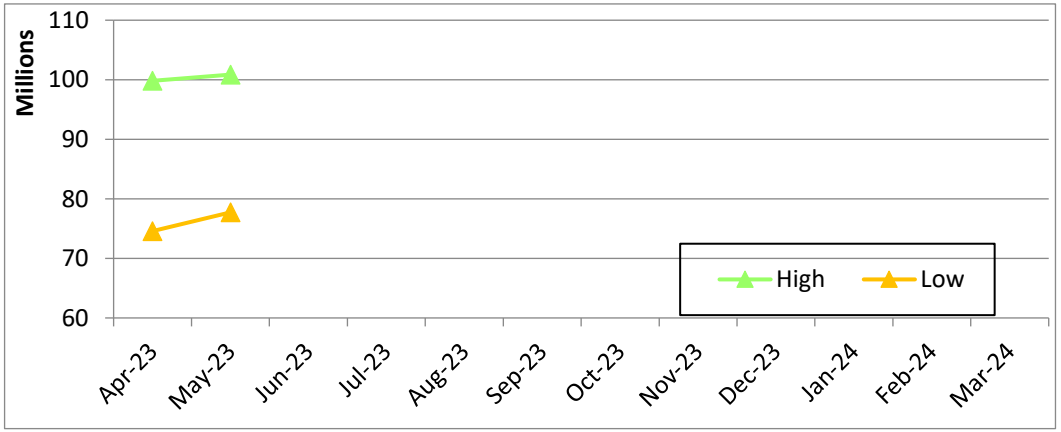
3.2 Cash Flow & Cash Flow Forecast 2022 / 2023



Cash remains healthy

Cash remains healthy and is expected to remain around the £80m value. The Trust is looking at investment options to maximise interest received.

	Plan £k	Actual £k	Variance £k
Opening Balance	74,585	74,585	
Closing Balance	75,720	77,736	2,016



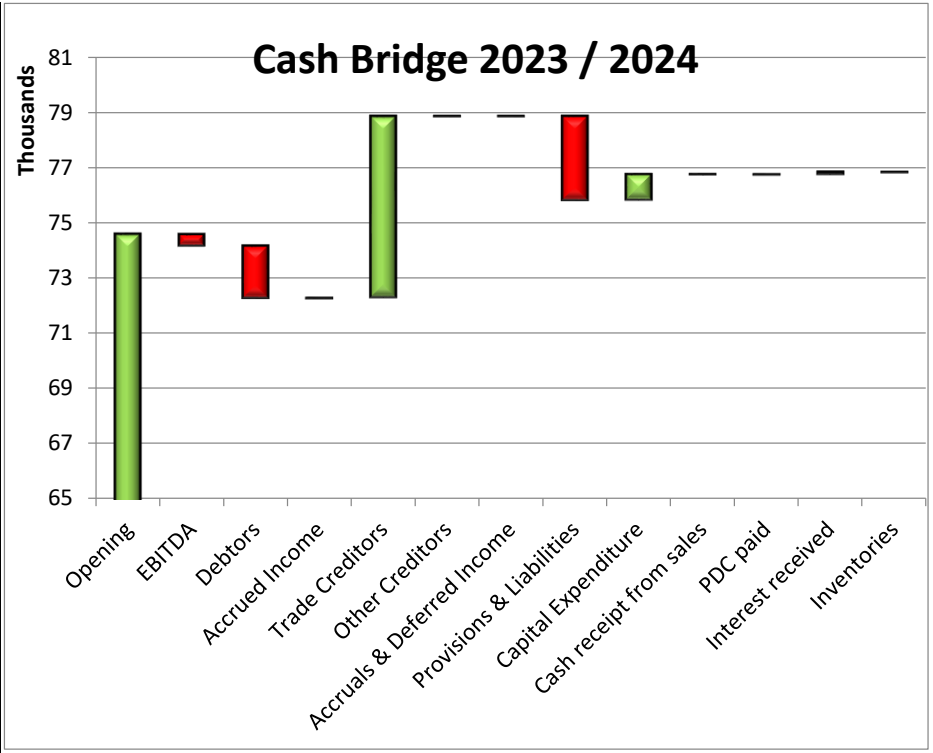
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £100.9m
The lowest balance is: £77.7m

This reflects cash balances built up from historical surpluses.

3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**74,585**	**74,585**	0	
Surplus / Deficit (Exc. non-cash items & revaluation)	2,748	2,335	(413)	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	707	(1,180)	(1,887)	
Trade Payables (Creditors)	(1,536)	5,031	6,567	
Other Payables (Creditors)	0		0	
Accruals & Deferred income	0		0	
Provisions & Liabilities	403	(2,633)	(3,036)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(1,699)	(772)	927	
Cash receipts from asset sales	0	0	0	
Leases	0	(231)	(231)	
PDC Dividends paid	0		0	
PDC Dividends received	0		0	
Interest (paid)/ received	512	601	89	
Closing Balances	**75,720**	**77,736**	**2,016**	



The table above summarises the reasons for the movement in the Trust cash position during 2023 / 2024. This is also presented graphically within the cash bridge.

Cash is £2m higher than plan, the main drivers is creditors (where NHS invoices have been delayed at the start of the year) offset by a movement in deferred income linked to the adult secure collaborative.

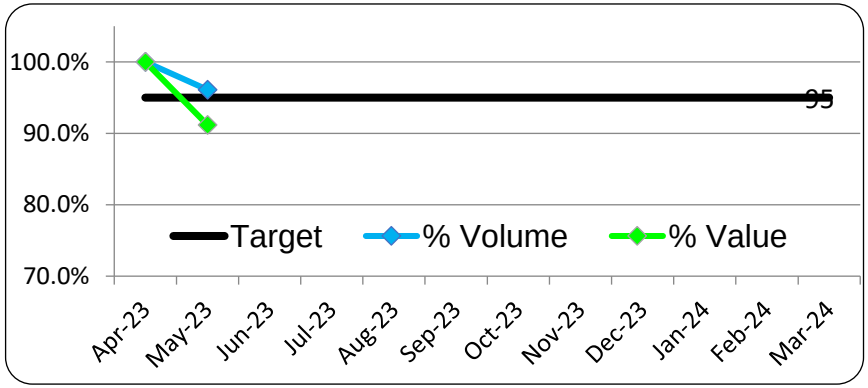
4.0 Better Payment Practice Code

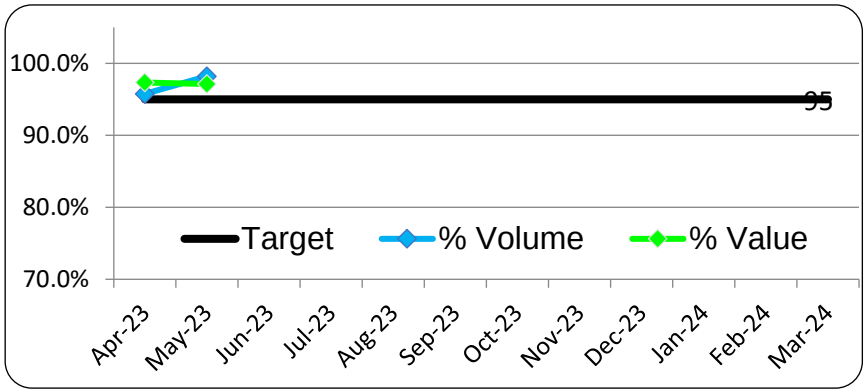
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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	96%	91%
Cumulative Year to Date	97%	96%

Non NHS	Number %	Value %
In Month	98%	97%
Cumulative Year to Date	97%	97%





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 (£)
12-May-23	Computer Software	Trustwide	Phoenix Partnership (Leeds) Ltd	14855	799,723
12-May-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	999400	575,400
16-May-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	999472	575,400
02-May-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS33	544,330
31-May-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS34	544,330
30-May-23	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	203290	511,436
22-May-23	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2100224982	500,000
22-May-23	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Tr	2100119072	500,000
02-May-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510007932	343,811
16-May-23	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 272	242,454
26-May-23	Regulator Fee	Trustwide	Care Quality Commission	43327845	219,969
04-May-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4891	181,295
02-May-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510007928	116,190
22-May-23	IT Services	Trustwide	Daisy Corporate Services	3I508753	90,250
15-May-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC012INV	81,813
30-May-23	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trus	323944	66,240
25-May-23	Drugs	Trustwide	Lloyds Pharmacy Ltd	115476	65,792
12-May-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	999399	63,962
16-May-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	999471	63,962
26-May-23	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	12811206	56,000
25-May-23	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	CHA03148	48,674
19-May-23	Utilities	Trustwide	Edf Energy Customers Ltd	000015280154	46,872
18-May-23	Drugs	Trustwide	NHS Business Services Authority	1000076860	42,214
03-May-23	Purchase of Healthcare	Barnsley	Touchstone-Leeds	SINV20230009	35,365
25-May-23	Mobile Phones	Trustwide	Vodafone Ltd	103880803	32,599
18-May-23	Purchase of Healthcare	Kirklees	Kirklees Council	8608025751	32,033
25-May-23	Mobile Phones	Trustwide	Vodafone Ltd	103693989	29,474
22-May-23	Utilities	Trustwide	Totalenergies Gas & Power Ltd	30126781823	29,077
02-May-23	Purchase of Healthcare	Kirklees	Ieso Digital Health Ltd	UK001307	28,672
12-May-23	Purchase of Healthcare	Barnsley	Cygnet Health Care Ltd	WKE0285916	28,590
12-May-23	Purchase of Healthcare	Kirklees	Socrates Clinical Psychology Ltd	SPS07831RMC7831	27,600
12-May-23	Purchase of Healthcare	Calderdale	Socrates Clinical Psychology Ltd	SPS07831RMC7831	27,600
23-May-23	Utilities	Trustwide	Edf Energy Customers Ltd	000015332536	27,190
15-May-23	Purchase of Healthcare	Kirklees	Priory Group Ltd	3900015956	26,085
12-May-23	Purchase of Healthcare	Calderdale	Cygnet Health Care Ltd	WKE0285915	25,830

4.2 Glossary

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

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

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

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

* Surplus - Trust income is greater than costs.

* Deficit - Trust costs are greater than income.

* Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.

* Forecast Surplus / Deficit - This is the surplus or deficit we expect to make for the financial year.

* Target Surplus / Deficit - This is the surplus or deficit the Board said it wanted to achieve for the year (including non-recurrent actions). This is set in advance of the year and before all variables are known.

* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. As such they are part of the forecast surplus, but not part of the recurrent underlying surplus.

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

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

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

* ICS - Integrated Care System. ICB - Integrated Care Board.

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

Appendix 2 - Statistical Process Control (SPC) Charts Explained

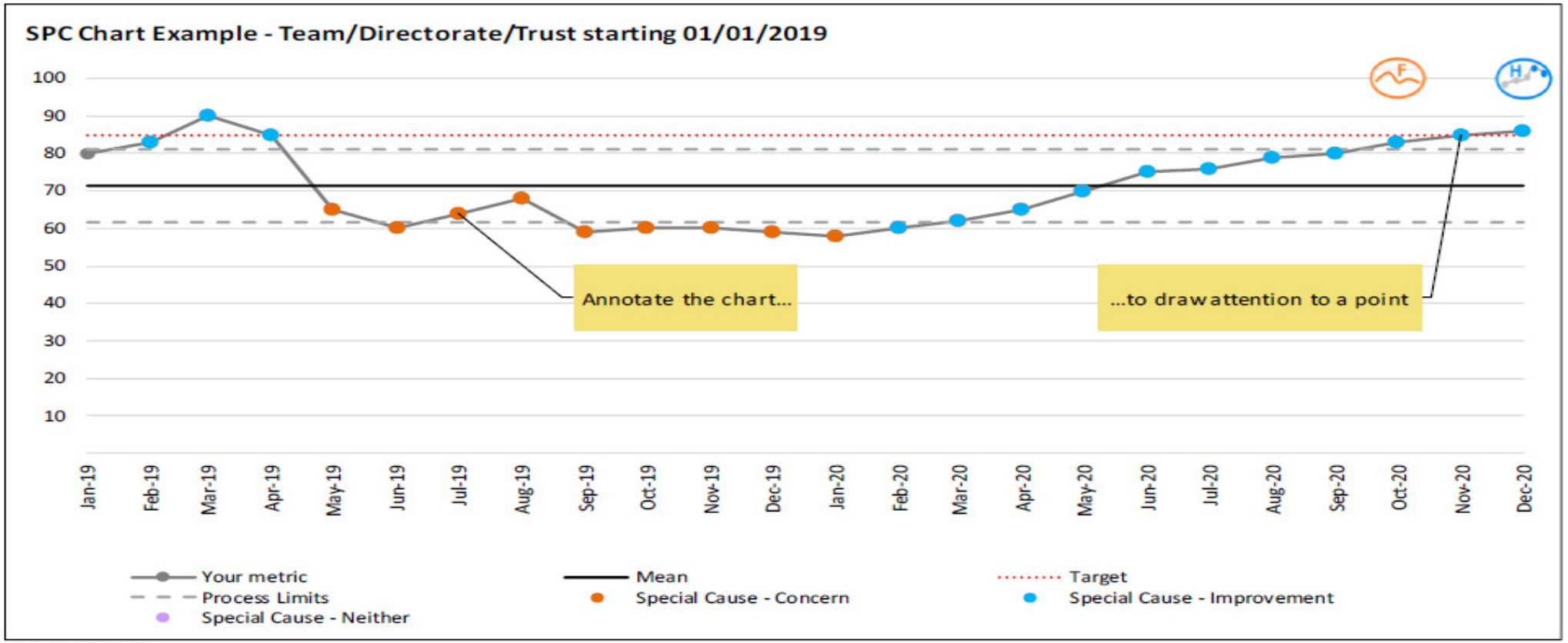
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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

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

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

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

Appendix 2 - Statistical Process Control (SPC) Charts Explained



Observations

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

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

Glossary

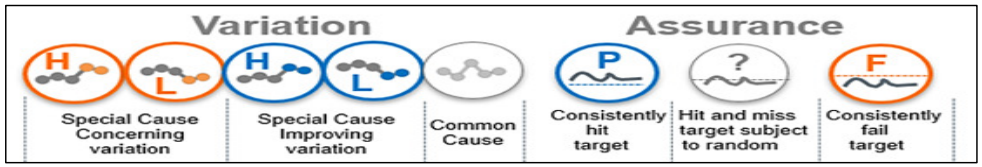
ACP	Advanced clinical practitioner
ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium 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 June 2023
Agenda item 9.2

Private/Public paper:	**Public**		
Title:	**National Staff Survey 2022: Communication, engagement and action planning update**		
Paper presented by:	**Lindsay Jensen – Deputy Chief People Officer**		
Paper prepared by:	Ashley Hambling, Senior Organisation Development Practitioner		
Mission/values:	Driving vision for the Trust as a Great Place to Work		
Purpose:	This report provides an update on the actions taken to communicate, engage and support action planning across the Trust.		
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 and staff experience and the inability to sustain safer staffing levels Risk 4.2 - Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively Risk 4.3 - Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Updates on the outcome of the national NHS staff survey allows the board of directors to see how the Trust benchmarks against other organisations and continue to support staff wellbeing, make SWYPFT a great place to work and contribute to the objectives of the ICP and ICB, and place-based partnerships.		
Any background papers / previously considered by:	Interim update paper on National Staff Survey 2022 administration was shared at April Board meeting.		
Executive summary:	The annual NHS Staff Survey was administered between 3rd October 2022 – 25th November 2022. Overall, the organisational results are positive compared to similar NHS providers and across our region, with 4 out of 9 key theme scores better than average.		

	The organisation development team (People Directorate) led a coordinated plan to communicate and engage key stakeholders, leaders and all staff with the survey results. The report provides an overview of the key themes arising from the service level action plans, linking these with the NHS People Promise focus areas. The majority of action plans focus on 3 of the NHS People Promise areas: We are safe and healthy (16); We are always learning(15); We are a team (11) Each service will provide an update on action plans to the People Experience team in Q2. Action plans are scheduled for discussion at the operational management group development day on 28/06/23 to align on implementation plans and maintaining momentum. The 2023 National Staff Survey will be administered in Sept/Oct 2023.
Recommendation:	**The Board are asked to NOTE and SUPPORT the updates provided in this paper.**

South West Yorkshire Partnership NHS Foundation Trust

National Staff Survey 2022: Communication, engagement and action planning update
Trust Board 27 June 2023

1. Introduction

The annual NHS Staff Survey was administered between 3rd October 2022 – 25th November 2022. The NHS staff survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experiences across the NHS. The survey is aligned to the NHS People Promise indicators.

Overall, the organisational results are positive compared to similar NHS providers and across our region, with 4 out of 9 key theme scores better than average. There are many examples of very positive results at service level, and there are also results which are below average particularly across our inpatient wards.

The Board received an update in April on the Trust results for substantive staff and bank only workers. This paper provides an update on the communications, engagement and action planning that has taken place since the results were received.

2. Survey Results – Communications, engagement and action planning

Employee surveys are a key tool to gather feedback and drive improvements in employee experience at work. The most essential component of survey projects is the actions which happen as a result. Managers of people and teams play a pivotal role in listening to and acting on feedback from their teams. Without this, the value of surveys is lost.

The Trust received an embargoed copy of the 2022 NHS Staff Survey Results on 21st of February 2023. The results are now publicly available for review via the NHS Staff Survey Coordination Site. Including the Trust overall benchmark report and detailed breakdown reports by Care Group/Business Service area

From early March 2023, the Organisation Development team rolled out a structured approach to communicating staff survey results across the Trust.

March ***Communicate Results***	• Key insights from the NHS Staff Survey results were shared with EMT, Trust Board and the People Remuneration Committee • March Extended EMT session included focused time to discuss results, align on ideas for how to improve our people theme scores, and commit to action planning with teams • The Brief – summary of key results for all staff • Staff Side- briefing on key results
April ***Engagement***	• The Brief – summary update on action planning and encouragement to get involved • People Experience OD team created and shared bespoke information packs with care groups and support services leaders. The packs detailed key insights at service level, as well as guidance on engaging staff and developing action plans • People Experience OD team meetings with General Manager, Quality leads to answer questions and provide expert support for survey action planning and engagement. Also attended leadership meetings.
May	• People Directorate/Staff side – planned meeting including agenda item to discuss staff survey results and action planning

Action plans	• Trust Partnership Forum - Staff side engagement discussions and alignment on insights and action planning • Operational Management Group – Briefing and update on survey results and action planning themes • Action plans completed by 12th of May. Services were asked to agree up to three NHS People Promise themes and actions to improve staff experience, using a standard action plan template
June	• The Brief – summary update on action plan themes and encouragement to get involved.

3 Summary of key themes in service level action plans

The table below provides the number of service lines across the Trust that have prioritised each NHS People promise theme. Many of the actions agreed by our services will improve staff experience across more than one theme.

NHS People Promise Theme	Number of service lines prioritising this theme
We are safe and healthy	16
We are always learning	15
We are a team	11
We are recognised and rewarded	9
We work flexibly	7
Morale	7
We each have a voice that counts	4
Staff Engagement	3
We are compassionate and inclusive	1

Care Group/Service Area Action plan themes

Barnsley

- Primary care and preventative services recently held a staff engagement day. An appreciative enquiry model of supervision has been implemented. Supervision will be used to discuss work life balance/flexible working and development conversations. Inpatient rehabilitation are looking to increase the effectiveness of team working, ensure all staff have a voice at work and increasing personal development opportunities. Team meetings are being used to reflect on 'Our Team' and 'Our Goals'. Workplace wellbeing sessions are also being planned.

- The long term conditions plan details the work to review staff working hours to meet both service demand and to support work life balance. Wellbeing champions are being recruited and work is ongoing to promote collective leadership. The health and welllbeing services plan includes facilitating team based learning and monthly discussion of personal development plans.

- The community mental health services plan includes further promotion of the Trust's wellbeing offer, development of team wellbeing plans, supporting team development and staff engagement in service improvement work.

Calderdale, Kirklees and Wakefield community mental health

- The Wakefield action plan focusses on workplace wellbeing and staff engagement. Each team is being supported to identify a wellbeing champion, the Wakefield wellbeing group is being re-launched and management supervision sessions will include a wellbeing conversation. The service is involving colleagues in service development through attendence at task and finish groups and project groups.

- Action plans for the community calderdale and kirklees mental health services include training and support for admin workers experiencing verbal abuse from service users, work on a standardised approach to hybrid working, and investment in learning and development. The Older People's plan has prioritised workplace wellbeing and flexible working, with each team agreeing their actions.

CAMHS

- The Wakefield CAMHS action plan has two priorities: improving service wide communication/ engagement, developing the role of the wellbeing champion.

- Kirklees and Calderdale CAMHS are seeking views from staff on how they can improve workplace wellbeing, sharing positive feedback from service users/families, and developing team working including arranging away days.

- Barnsley CAMHS have agreed to embed learning and reflective practice into their job plans, discuss workplace wellbeing in team meetings and spend time reflecting on the Trust values. The Wetherby and Adel Beck plan has prioritised learning and development opportunities, with the Wetherby service developing their own mission statement to strengthen team identity.

Mental Health inpatients

- The inpatients plan prioritises health and wellbeing given the concerns expressed by staff around safety and staffing pressures.
- Work is ongoing to reduce violent incidents and increase staffing levels.
- The plan also prioritises learning and development. The learning needs analysis has recently been reviewed and service development days are being arranged.

Forensics

- The Forensic action plan includes work to improve workplace wellbeing, increase staff recognition and support team development.
- A development session for wellbeing champions is being planned, the service is looking at ways to celebrate good practice and recognise staff's contribution.
- The service is considering ways to improve staff experience, for example increasing the amount of time staff spend with service users and reducing time spent on administrative tasks.

Learning Disabilities

- The action plan includes away days for the community teams, promoting staff engagement through question-and-answer sessions with the service director, and the service manager meeting with all new starters.
- Locality trios are being established to increase the support provided to staff.
- Work is ongoing in the Horizon centre including wellbeing champions, improving supervision arrangements and development sessions.

Support Services

- Each support service has also been developing their action plans.
- The People directorate used an away day to agree three priorities, we are recognised and reward, we are always learning and improving morale. Each operational team has agreed actions against these priorities.

- Pharmacy is arranging their own local team excellence awards to improve staff recognition. Representives from each staff group will attend leadership team meetings to share staff views. The other medical directorate teams have also agreed local actions.

- The nursing and quality plan was developed through their staff meeting, looking at ways to improve wellbeing and staff experience.

- The strategy and change team and the communications team have each agreed their action plans. These include looking at ways to increase connections between staff in the strategy team and improving staff recognition in the communications team.

- Estates and facilities are recommencing their workplace wellbeing group, using staff meetings to improve communications and will be promoting learning opportunities.

- The Finance plan also includes the promotion of learning opportunities and a review of hybrid working to increase time staff spend together and interacting.

- The Corporate governance and performance action plan includes a review of how the time teams spend together can improve team working and wellbeing. Appraisal discussions will be used to produce a learning needs assessment.

- The IM and T plan includes increasing opportunities for staff to share their views, ensuring all staff can access learning opportunities and continued review of hybrid working.

4. Next steps

We will continue to communicate with staff during 2023 to update them on action planning and provide OD support to encourage involvement in the implementation of service action plans. Each service will be asked to provide an update to the people experience team in quarter two, prior to the launch of the 2023 survey. The operational management group development day on the 28th June will be used to discuss action plans and our plans to engage and involve colleagues in their implementation during 2023.

Report Prepared by:
Ashley Hambling
Senior Organisation Development Practitioner

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2023
Agenda item 10.1

Private/Public paper:	**Public**		
Title:	**Incident management annual report 2022/23**		
Paper presented by:	Darryl Thompson, Chief Nurse/Director of Nursing, Quality and Professions		
Paper prepared by:	Helen Roberts, Patient Safety Manager		
Mission/values:	The report demonstrates the Trust's commitment to delivering safe and effective services and upholding our values.		
Purpose:	The purpose of the paper is to provide assurance to Trust Board that robust incident management arrangements are in place and to provide an overview of all incidents that take place within the Trust. The report includes data on Learning from Healthcare Deaths and learning from experience.		
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 leaving to a negative impact on quality of care.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Delivering safe and effective services is a priority of all health and social care providers. This is a shared priority across the Integrated Care System, Integrated Care Board, Place based partnerships and is a regular feature of our shared objectives and actions. Ensuring there is understanding of the incidents which take place within our services, the impact of these and the learning to ensure future risk or harm can be avoided, or reduced is essential. Sharing learning and best practice, themes, trends and analysis can help to identify opportunities to work together to address concerns or celebrate good practice. Learning form incidents can support to improve patient safety, staff and service user/carer experience and to provide assurance of good governance and risk management processes. All of which are required to deliver safe and effective services.		
Any background papers / previously considered by:	Clinical Governance and Clinical Safety Committee and Trust Board have received quarterly and annual Incident Management reports. Committee recommended this report to Board for approval in June 2023. Some minor		

	amendments have been made to the report since committee in response to further review prior to submission to Board.
Executive summary:	• The Trust continues to have a robust incident management process, maintained through a high level of scrutiny and governance. • We continue to focus on improving the quality of incident recording, and to strengthen our data quality processes for incident data to ensure accuracy. • We have also continued to develop the capture of protected characteristics for people affected by incidents. • Datix has been updated to capture abuse/hate related to any protected characteristic and this is reported into Clinical Risk Panel each week. • We have continued to develop our work to improve sexual safety. • We have continued to promote falls prevention, with promotion of falls assessments and post-fall protocol, and the Trust has appointed a dedicated Falls Coordinator. • The report includes achievements in the past year, and a summary of our work plan which aligns with the Quality Account areas for improvement and primarily focusses on work related to implementation of the Patient Safety Incident Response Framework (PSIRF) and Learn from Patient Safety Events. • The number of incidents reported across the Trust (14,352) has increased by 12% on the previous year. Analysis of the data has shown that harm levels have not overly increased despite the overall increase, and our serious incidents have reduced. We have continued to raise awareness and promote incident reporting through our learning sessions this year. • There is also a rise in the number of reported incidents of deliberate self-harm, from 770 in 2021/22 to 1,067. A group has been established to review our learning from this, which will report into the Clinical Governance Group and then Clinical Governance Clinical Safety Committee • 97% of all incidents reported resulted in no harm or low harm to patients and staff or were external to the Trust's care. A high level of incident reports, particularly of less severe incidents is an indication of a strong safety culture. • The number of serious incidents reported in the year has reduced (16) compared to last year; this is also reflected in the proportion of serious incidents to all incidents (0.11%). We have continued to strengthen our initial review process to ensure we are using our resources to investigate the right incidents, as this will be the approach in the future under the Patient Safety Incident Response Framework (PSIRF). • There were no 'Never Events' recorded during 2022/23. • As part of our usual processes, we have reviewed 253 deaths that were in our 'learning from healthcare deaths' scope. This compares with 307 in 2021/22. The reviews ranged from accepting the death certification, case record reviews through to investigations, in line with the National Quality Board levels.

	• Clinical Governance Clinical Safety Committee noted an increase in pressure ulcers from 717 incidents in 2021/2022 to 1,328 incidents in 2022/2023, an 85% increase. This increase is understood to be caused by multiple factors, including population-based factors such as deprivation, industrial disease, health inequalities and obesity, as well as the cost-of-living crisis, an increase in weather temperatures and patient acuity within that service. An increase in pressure ulcers has been noted nationally and internationally. Further team training, awareness sessions and learning from incidents is in place. All reported pressure ulcer incidents will continue to be reviewed in the weekly Clinical Risk Panel, for learning and to identify any potential lapses in care. A further analysis of pressure ulcers is underway, and findings will be submitted to the Clinical Governance Group in Quarter 2, and then Clinical Governance and Clinical Safety Committee. A sub-group of PSIRF will be focussing on understanding the learning. • We have incorporated 'learning from experience' into the report this year (Section 5). This illustrates our learning systems and examples of learning in practice and replaces the previously separate 'Our Learning Journey' report. It is proposed that going forward, the learning will be presented in this way in each quarterly incident report. **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 The incident management process supports the drive to reduce harm and learn from incidents to reduce risk and prevent recurrence in the future. For learning from healthcare deaths, we continue to meet the national guidance, and make revisions as needed. We publish our quarterly data on deaths on the internet page.
Recommendation:	**Trust Board is asked to RECEIVE and APPROVE the annual report on incident management and to NOTE the next steps identified.**

South West Yorkshire Partnership NHS Foundation Trust

Incident Management Annual Report

April 2022 to March 2023

Patient Safety Support Team

June 2023

With **all of us** in mind.

Executive Summary

This report provides an overview of **all** the incidents reported in the Trust during 2022/2023. It also includes further analysis of serious incidents reported and action themes arising from completed Serious Incident investigations submitted to commissioners for the period of 1 April 2022 to 31 March 2023 (data as at 6/4/2023). The report includes a summary of our learning from deaths activity and learning through the year.

- **14,352** incidents reported
- **12%** increase in reporting on 2021/2022
- **97%** of incidents resulted in no/low harm
- **16** Serious incidents reported
- No Never Events
- Serious Incidents account for **0.11%** of reported incidents
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture[1]

The Trust reported **14,352** incidents during the year: a 12% increase on 2021/2022. This is a demonstration of our good safety reporting culture, where staff feel able to report incidents and near misses. Analysis of the data has shown that whilst there is an increase in reported incidents overall, harm levels have not overly increased and our serious incidents have reduced[1]. This may, in some part, be due to the promotion of incident reporting through our learning sessions. A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety reporting culture. 97% of reported incidents resulted in low or no harm to patients, service users and staff, recognising that the Trust has a risk based and good reporting culture (compared with 97% in 2021/2022).

There were **16** serious incidents reported during the year, accounting for 0.11% of all incidents. The highest overall category of serious incident is apparent suicide of service users in current contact with community services (9), a reduction on 2021/2022 (16). It should be noted that not all suicides are investigated as serious incidents.

No 'Never Event' (Department of Health, DOH) incidents were reported by the Trust in 2022/2023. The last Never Event reported by the Trust was in 2010/2011. A Never Event is a list of serious, largely preventable patient safety incidents that should not occur if the available, preventative measures have been implemented.

[1] NaPSIR 2021 (england.nhs.uk)

Contents

Introduction

This incident management annual report focusses on incidents and serious incidents reported within the Trust during 2022/2023 and incorporates Learning from Healthcare Deaths reporting. It provides an overview of all incidents reported however does not include detail of specific incident types. Specialist advisors produce separate annual reporting for this purpose. The report does not cover incidents that are managed through other processes such as safeguarding (including Serious Case Reviews (now known as Safeguarding Child Practice Reviews), Domestic Homicide Reviews or whistleblowing (staff survey). The information in this report is high level, and further breakdown is possible on Datix. Further information can be provided on request.

The patient safety support team prepared a separate 'Apparent suicide report' for deaths occurring in 2022/2023, and this was presented to Clinical Governance Clinical Safety Committee in May 2023.

This year, a new section of the report has been introduced to cover learning. This provides an overview of our learning systems, and gives examples of learning from Care Groups, specialists and also learning from serious incidents and exploration of our main action themes.

The report does not include detail about broader patient safety work, this will be updated on separately when available/ as required.

The report is structured into the following sections:

Section 1 includes a summary of all reported incidents occurring from 1 April 2022 to 31 March 2023. It should be noted that this report provides only an overview; further reports are prepared for covering more breakdown through the year, and specialist advisors run/analyse incident reports.

Section 2 focusses on incidents reported as serious incidents during 2022/2023. This is broken down into two sections, The incident type, and then the detail.

Section 3 sets out an analysis of the serious incident investigations that have been completed and sent to commissioners during 2022/2023. It includes an analysis of the themes arising from serious incident recommendations.

Section 4 focusses on reported deaths in line with the Learning from Health care deaths policy.

Section 5 provides a summary of our learning systems, and learning from serious incidents, examples of learning from Care Group and specialist areas.

Section 6 is an overview of incident management plans for 2022/2023.

What we did in the past 12 months

Throughout 2022/2023, we have continued to make good progress with our patient safety strategy work in line with national priorities and developments. We have:

- Reviewed our internal patient safety strategy and agreed that our ambitions remained current as it is structured around the NHS patient safety strategy and reflects the ongoing national workstreams (described below). We will review our strategy at the end of 2023/2024 to consider future arrangements in line with NHS Patient Safety Strategy developments.
- Our patient safety specialists have joined a number of developing patient safety networks within all our places and with Integrated Care Boards (ICBs) and provider collaboratives colleagues along with regional and national level networks to support the patient safety priorities. Their work through the year has focused on those national priorities, as summarised below:

Improving quality of incident reporting

- Continued to focus on improving the quality of incident recording
- Continued to strengthen our data quality processes for incident data to ensure accuracy
- Delivered bite sized learning sessions on Duty of Candour, completing Manager's 48-hour reviews, reporting incidents, reviewing incidents, grading incidents, searching, and navigating Datix. These sessions aim to improve quality of information
- Continued to develop the capture of protected characteristics for people affected by incidents. Datix has been updated to capture abuse/hate related to any protected characteristic. This is reported into Clinical Risk Panel each week

Improving safety culture

Overall numbers of incidents and levels of severity and harm are monitored at Care Groups, Clinical Governance and Clinical Safety Committee and Board through a range of reports. The Trust continues to work to increase overall incident and near miss reporting as part of safety culture work. In 2022/2023, 97% of all incidents reported resulted in no or low harm or were not related to Trust care. 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.

This year we have seen a change in incident reporting patterns with a 12% increase on the previous year. This is a demonstration of our reporting culture, where staff feel able to report incidents and near misses. Analysis of the data has shown that whilst there is an increase in reported incidents overall, harm levels have not overly increased and our serious incidents have reduced. This may, in some part, be due to the promotion of incident reporting through our learning sessions.

In addition, we have:

- Developed policies and procedures in the People Directorate that support a restorative and just culture
- Continued to promote our Freedom to Speak Up Guardians and training
- We have supported Forensic Services with undertaking culture surveys to help with safety culture, team working and communication
- Teams have continued to use safety huddles to aid team communication and support safe care

Transition to the new Learn from Patient Safety Events (LFPSE) service.

- Learn From Patient Safety Events (LFPSE) is 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)
- We have been configuring our Datix test environment and achieved the technical connectivity to LFPSE by the 31 March 2023 timescale. We continue to work on our live system transition by 30 September 2023.

Preparations for Patient Safety Incident Response Framework (PSIRF)

The Patient Safety Incident Response Framework (PSIRF) was launched by NHS England in August 2022. It sets out NHS England's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. There is a 12-month preparation guide we are working through with the aim of transitioning in Autumn 2023. The culmination of the preparation work will be two documents:

- Patient Safety Incident Response Plan - setting out how we will respond to our patient safety priorities with a focus on learning and improvement.
- Patient Safety Incident Response Policy – describing the systems and processes we develop to learn and improve following a patient safety incident.

We have, and continue to work on, a number of workstreams to support our transition:

- Held a launch event in October 2022 with Trust stakeholders
- Established PSIRF implementation team and project groups
- Reviewed our existing investigation processes against the PSIRF Standards and process mapped to identify areas for improvement that will support our transition to PSIRF
- Mapped our services
- Commenced mapping our current incident responses to help us understand our capacity for responding to patient safety incidents
- Commenced analysis of patient safety incident data, and this continues to be refined
- Reviewed our processes to ensure aligned with Just culture
- Mapped our existing improvement activity
- Reviewed our existing engagement processes against the new requirements and identified areas for improvement
- Continued to attend PSIRF network meetings at place, region and national levels for insights into best practice
- Sought extensions to our existing related policies so they can be reviewed as part of our PSIRF work.
- Continued our liaison with ICB and provider collaborative colleagues regarding oversight of the process
- Invited to be part of the Patient Safety Collaborative PSIRF Steering group
- Reviewed our Clinical Risk Panel meeting and processes to ensure it aligns with PSIRF for the future

Responding to National Patient Safety Alerts

- A new provider process flow for National Patient Safety Alerts was published in March 2023. We have been reviewing our process for managing alert implementation.

Improving patient safety education and training

- Patient safety training for all staff is essential in supporting learning and improvement and in understanding how all our roles support patient safety. The training is available on our Electronic Staff Record.
- Throughout the year, we have developed business cases to support:
  - Level 1 essentials training for all staff began in November 2022 and we are making good progress. It will be mandated from November 2023
  - Level 2 training (access to practice) is also available for groups of staff who have roles relating to patient safety or incident management
  - We are currently planning our implementation of Level 3 training (investigation, oversight, and engagement and involvement) for those in specialist roles

Patient safety improvement work

We have:

- Continued to work with the patient safety collaborative on reducing restrictive practice
- Launched our Suicide Prevention Strategy
- Continued to develop our work to improve sexual safety including recording on Datix
- Continued to promote falls prevention, with promotion of falls assessments and post fall protocol and appointed a dedicated Falls Coordinator
- Continued our implementation of e-prescribing system to aid medication safety

- Delivered systems analysis training for Care Group and specialist colleagues
- Delivered other training previously mentioned
- Incorporated our Care Group patient safety actions into their local quality improvement plans
- The patient safety strategy group has met less frequently to enable focused work on PSIRF, LFPSE and data requests; however, work has continued, and we have provided updates via other routes, e.g., Governance Group and Clinical Governance and Clinical Safety Committee.
- An internal audit of our serious incident action planning was concluded in August 2022, receiving significant assurance. The audit identified three actions to further strengthen our processes. As a result, we have developed a procedural document to standardise our approach and amended our reports to highlight outstanding actions and capture the rational for any delays. All actions have been completed.
- We undertook a review of the identification of Notifiable Safety Incidents and Duty of Candour monitoring recording during the year. We found some common themes particularly around Notifiable Safety Incidents. We shared the learning with quality and governance leads.
- Continued to develop and improve our method of sharing learning (see separate section)
- Made further improvements to Datix for the collection of protected characteristics data for those restrained in line with the Use of Force Act (2021)
- Datix system upgraded to ensure alignment with latest developments and best practice.

Learning

Through the year, we have continued to develop our learning systems. Our learning summary is included in Section 5, learning from experience.

Section 1 - Incident Reporting Analysis

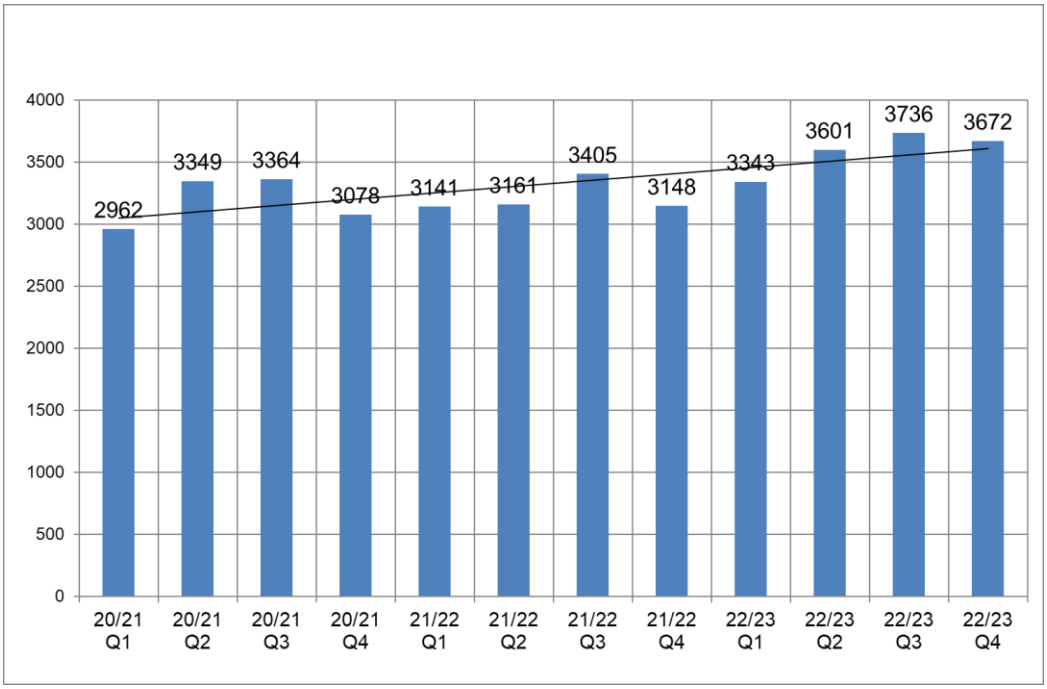
Headlines

The Trust reported **14,352** incidents of all severities during the year, a **12%** increase on 2021/2022 (12,807). This is a demonstration of our reporting culture, where staff feel able to report incidents and near misses. Analysis of the data has shown that whilst there is an increase in reported incidents overall, harm levels have not overly increased and our serious incidents have reduced. [2]. This may, in some part, be due to the promotion of incident reporting through our learning sessions.

- **14,352** incidents reported
- **12%** increase in reported incidents compared with 2021/2022
- **97%** of incidents resulted in **no/low harm**
- **16** Serious incidents reported (0.11% of all incidents)
- 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 over the last three financial years, and indicates the average is increasing gradually, with natural fluctuations each quarter. It should be noted that direct comparisons should be viewed with caution due to the potential changes in service provision over time.

Figure 1 Comparative number of incidents reported by financial quarter 2020/2021 to 2022/2023

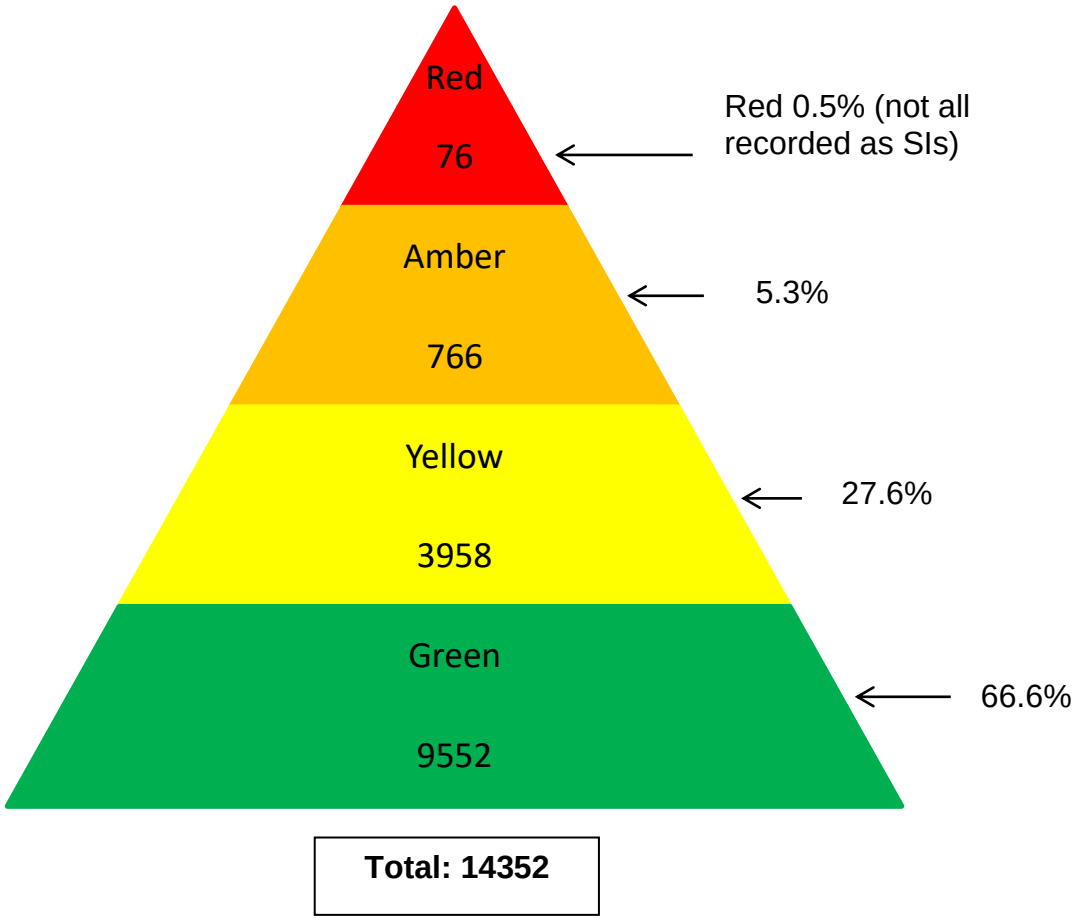


[2] NaPSIR 2021 (england.nhs.uk)

Severity

Severity 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). The distribution of these incidents in terms of severity is pyramid-shaped (figure 2) with red incidents being fewest in number; and 66.6% being graded green.

Figure 2 Incidents reported by severity 2022/2023



Note: The red incidents in this chart are based on the date when the incident occurred, which is often different to the date it was reported on the Strategic Executive Information System (StEIS) as a Serious Incident (SI), which uses the date reported on StEIS. Not all red incidents are reported as SIs. Red incidents include unexpected deaths where the cause of death is not yet known. Incidents are re-graded as further information is received.

Actual harm

In addition to the severity of incidents, we also record the level of harm that was caused by an incident, irrespective of the severity. This is called the degree of harm. In 2022/2023, 97% of incidents resulted in no harm or low harm to patients and staff or were external to the Trust's care. The proportion of no/low harm incidents has remained consistent with previous years. An organisation with a high reporting rate, particularly with a high proportion of no/low harm is indicative of a positive safety culture where staff are encouraged to report incidents and near misses.

Type and category of incidents

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 ‘sub-categories’.

Figure 3 below shows all reported incidents in 2022/2023 by the type of incident. Violence and aggression incidents are the highest type of incident.

Figure 3 Trust-wide incidents reported by type of incident during 2022/2023

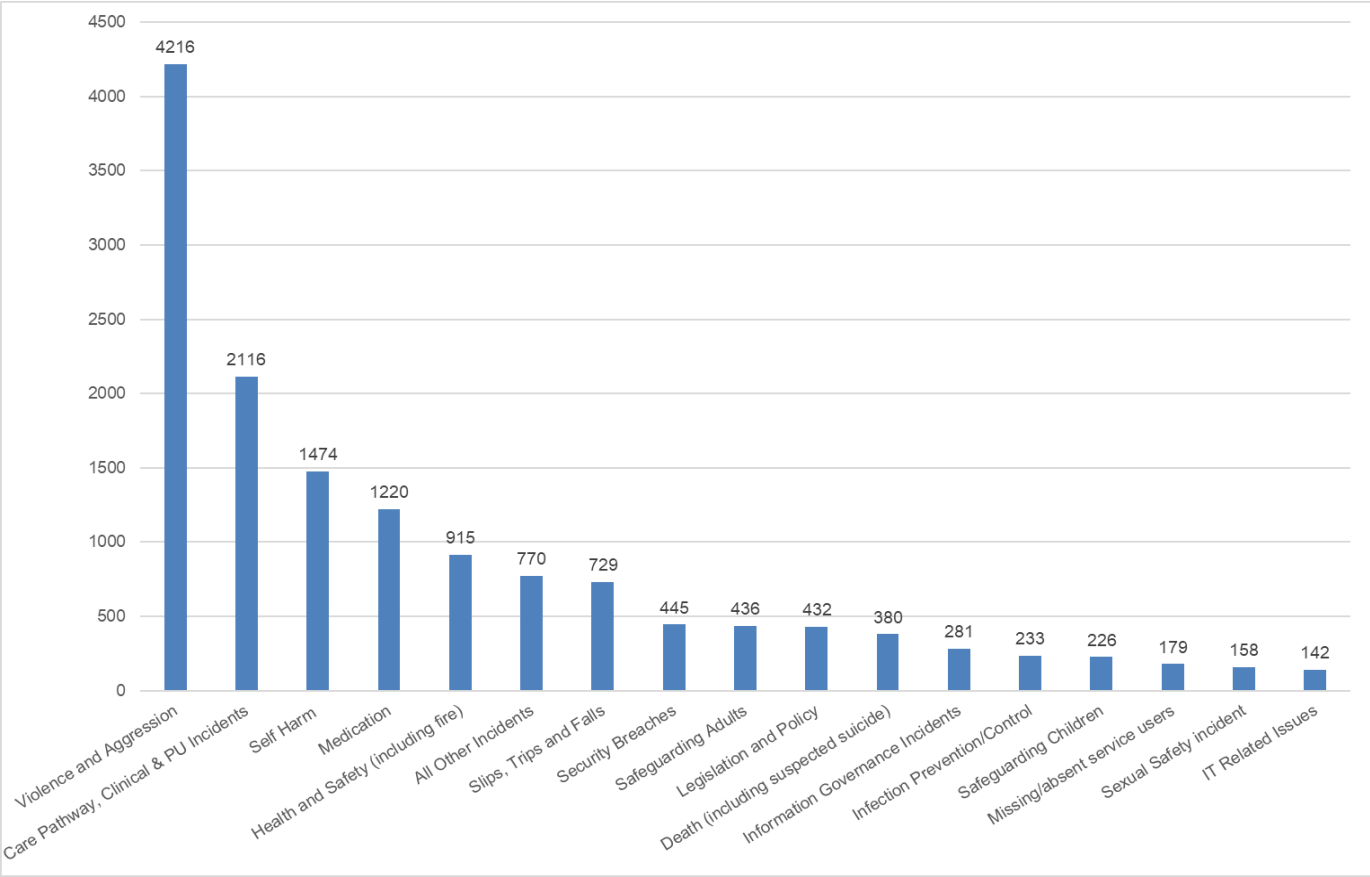
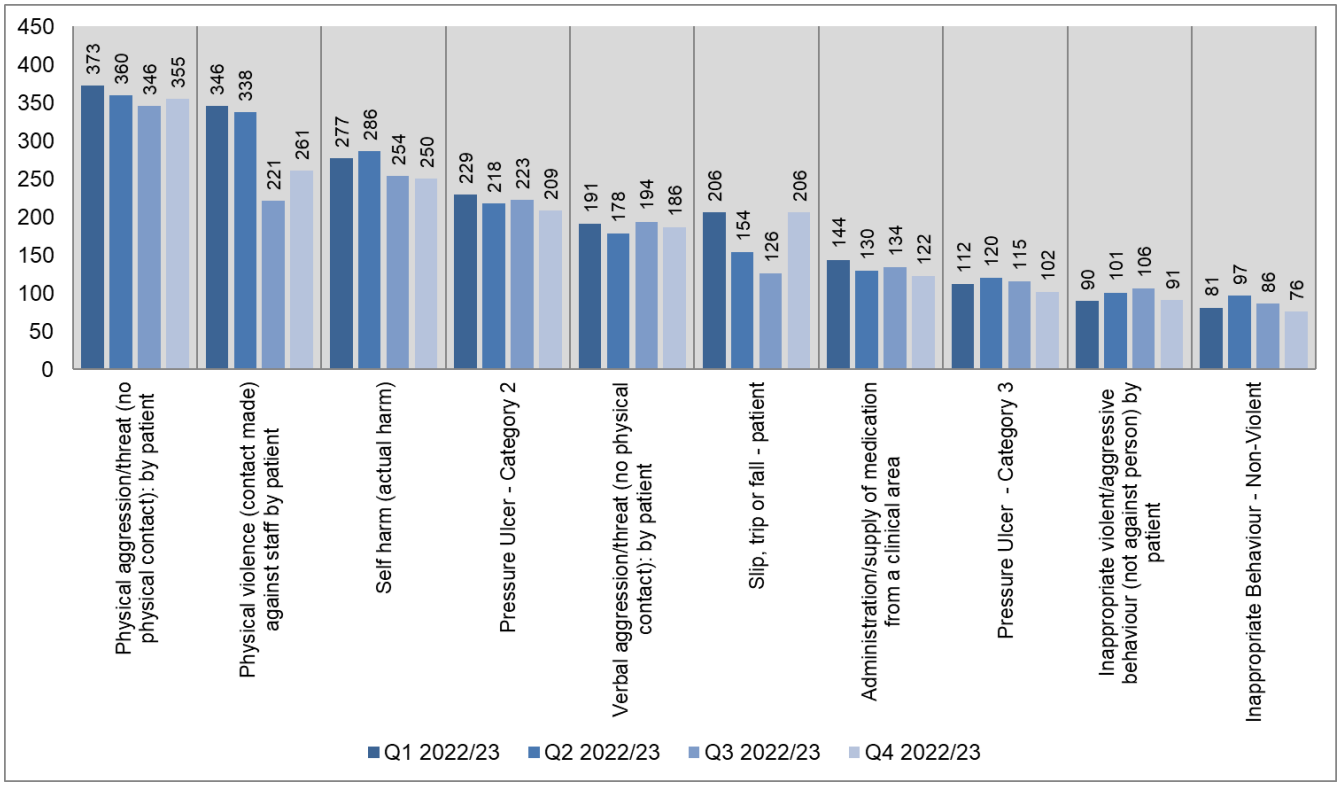


Figure 4 shows the top 10 highest reported categories of incidents across the Trust during 2022/2023. During 2022/2023 incidents were reported against 156 different categories of incident. The top 10 categories account for 54% of all incidents reported, which is consistent with the proportion in previous years.

Figure 4 Trust-wide Top 10 most frequently reported incident categories in year 2022/2023



Analysis:

Physical aggression/threat

'Physical aggression/threat (no physical contact): by patient' was the highest reported incident category in 2022/2023 with a total of 1,434 incidents, accounting for 10% of all incidents reported. This is an increase on 2021/2022 (1,362) but this has remained the top reported category in the last five years. 98% of these incidents resulted in no harm or low harm. This includes incidents such as threatening behaviour against others or where physical violence was prevented.

There are three categories of violence and aggression related incidents appearing in the top 10; 'Verbal aggression/threat (no physical contact): by patient', 'Physical violence against staff by patient (where contact was made)' and inappropriate violent/aggressive behaviour (not against person) by patient.

In 2022/2023, there have been some service users admitted with complex and challenging needs. Horizon centre had two service users for the first two quarters then three for the next two quarters with complex and challenging needs accounting for virtually 100% of the aggressive incidents, restraints, and seclusions within the wards. When we consider these service users and the effect on the whole figure across the four financial quarters the impact can be seen, 32.4% of assaults on staff contact made in Q1, 33.3% of assaults on staff contact made in Q2, 45.3% of assaults on staff contact made in Q3 and 38.9% of assaults on staff contact made in Q4 and 38.3% for the whole financial year. The reducing restrictive physical interventions (RRPI) team have been working alongside the staff team on the Horizon centre offering individual specialist advise and additional bespoke training sessions to assist in the reduction of incidents.

The main trigger for assaults on staff (contact made) are the occasions that staff must intervene i.e., to assist with personal care with service users who are significantly cognitively impaired, to stop service users' behaviours that pose a risk to self or others and to enforce medication under the Mental Health Act.

In relation to verbal aggression/threat (no physical contact): by patient, and inappropriate violent/aggressive behaviour (not against person) by patient it is understood that individuals within our services have high levels of stress, a significant trauma history and mental health problems or a combination, this can lead to times of high expressed emotion. The Trust and the RRPI Team are looking at all interventions that may alleviate this e.g., strengthening the use of advanced statements that put the service users wishes at the centre of the care given. The Trust is working towards being a trauma informed care led organisation, this along with de-escalation and managing incidents without force forms a large part of the RRPI training and ethos. The RRPI Team have once again been revalidated by The Restraint Reduction Network (RRN) a nationally recognised organisation in best practice in restrictive physical interventions. The RRPI Team supported by the Trust have now increased the ability to gather data on service users protected characteristics to examine any potential impacts these may have on an individual's behaviour.

The Trust in collaboration with the RRPI Team continues to look at all interventions that help in reducing physical interventions by actively taking part in research projects helps to find effective solutions for reducing violence and aggression. The increased activities within the therapeutic interventions and the work of the RRPI teams in supporting staff to plan care and interventions with the support of a positive behaviour support (PBS) care plan, have all contributed to a decline in patient on patient violence and aggression.

Self-Harm (actual)

The third highest category of incident is 'self-harm (actual)'. In 2022/2023 there were 1,067 actual self-harm incidents which is an increase from 2021/2022 (770). Whilst this is an increase, 2021/22 was a lower figure than the previous year (933). The figures for self-harm fluctuate through the year and numbers are closely affected by individual service user presentation. This has moved from the fourth highest incident in 2021/2022 to third highest in 2022/2023, with an increase of 38%. Self-harm data is being explored through the Patient Safety Incident Response Framework Implementation Groups to identify where we need to identify new learning, and what improvement work may be required going forward. This work will be communicated to the Clinical Governance Group and then Clinical Governance Clinical Safety Committee.

Pressure Ulcers

Pressure ulcer category 2 and 3 appears in the top 10, this has increased from 717 incidents in 2021/2022 to 1,328 incidents in 2022/2023 which is an 85% increase. It should be noted these are incidents that are generally identified by staff in the general community services, and many are attributable to other agencies. The Datix system is used to capture the identification and actions taken by our staff.

There is discussion in the tissue viability community both nationally and internationally which suggests pressure ulcers have increased since the pandemic, which could be linked to a rise in obesity, diabetes, cancer, orthopaedics, co morbidities, and patients who are taking multiple medications to manage other long-term conditions. We are awaiting evaluation papers. The increase in pressure ulcers has seen a dramatic increase not just in patients being referred into the Trust but also patients under the care of the Trust.

The majority of pressure ulcers occur within Barnsley neighbourhood nursing teams, and the care and treatment falls within the role of these teams. The services as a whole in Barnsley physical health care services have seen referrals increase and greater demand across all specialties; this reflects in longer service waiting times. Late treatment, consultations, reviews etc. all have an impact on people's management of long-term conditions. They become frail generally, have reduced mobility, poly pharmacy and temporary measures are put in place whilst patients wait for correct treatment.

It must be noted in comparison to the number of patients on caseloads that are at risk of pressure damage and have a preventative care plan in place vs patients with a pressure ulcer is a reduced percentage from previous years. This is going to be further explored through the pressure ulcer quality improvement work.

The tissue viability team have trained care home and agency staff bi-annually as well as producing pressure ulcer classification leaflets and guides.

Patient Falls

Patient falls appears in the top 10, as it has done in previous years. The reporting remains relatively consistent through the year and is smaller to previous years. The degree of harm has remained similar to 2021/2022 with 98% of patient falls resulting in no harm or low harm or were external to the Trust's care.

Most falls are linked to increasing frailty, age, and loss of balance. There is also a higher percentage of patients with dementia, Parkinson's disease, agitation, and associated medications that are prescribed due to unsettled presentation or inability to sleep that can have a sedative effect, increasing the chances of having a fall. Nearly 40% of the falls between 1 August 2022 – 31 January 2023 were linked with 16 patients who had repeated falls, with a higher percentage of those having a dementia related diagnosis. However, overall, they were found to have less significant injury. High percentages of the slips, trips and falls were unwitnessed.

Planned intervention:

- The Trust appointed a full time falls coordinator in 2022/2023
- The falls coordinator will review slip, trip and fall incidents figures weekly. To support a proactive approach and have early recognition of any potential repeat fallers. These accounted for a high percentage of the total slips, trips, and falls' figures
- Environment Risk Assessment Tool is being reviewed/developed by the Matron for Wards 19/18. Eventually, this is planned to be used Trust-wide to identify environmental falls, risks and support early intervention on the wards
- Due to the ongoing development on Ward 19, some other interventions that have been in place to minimise the risk of falls are:
    - Motion sensor lights that are activated when they detect unusual movement
    - Revised training on the use of post falls protocol
    - Remote falls alarms (for beds and chairs)
    - Fixed Passive Infrared (PIR) falls sensors in each bedroom
    - Handrails for support on the elderly wards
- Falls coordinator is contacting key staff across the Trust to introduce self and falls awareness
- Falls awareness e-learning package is being developed for all staff across our Trust
- Two day falls, and osteoporosis risk/awareness training is available. Key staff across inpatient services are being identified to attend to hopefully champion falls awareness and risk assessment. This training has historically been accessed by Barnsley community staff

Administration/supply of medication from a clinical area

Administration/supply of medication from a clinical area appears in the top 10, as it has done in previous years. This is the only incident category which has decreased in the top 10. In 2021/2022 582 incidents were reported compared with 2022/2023 when 530 incidents were reported.

These incidents have steadily decreased quarter on quarter over the last 18 months, likely due to the implementation of electronic prescribing and medicines administration (EPMA) which has been rolled out in the Trust over the last 18 months. Since the introduction of electronic prescribing there has been a significant reduction in missed doses and duplicate doses.

All medicine incidents are reviewed by the safe medicines practice group.

Affected Party Demographics

Appendix 1 provides a breakdown of some protected characteristics of those affected in the incidents.

External Review

Reporting to National Reporting and Learning System

The Trust captures the severity of all incidents locally on Datix using the risk matrix which scores incidents ranging from green through to red (see Figure 2). This includes actual and potential harm of all incidents and near misses (i.e., psychological harm, potential risks).

The Trust uploads patient safety incidents[3] (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. 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 harm was not to a patient. The NRLS scores the **actual** degree of harm caused, as opposed to including potential harm as collected locally.

The NHS patient safety strategy [4] published in July 2019 sets out plans for a new national reporting and learning system, Learn from Patient Safety Events (LFPSE), which will combine and replace NRLS and the Strategic Executive Information System (for reporting serious incidents). NHS England/Improvement expect all providers currently reporting to the NRLS to have transitioned to the new LFPSE system by the end of September 2023. We have begun work on our Datix test environment in preparation but are awaiting updates to functionality which will be available in Summer 2023.

The Learn from Patient Safety Events (LFPSE) system will:

- Collect information that is better suited to learning for improvement than what is currently gathered by existing systems.
- Make data on safety events easier to access, to support local and specialty-specific improvement work.
- Utilise new technology to support higher quality and more timely data, machine learning, and provide better feedback for staff and organisations.

In 2022/2023 the Trust uploaded a total of 6,035 patient safety incidents to the NRLS, compared with 6,097 reported in 2021/2022 Quality Accounts. 94% of the 6,035 incidents resulted in no harm or low 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[5].

The Trust reported a total of 63 severe harm and patient safety related death incidents in 2022/2023, compared to 53 incidents in 2021/2022 (as at 11/04/2023). This is a snapshot in time, but data may change if further information comes to light.

[3] 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.

[4] https://improvement.nhs.uk/resources/patient-safety-strategy/

[5] NaPSIR 2021 (england.nhs.uk)

In relation to the total number of incidents uploaded, the percentage of severe harm incidents has increased to 0.71% when compared with 0.31% in 2021/2022. The percentage of patient safety related deaths (uploaded to NRLS) has decreased to 0.33% compared with 0.55% in 2021/2022.

There has been a 12% increase in the total number of all incidents reported in 2022/2023. It should be noted that there is currently a backlog with data quality checks prior to uploading any patient safety incidents to the NRLS associated with the increased volume overall. There is a risk of delay in routine patient safety incident data reaching NRLS and onwards to the CQC, however serious incidents are manually submitted. We continue to upload on a weekly basis; however, the volume has been smaller. We have acted by protecting a day per week in the team to address this. We have prioritised some types of incidents for approval such as if an incident is linked to a CQUIN (Commissioning for Quality and Innovation).

National Reporting and Learning System reports

Patient Safety Incidents are currently uploaded to the National Reporting and Learning System (NRLS) when they have been through the internal management review and governance processes. This ensures that the data uploaded externally is as accurate as it can be. Data can also be refreshed if details change. 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.

NHS England publishes data from the NRLS system on annual basis. These reports are designed to assist NHS trust boards to understand and improve their organisation's patient safety culture and reporting of patient safety incidents to the NRLS and learn from incidents that have occurred. NHS England encourages organisations to compare their own data over periods of time, rather than trying to benchmark against other organisations which may not be comparable for a number of reasons.

Organisation Patient Safety Incident Report (OPSIR)

The OPSIR Report provides data by organisation on incidents reported from 1 April 2021 to 31 March 2022 and submitted to the NRLS by 31 May 2022.

National Patient Safety Incident Reports (NaPSIR)

The latest NaPSIR Report published in October 2022, covers the period 1 April 2021 to 31 March 2022 which were submitted to the NRLS up to June 2022. The report is published annually.

Two sets of data and analysis are presented in the NaPSIR data report:

- The number of reports made to the NRLS by quarter, using data based on the date that the report was received.
- An overview of patterns and trends in incident reports using data based on the date that the incidents occurred.

Internal Audit

An internal audit of our serious incident action planning was concluded in August 2022, receiving significant assurance. The audit identified three actions to further strengthen our processes. As a result, we have developed a procedural document to standardise our approach and amended our reports to highlight outstanding actions and capture the rational for any delays. All actions have been completed.

Duty of Candour

Duty of Candour applies to Notifiable Safety Incidents where harm occurred to a patient and resulted in moderate harm or above. The Trust has been following the principles of being open since 2008 and had a policy in place since that time. The NHS contract includes Duty of Candour for Notifiable Safety

Incidents, and the Trust has been reporting on this since April 2014. In November 2014 this was strengthened when this became a statutory CQC regulation[6] to fulfil the Duty of Candour requirement.

The CQC Regulation 20 sets out three questions that assist with deciding if something qualifies as a Notifiable Safety Incident or not. Healthcare professionals involved must use their judgement when answering the questions. The incident must meet all three to be a Notifiable Safety Incident* where the Duty of Candour must be applied:

1. It must have been unexpected or unintended (in relation to an incident which happened during the care and treatment we were providing, not the outcome of the incident)
2. It must have occurred during the provision of care and treatment by the Trust, which is regulated by the CQC
3. In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care. (This varies slightly depending upon the type of provider).

*Further guidance on the questions is available in the Regulation 20 document.

If any of these three criteria are not met, it is not a Notifiable Safety Incident. However, in these cases, we still have a duty to be open, honest and transparent with those affected. This is what we call Being Open.

Failure to comply with the contractual requirements could result in recovery of the cost of the episode of care or £10,000 if the cost of the episode of care is unknown (NHS Contract) and/or it is a criminal offence to fail to provide notification of a notifiable safety incident and/or to comply with the specific requirements of notification. On conviction a health service body would be liable to a potential fine of £2,500.

The data contained in this section of the report was correct at the time of reporting (12/4/2023). The data is extracted from a live system and is subject to change.

During 2022/2023, there were 374 potentially applicable Notifiable Safety Incidents (2.6% of all incidents reported; an increase on 2.03% in 2021/2022). It should be noted that there has been a 12% increase in the total number of all incidents reported in 2022/2023. The higher proportion of applicable incidents is particularly due to an increase in category 3 pressure ulcers (moderate harm), and category 4 pressure ulcers (severe harm). Please refer to comments earlier in the report regarding the increase in pressure ulcer incidents.

Monitoring of Notifiable Safety Incidents is reported via the Integrated Performance Report and to the Operational Management Group on a monthly basis.

We undertook a review of data in Quarter 1 2022/2023 and identified that staff were often cautious when answering the three questions resulting in potential over reporting of Notifiable Safety Incidents, or there were gaps in recording, but Duty of Candour had been completed. This impacts on the ability to run reports – we have to include any potential Notifiable Safety Incident in our figures at the present time. Further guidance has been issued by CQC in Regulation 20 to clarify the 'unexpected or unintended' question. We have completed quality improvement work to share learning, through delivery of a question and answer session on the changes and how to answer the three questions correctly, (which was recorded and this shared on the intranet) continued to offer advice to staff, and have updated the intranet pages accordingly.

Figure 5 shows the 374 incidents by Care Group with the highest number of potentially applicable incidents in Barnsley General Community Services with 245 incidents [an increase on 2020/2021 102]. A high proportion of these were pressure ulcers, category 3 (moderate harm).

[6] Care Quality Commission. Duty of Candour guidance

Figure 5 Duty of Candour applicable incidents in 2022/2023 by Care Group and financial quarter

Care Group	BDU	Quarter 1 2022/2023	Quarter 2 2022/2023	Quarter 3 2022/2023	Quarter 4 2022/2023	Total
Barnsley Integrated Care Group	Barnsley General Community Services	57	56	63	69	245
	Barnsley Community Mental Health Services	2	1	2	8	13
Adult and Older People Mental Health Care Group	Mental Health Inpatient Services	10	13	15	13	51
	Wakefield Community Mental Health Services	5	5	7	5	22
	Kirklees Community Mental Health Services	5	4	3	5	17
	Calderdale Community Mental Health Services	4	4	2	3	13
Forensic Care Group		5	2	3	1	11
Learning Disability and ADHD/ ASD Care Group		1	0	0	0	1
Trust wide (Corporate support services)		0	0	1	0	1
Total		**89**	**85**	**96**	**104**	**374**

There is often a higher figure in Quarter 4 due to incidents that are awaiting Manager's review or Care group monitoring check of the accuracy of identifying Notifiable Safety Incidents.

Compliance with Duty of Candour

Each Care Group should have identified lead/s who are responsible for reviewing their Care Group's compliance with Duty of Candour and for supporting their staff with decision making and recording. All Trio managers/leaders have access to live data on Datix Dashboards to aid monitoring. Further breakdowns are provided to deputy/service directors when required.

Patient safety support team routinely provide information on Notifiable Safety Incidents and Duty of Candour compliance to the Operational Management Group to enable them to monitor Care Groups compliance. The number of incidents achieving compliance, breaches and exceptions are provided in the Integrated Performance Report each month. The annual figures are summarised below.

Figure 6 shows the monitoring position which breaks down as below:

- In 89% of cases (333), a verbal conversation has happened with the patient and/or family within 10 working days of the incident occurring or being identified (as per the contract).
- There were 18 cases where Duty of Candour was not completed but exception reasons were given (5%). The number of exceptions has decreased from 7% in 2021/2022)
- There were 17 cases (5%) where the Duty of Candour monitoring was not yet completed by the Care Group (at 6/4/23), (including waiting for further clarification from the manager) these could include possible breaches. This compares with 7% (18) reported in 2021/2022 annual report.

There were six breaches of Duty of Candour reported, representing 1.6% of all applicable incidents.

The six Duty of Candour breaches all involved community patients who self-harmed resulting in moderate or severe harm. The breakdown of the six breaches are below:

1. A community patient self-harmed at home. Staff contacted emergency services and the patient was taken to the acute hospital in an ambulance and was treated in an Intensive Care Unit (ICU). The team were unable to undertake duty of candour because the patient was uncontactable in ICU. The team subsequently spoken to the patient's mother who contacted them, and an apology was provided to her.
2. A community patient self-harmed. The patient received treatment in the acute hospital as a result of the self-harm. The Duty of Candour apology was carried out during home visit at a later date.
3. A community patient self-harmed at home. The patient was transferred to the acute hospital and was treated in an Intensive Care Unit (ICU). The community team contacted family at the time of the incident to offer support which was declined. The patient was in ICU therefore staff were unable to apologise within the time frame. Associate quality & governance lead visited the service user following transfer to a Mental Health ward and Duty of Candour completed in person.
4. A community patient self-harmed. The patient was transferred to the acute hospital for medical intervention to the wounds as a result of self-harming. Due to the patient's injuries and subsequent hospital admission out of area it was difficult to make contact within the specified time frame for duty of candour despite many attempts by a member of the team. Duty of candour was completed as soon as possible following discharge. Staff did speak to the family and unfortunately missed the opportunity to complete the duty of candour.
5. A community patient self-harmed. The patient was taken to accident and emergency and admitted to an Intensive Care Unit. Duty of Candour was delayed as patient was in Intensive Care and whilst the Care Coordinator had been in contact with patient and family it was not felt to be an appropriate time due to mental state. Apology given when patient was more stable.
6. A community patient self-harmed. The patient was transferred to the acute hospital and was treated in an Intensive Care Unit. The clinical judgement was to deliver the apology at the next appointment with the therapist. However, the patient did not attend the appointment, a letter was therefore sent offering a further appointment with duty of candour being completed within the letter.

Figure 6 Duty of Candour compliance 2022/2023

Duty of Candour compliance		Stage 1 Duty of Candour - verbal apology completed within 10 days	Stage 1 Duty of Candour - not completed (exception)	Stage 1 Duty of Candour verbal apology not given following MDT decision (exception)	Stage 1 Duty of Candour - verbal apology completed after 10 days	Stage 1 Duty of Candour - awaiting further clarification from manager	Awaiting Care Group monitoring	Total
Barnsley Integrated Care Group	Barnsley General Community Services	238	1	0	0	0	6	245
	Barnsley Community Mental Health Services	7	1	3	1	0	1	13
Adult and Older People Mental Health Care group	Calderdale Community Mental Health Services	10	0	0	2	0	1	13
	Kirklees Community Mental Health Services	11	4	0	1	0	1	17

	Wakefield Community Mental Health Services	15	3	0	2	0	2	22
	Mental Health Inpatient Services	42	4	1	0	0	4	51
Forensic services Care Group	Forensic Service	9	1	0	0	1	0	11
Learning Disability and ASD/ADHD Care Group	Learning Disability services	0	0	0	0	0	1	1
Trustwide support services	Trust wide (Corporate support services)	1	0	0	0	0	0	1
	Total	**333**	**14**	**4**	**6**	**1**	**16**	**374**

Exception reasons include verbal apology not being given following Multi-Disciplinary Team (MDT) decision due to clinical presentation or being detrimental to patient's wellbeing, unable to make verbal contact with service user or next of kin therefore a letter was sent as an alternative and patient admitted to general hospital.

58% of the exceptions related to self-harm incidents. In other cases, Duty of Candour was not possible with the patient as they were too unwell.

Section 2 - Serious Incidents reported during 2022/2023

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." [7]

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:

Serious incidents in the NHS must be considered on a case-by-case basis using the description below and include acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

- 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*[8]

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 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. We have a 'watching brief' arrangement with some commissioning bodies where we can verbally report a potential serious incident, whilst further information is gathered.

As described on page 6, we are preparing to transition to the Patient Safety Incident Response Framework (PSIRF) in the Autumn 2023. We will continue to report and investigate serious incidents until we transition, although we are trying to apply the theory of PSIRF to ensure we use our resource to investigate for the greatest learning opportunity. Upon transition to working under PSIRF we recognise that we will continue to have an overlap period where will be begin to use the new methodologies, whilst concluding our existing serious incident investigations. We will adapt our reporting based on this.

[7] NHS England. Serious Incident Framework. March 2015
[8] NHS Improvement. Never Event policy and framework 2018

Headlines

During 2022/2023, 16 serious incidents were reported to the relevant commissioning body via the NHS England Strategic Executive Information System (StEIS)

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 which is examined through the investigation process. This includes:

- Managerial support
- Team/peer support
- Occupational health support. There is information available for staff and managers on referring to occupational health in the Supporting staff following trauma or stressful incidents policy. This page also provides information on Support for staff following suicide or critical incidents (sharepoint.com). This includes postvention suicide bereavement support for staff.
- Legal services offer support to staff involved in coronial processes.

We have a strong emphasis on involving staff in our investigation process. One of the principles of the investigation process is that we do not focus on individual practice and look towards systems-based issues. We engage staff throughout the process as described in our 'What happens if I am involved in a serious incident? Staff guide to serious incidents'. This was recognised as good practice by the Royal College of Psychiatrists during a review to achieve accreditation. Staff gave independent feedback to assessors.

The serious incident investigators will:

- Provide information about the investigation process to staff involved
- Ask a standard question about the support they have received following the serious incident and if they are aware of what and how they access support
- Check that support has been offered by the manager/s. Often staff will report being supported by team managers and their team colleagues
- Some teams provide debriefs and staff have regular supervision
- They will talk about being supported by manager and peers within the team
- Support for staff is reported on in the investigation report, and where this is found to have been lacking, recommendations for improvement may be made
- Where investigators identify staff support needs through the course of their investigations, they will raise with the service

Further developments

Our staff support arrangements will be reviewed as part of our preparations for the Patient Safety Incident Response Framework.

- 16 Serious incidents reported
- Serious incidents account for 0.11% of all incidents
- Apparent suicide is the highest serious incident category (9)
- No Never Events

No 'Never Event[9]' incidents were reported by the Trust in 2021/2022. The last Never Event reported by the Trust was in 2010/2011. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There is a list of Never Events defined by NHS England. Examples of Never Events relevant to the Trust include failure to install functional collapsible shower or curtain rails in mental health settings; and in all settings, overdose of insulin due to abbreviations or incorrect device; falls from poorly restricted windows; chest or neck entrapment in bed rails; scalding of patients; unintentional connection of a patient requiring oxygen to an air flowmeter. A list of current Never Events is available on the Trust intranet. There is specific guidance for circumstances of each Never Event.

Serious Incident Analysis

Figures 7 and 8 below shows all serious incidents reported on StEIS between 1 April 2018 and 31 March 2023, with figure 7 showing breakdown by financial quarter.

Figure 7 Breakdown of serious incidents reported each financial year by financial quarter 2018/2019- 2022/2023

	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Quarter 1	8	12	8	8	6
Quarter 2	9	12	10	5	4
Quarter 3	10	8	8	8	4
Quarter 4	17	15	6	1	2
Total	**44**	**47**	**32**	**22**	**16**

The data in figure 7 shows a reduction in the number of serious incidents reported over a 5-year period by financial quarter. During this time, we have strengthened relationships with our commissioners. In recent years, we have received feedback from them which told us that as a Trust, we had a culture of over reporting serious incidents historically. We took their advice and used other review processes to identify issues at an earlier stage (e.g., manager's 48-hour review, structured judgment review (introduced in 2018). Where these processes do not identify any potential care and service delivery issues or learning, these would not proceed to a Serious Incident. In addition, where a serious incident investigation has taken place, but has not revealed any learning or problems in the

[9] NHS Improvement. Never Event policy and framework 2018
^ Mental health homicide which will be removed from SI figures, investigation led by NHS England

care provided, these cases are removed from the serious incident figures in agreement with commissioners. All red and amber incidents are discussed at a weekly Clinical Risk Panel where decisions are confirmed for other review processes, which may assist in deciding if a case meets the criteria for an investigation, such as a structured judgement review or a service level investigation. Our proportion of serious incidents to all incidents reported remains very low (0.11%). We encourage staff to report incidents, and it is recognised that a high reporting rate with high proportion of no/low harm is indicative of a positive safety culture where we are proactive in reporting incidents and near misses. We continue to work on reducing suicides through our suicide prevention work. We learn lessons from incidents to prevent incidents becoming more serious in future. We actively share learning through the Learning Library and Learning Network and where urgent risks are identified, shared through Bluelight alerts. As we progress to implementation of the NHS Patient Safety Incident Response Framework by Autumn 2023, the way we respond to patient safety incidents will change to a focus on learning and improvement.

Figure 8 Total number of Serious Incidents reported by financial year 2018/2019- 2022/2023

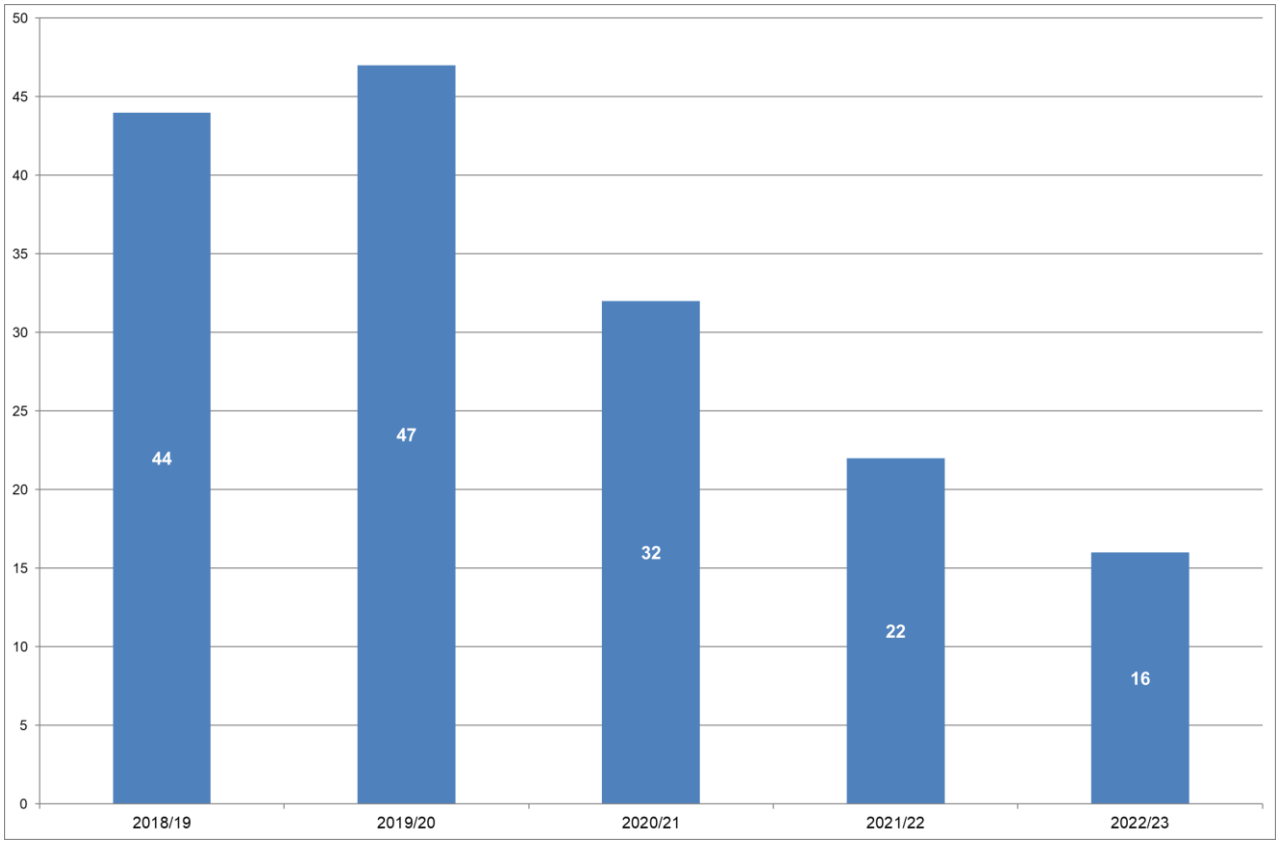
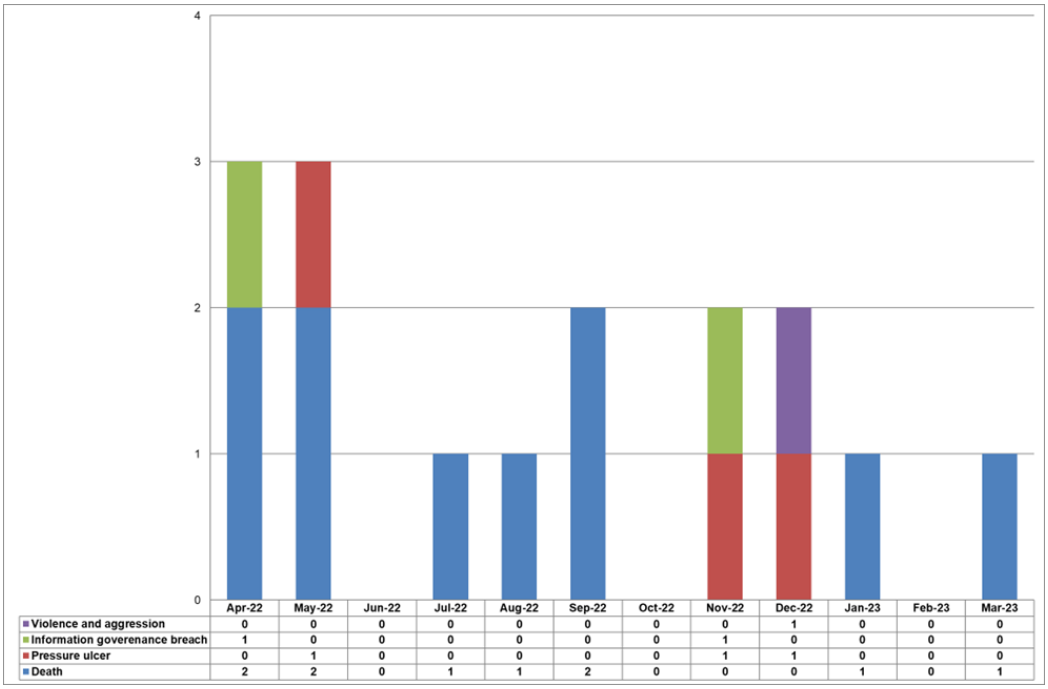


Figure 9 shows a breakdown of the 16 serious incidents reported during 2022/2023 by the type of incident and month reported.

Figure 9 Types of All Serious Incidents reported in 2022/2023 by date reported on StEIS and type of incident

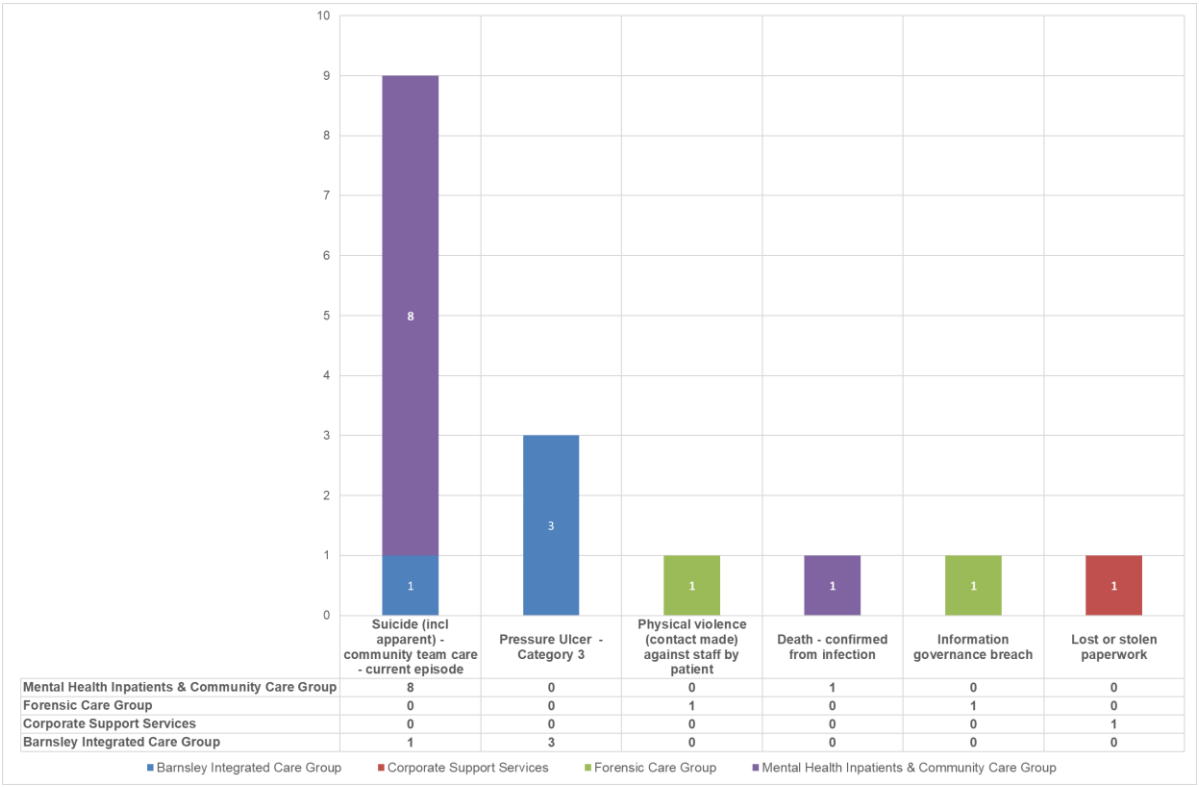


	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Violence and aggression	0	0	0	0	0	0	0	0	1	0	0	0
Information goverenance breach	1	0	0	0	0	0	0	1	0	0	0	0
Pressure ulcer	0	1	0	0	0	0	0	1	1	0	0	0
Death	2	2	0	1	1	2	0	0	0	1	0	1

As in previous years, the highest type of serious incident is death of a service user (10) including death by apparent suicide or unexpected death.

Figures 10 and 11 show the breakdown of the reported serious incidents by category and Care Group. The category of incident (a subset of 'type', as shown in figure 9) provides more detail of what occurred. It shows that apparent suicide of service users in current contact with community teams is the highest reported category (9).

Figure 10 Serious Incidents reported during 2022/2023 by reported category and Care Group



	Suicide (incl apparent) - community team care - current episode	Pressure Ulcer - Category 3	Physical violence (contact made) against staff by patient	Death - confirmed from infection	Information governance breach	Lost or stolen paperwork
Mental Health Inpatients & Community Care Group	8	0	0	1	0	0
Forensic Care Group	0	0	1	0	1	0
Corporate Support Services	0	0	0	0	0	1
Barnsley Integrated Care Group	1	3	0	0	0	0

Barnsley Integrated Care Group · Corporate Support Services · Forensic Care Group · Mental Health Inpatients & Community Care Group

Figure 11 shows all reported serious incidents by reporting team (primary involvement at the time of the incident) and financial quarter. These have been grouped by Care Group. It should be noted that some incidents involve several other teams.

Figure 11 Serious Incidents reported by Team, Care Group and financial quarter

Care Group	Team	Q1 2022/2023	Q2 2022/2023	Q3 2022/2023	Q4 2022/2023	Total
Adult and Older People Mental Health Care Group	Intensive Home-Based Treatment Team / Crisis Team - Calderdale	1	1	0	0	2
	Intensive Home-Based Treatment Team (Kirklees)	2	0	0	0	2
	Enhanced Team West - Wakefield	0	1	0	0	1
	Enhanced Team South 2 - Kirklees	0	0	0	1	1
	Core Team West - Wakefield	0	1	0	0	1
	Crofton Ward (OPS), Wakefield	0	1	0	0	1
	Enhanced Calder Valley Team - Calderdale	1	0	0	0	1
Barnsley Integrated Care Group	Neighbourhood Team – North-east (Barnsley)	1	0	0	0	1
	Neighbourhood Team - North (Barnsley)	0	0	1	0	1
	Neighbourhood Team - Dearne (Barnsley)	0	0	1	0	1
	Core Team - Barnsley	0	0	0	1	1
Forensic Care Group	Newhaven Forensic Learning Disability Unit	0	0	1	0	1
	Bronte Ward, Newton Lodge, Forensic	0	0	1	0	1
Corporate Support Services	Estates and Facilities Team	1	0	0	0	1
	Total	**6**	**4**	**4**	**2**	**16**

Breakdown of all Serious Incidents

Deaths

Of the 16 serious incidents reported, 10 related to the death of a service user. Please note this is not all deaths that were reported on Datix, only those reported on StEIS.

Figure 10 shows the apparent category of death. This is extracted from Datix and was correct at the time of writing, based on information known at the time. This is subject to change as more information comes to light or inquest conclusions are received. Apparent suicide is based on the circumstances of death.

Nine of the deaths occurred within Adult and Older People Mental Health Care Group, eight of which were apparent suicides, all under the care of community teams at the time of death. The teams can be seen in Figure 11. The remaining death was on an Older People's Mental Health ward.

Apparent Suicide

Nine deaths reported as serious incidents were apparent suicides of people who were under the care of community mental health teams at the time of death. Of the nine apparent suicides, eight occurred under the care of community mental health teams within the Adult and Older People Mental Health Care group. The ninth apparent suicide occurred whilst under the care of a community mental health team within Barnsley Integrated Care Group (mental health). Further detailed analysis will be included in future apparent suicide reports.

Other deaths

A patient had been discharged from a mental health Older People's unit but had acquired COVID-19 during an outbreak on the ward, and subsequently died from this in the community. This was identified through Infection Prevention and Control team follow up at 28 days.

Pressure ulcers

During 2022/2023 there were three category 3 pressure ulcers reported as serious incidents. These were where the initial review identified lapses in care.

Information Governance

During 2022/2023 there were two serious Information Governance breaches. The first related to the theft of a Trust vehicle which contained patient identifiable information. The second involved a breach of confidentiality by a student.

Violence against staff

During 2022/2023 there was one incident of violence and aggression reported as a serious incident. This involved a patient assaulting a member of staff.

Affected party demographics

Appendix 1 provides a breakdown of some protected characteristics of the individuals affected in these serious incidents, where relevant.

Section 3 - Findings from Serious Incident Investigations completed during 2022/2023

This section of the report focusses on the 18 serious incident investigation reports which were completed and submitted to the relevant commissioner during the period 1 April 2022 to 31 March 2023. Please note this is not the same data as those reported in this period (see Section 3) as investigations take a number of months to complete. The term 'completed' is used in this section to describe this.

- 18 serious incident investigations completed (23 2021/2022)
- 107 associated actions (127 in 2021/2022)
- All investigations include a recommendation to share learning
- Top three action themes:
  1) Record keeping
  2) Staff education, training, and supervision
  3) Team service systems, roles and management (joint third)
  3) Care pathway (joint third)
  3) Care delivery (joint third)

Headline data

Of the 18 serious incident investigation reports completed and submitted to the relevant commissioner between 1 April 2022 and 31 March 2023, there were 107 actions made (compared with 127 during 21/2022).

Of the 18 serious incident investigations completed between 1 April 2022 to 31 March 2023, two were completed within the 60 working days. The 60 working days timescale for completing a serious incident investigation was suspended in March 2020 due to Covid 19 and remains suspended at 13/4/2023. The progress of all serious incident Investigations continues to be reviewed weekly in the patient safety support team. We have continued to liaise with commissioners to agree extensions throughout the year, despite the timescales being suspended. We have also liaised with families to ensure they are aware of delays in completion of investigations.

All serious incident investigations including a standard recommendation to share learning. This increases the number of actions.

One incident investigation can generate a high number of actions. The breakdown by Care Group/ Business Development Unit (BDU) and team type is shown in figures 12 and 13.

Figure 12 Breakdown of the number of serious incidents completed in 2022/2023 per Care Group/BDU, compared with the number of actions

Care Group	BDU	SI investigations completed	SI actions
Barnsley Integrated Care Group	Barnsley Community Mental Health Services	2	6
	Barnsley General Community Services	2	3
Adult and Older People Mental Health Care Group	Calderdale Community Mental Health Services	2	8
	Kirklees Community Mental Health Services	7	50
	Wakefield Community Mental Health Services	1	6
	Mental Health Inpatient Services	2	12
Forensic Services Care Group	Forensic Service	1	15
Trust wide Support Services	Trust wide (Corporate support services)	1	7
	Total	**18**	**107**

Figure 13 Breakdown of the number of serious incidents completed in 2022/2023 per team type, compared with the number of actions

Specialty	SI investigations completed	SI actions
Enhanced Pathway	6	44
Crisis/IHBTT/Police Liaison (Adult)	5	20
Rehabilitation inpatient units - Forensics	1	15
PICU Inpatient Services (Adult)	1	9
Estates and Facilities	1	7
Liaison Services	1	6
District Nursing	2	3
Acute Inpatients (Adult)	1	3
Total	**18**	**107**

Over the last three years the highest numbers of actions have arisen from apparent suicide incidents. This correlates with this being the largest type of serious incident reported. During 2022/2023 completed serious incident investigations for apparent suicides resulted in 42 actions (39%) (Figure 13).

Figure 14 of the number of serious incidents completed in 2022/2023 per team type, compared with the number of actions

Action theme	Suicide including apparent (community team care)	Unexpected death (inpatient)	Security	Serious self-harm	Information Governance	Unexpected death - community patient	Suicide including apparent (inpatient)	Pressure Ulcer	Total
Sharing learning	8	2	1	2	1	1	1	1	17
Record keeping	8	2	1	0	1	2	1	0	15
Staff education, training and supervision	2	4	1	0	3	0	0	0	10
Care delivery	3	3	2	1	0	0	0	0	9
Care pathway	3	2	2	2	0	0	0	0	9
Team service systems, roles and management	2	4	2	0	1	0	0	0	9
Risk assessment	3	2	2	1	0	0	0	0	8
Policy and procedure - in place but not adhered to	4	0	1	0	1	0	1	1	8
Policy and procedures, not in place	2	0	2	0	0	0	0	0	4
Organisational systems, management issues	1	0	1	2	0	0	0	0	4
Communication	0	1	1	1	0	0	0	0	3
Care coordination	1	0	0	1	0	1	0	0	3
Physical healthcare (MH patients)	0	3	0	0	0	0	0	0	3
Carers/family	1	0	0	0	0	1	0	0	2
No recommendations	0	0	0	0	0	0	0	1	1
Discharge/follow up	1	0	0	0	0	0	0	0	1
Environmental	0	1	0	0	0	0	0	0	1
Total	**39**	**24**	**16**	**10**	**7**	**5**	**3**	**3**	**107**

It is important to understand that in undertaking an investigation of an incident, the Trust takes the view that all areas for learning or improvement should be identified and lead to a recommendation being made. These generally arise for review of the care and treatment and arise from care and service delivery issues, and are actions to address the contributory factors, which are not considered to be causal to the incident occurring.

The majority of the recommendations from serious incident investigations apply directly to the team or Care Group involved. Each Care Group lead investigator works closely with the practice governance coaches and Care Groups and has produced the information in section 5 of this report. From July 2023 onwards, this will be included in our quarterly reports.

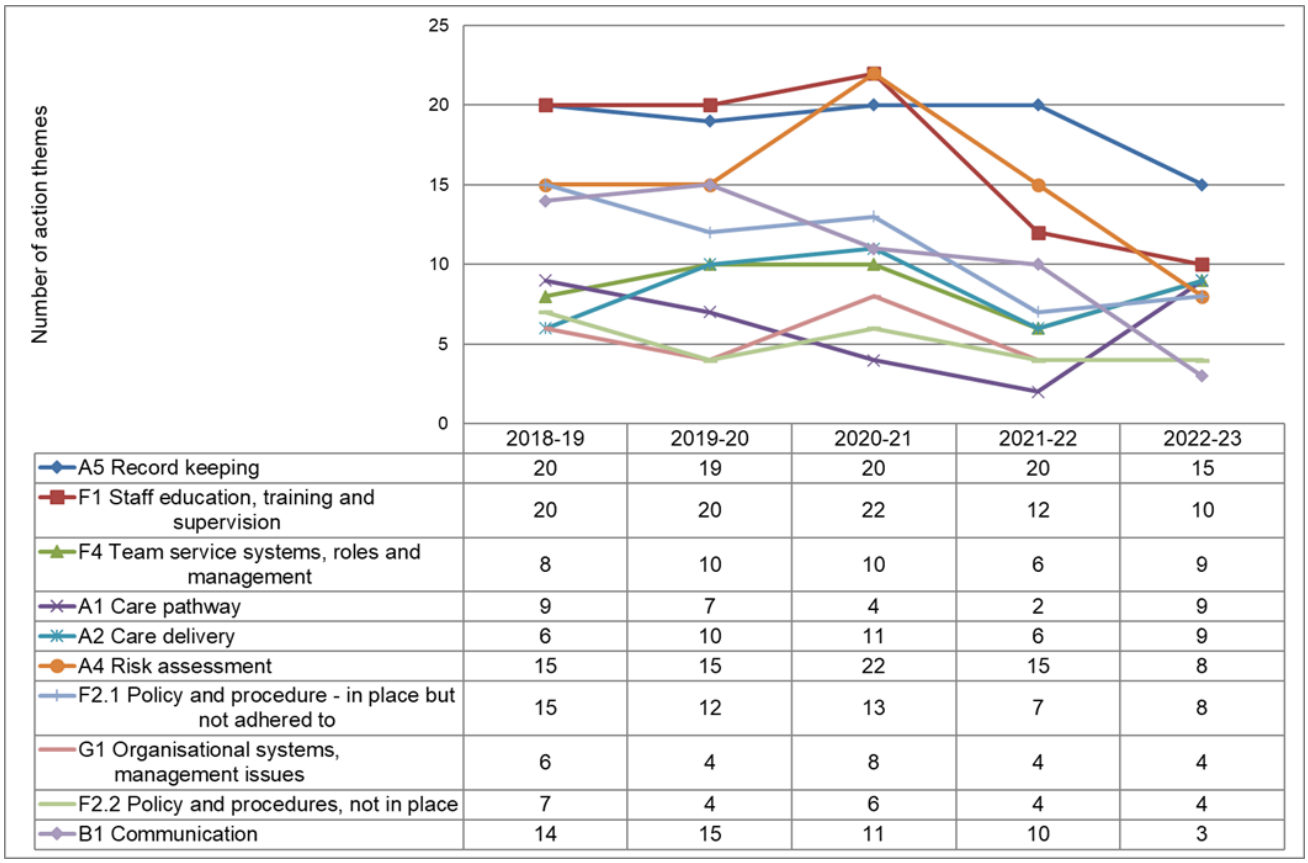
Categorisation of Actions

Each action is given a theme to capture the issue/theme that best matches the action from a pre-designed list of approximately 20 themes, this supports analysis of the actions. A sub-theme is also added to group similar issues together. In an attempt to gain consistency, this is undertaken by the Lead serious incident Investigators. The recording of themes and sub-themes is subjective and is not always straightforward to identify which theme/sub-theme an action should be given. Some do not easily fit into any one theme and could be included under more than one.

The types of serious incidents completed within the year affects the action themes, for example, an Information governance serious incident, is more likely to have actions related to organisational systems, increasing that figure.

The top 10 action themes have been reviewed over the last five financial years for comparison. As shown in figure 15, some of the historically highest themes (record keeping; staff education, training and supervision; risk assessment) have seen a reduction in number over time.

Figure 15 top 10 action themes in the 5 years between 1/4/2018 and 31/3/2023



	2018-19	2019-20	2020-21	2021-22	2022-23
A5 Record keeping	20	19	20	20	15
F1 Staff education, training and supervision	20	20	22	12	10
F4 Team service systems, roles and management	8	10	10	6	9
A1 Care pathway	9	7	4	2	9
A2 Care delivery	6	10	11	6	9
A4 Risk assessment	15	15	22	15	8
F2.1 Policy and procedure - in place but not adhered to	15	12	13	7	8
G1 Organisational systems, management issues	6	4	8	4	4
F2.2 Policy and procedures, not in place	7	4	6	4	4
B1 Communication	14	15	11	10	3

In 2022/2023 the top three most common action themes were ‘record keeping’, ‘staff education, training and supervision’, followed by three themes that were joint third in order - ‘team service systems, roles and management’, ‘care pathway’ and ‘care delivery’.

In previous years, ‘risk assessment’ appeared in the top three themes. Below is a summary of the recommendations identified within these themes; these have been grouped together (subthemes). There is natural overlap between themes and subthemes. Data can be extracted from Datix by subtheme and drilled into.

Learning and Improvement

The patient safety support team have established 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 three-monthly basis and is available to use as a data resource for policy leads to use through the Trust's Clinical Policy Ratification Group.

As part of our work to prepare for the Patient Safety Incident Response Framework (PSIRF) implementation, we are reviewing action themes as part of our data analysis.

1) Record keeping:

Record keeping has remained within the top three action themes in the last nine years. There were 15 actions relating to record keeping. Where possible these have been grouped by broad sub-theme:

Figure 16 Record Keeping - Subtheme by Care Group /BDU

	Barnsley Integrated Care Group		Adult and Older People Mental Health Care Group				Forensic Services Care Group	Trustwide support	Total
Theme and Subtheme	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 Service	Trust wide (Corporate support services)	Total
Contemporaneous recording	0	0	0	4	0	1	0	0	**5**
Operational policy	0	0	0	1	0	0	1	1	**3**
Clinical Record Keeping - The System	0	0	0	1	0	0	1	0	**2**
MDT working and meetings	0	0	0	1	0	0	0	0	**1**
Medical plan	0	0	1	0	0	0	0	0	**1**
Communication with other agencies	0	1	0	0	0	0	0	0	**1**
CPA documentation	0	0	0	1	0	0	0	0	**1**
Care plan	0	1	0	0	0	0	0	0	**1**
Total	**0**	**2**	**1**	**8**	**0**	**1**	**2**	**1**	**15**

Below is a summary of the actions identified:

Contemporaneous recording

Reinforce with medical teams the importance of recording discussion with patients regarding medication.

The clinical record for the date of the incident should be updated to provide a clear record of what happened by the staff involved.

Reinforce with the Intensive Home-Based Treatment Team the importance of contemporaneous record keeping and to avoid significantly late entries as far as possible.

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.

Staff should be reminded that when a retrospective clinical entry is made, they should document that it is a retrospective entry.

Operational policy

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.

Review the process for completion of the psychiatric assessment template on SystmOne where a duty doctor is undertaking the admission.

A record keeping audit of the transport department to be completed.

Clinical Record Keeping - The System

The Care Groups 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.

MDT working and meetings

The Enhanced team should document flexible assertive community treatment multi-disciplinary team meeting discussions and outcomes in the electronic clinical record.

Medical plan

The service clarifies with the medical staff within the team which documentation should be completed following a consultation.

Communication with other agencies

For the service to provide assurance that when a service has ongoing involvement with external agencies the nature of that involvement is accurately recorded and liaison with the agency is maintained throughout the contact with the Trust

Care Programme Approach (CPA) documentation

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 support by care plans and updated risk assessments.

Care plan

For the service to provide assurance that:

i) information included in care plans is up to date and accurate
ii) that individuals responsible for carrying out/delegating actions are identified at Case Management Reviews

iii) that any problems in carrying out actions are reported and resolved at Case Management reviews

2) Staff education, Training and Supervision:

Staff education, training and supervision has been in the top three in the last nine years. There were 10 actions relating to staff education, training and supervision. These have been grouped by broad sub-theme:

Figure 17 Staff education, training and supervision- Subtheme by Care Group/BDU

Theme and Subtheme	Barnsley Integrated Care Group		Adult and Older People Mental Health Care Group				Forensic Services Care Group	Trustwide support services	Total
	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 Service	Trust wide (Corporate support services)	Total
Supervision	0	0	0	0	0	0	1	1	2
Induction	0	0	0	0	0	1	0	1	2
Operational policy	0	0	1	0	0	1	0	0	2
Various training	0	0	0	0	0	0	0	1	1
Suicide Prevention	0	0	0	0	0	1	0	0	1
Knowledge and Skill Gap	0	0	1	0	0	0	0	0	1
Roles and Responsibilities	0	0	0	1	0	0	0	0	1
Total	**0**	**0**	**2**	**1**	**0**	**3**	**1**	**3**	**10**

Below is a summary of the actions identified:

Supervision

All transport staff should have robust supervision outlining tasks and expectations documentation should be available to ensure this has been achieved.
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.

Induction

All staff working within the Trust should,

a. Complete the Trust resuscitation training regardless of whether they have completed it at another trust as policy varies between trusts.

b. The resuscitation training should inform staff that the trust does not provide a hospital crash response in the event of cardiac arrest.

A robust induction for staff to be devised this should then be discussed and signed off by staff and manager.

Operational policy

In-patient services should provide assurance that all staff are booked onto appropriate Cardiopulmonary Resuscitation/Basic Life Support/Immediate Life Support training, in line with Trust policy.

The IHBTT [intensive home-based treatment team] practitioner is informed of the requirement and process to broker a referral for single point of access (SPA), out of hours and that this process is reinforced within the wider team.

Various training

A clear training need within the Transport and Estates department around the Travel at Work Policy the local work instruction driver's manual and job risk assessments.

Suicide Prevention

The Trust re-launches the suicide prevention strategy, following its review, this should include details of all information and resources available to staff and provide regular updates for staff.

Knowledge and Skill Gap

As a reminder of available services and to update knowledge, information regarding postventions services should be shared with staff.

Roles and Responsibilities

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.

3) Team service systems, roles and management (joint third):

Team service systems, roles and management is new in the top three action themes. There were nine actions relating to team service systems, roles and management. Where possible these have been grouped by broad sub-theme:

Figure 18 team service systems, roles and management - Subtheme by Care Group/BDU

	Barnsley Integrated Care Group		Adult and Older People Mental Health Care Group				Forensic Services Care Group	Trustwide support services	Total
Theme and Subtheme	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 Service	Trustwide Support Services	Total
Risk Assessment and Management	0	0	0	1	0	0	1	0	2
Standard Operating Procedures	0	0	0	0	0	2	0	0	2
Operational policy	0	0	0	0	0	0	0	1	1
Supervision	0	0	0	0	0	0	1	0	1
Access to clinical information	0	0	0	0	1	0	0	0	1
MDT working and meetings	0	0	0	1	0	0	0	0	1
Team building and Staff Development	0	0	0	1	0	0	0	0	1
Total	**0**	**0**	**0**	**3**	**1**	**2**	**2**	**1**	**9**

Below is a summary of the actions identified:

Risk Assessment and Management

Reinforce with teams that in circumstances where there is no consent to share with family and carers this does not preclude the service encouraging and hearing concerns from them regarding risks.

Review the Advanced Nurse Practitioner (ANP) role and consider a shift of emphasis to supporting staff with:

i) Specialist risk assessments and formulations
ii) Care planning for substance misuse/addition
iii) Liaison with specialist substance misuse services

It is also recommended that the postholder seeks to connect with regional clinical networks in order to share, and benefit from, best practice and treatment.

Standard Operating Procedures

The Trust to review its access permissions to include emergency access to on-call doctors.

Each ward/team should have the appropriate Emergency Response Procedure for that area attached to/within their emergency bag/automated external defibrillator for staff to follow/consult in an emergency.

Operational policy

An audit system should be in place to identify what is picked up and when is it is delivered ensuring an accurate record is always available of the contents of the vans.

Supervision

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.

Access to clinical information

The service should ensure all staff who require access to the alternative clinical records of EMIS are provided with guidance and support to do so.

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.

3) Care Pathway (Joint Third):

Care pathway is new in the top three action themes. There were nine actions relating care pathway. Where possible these have been grouped by broad sub-theme:

Figure 19 Care pathway- Subtheme by Care Group/BDU

Theme and Subtheme	Barnsley Integrated Care Group		Adult and Older People Mental Health Care Group				Forensic Services Care Group	Trustwide support services	Total
	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 Service	Trustwide Support Services	Total
Care planning	0	0	0	2	0	1	1	0	4

Organisational systems	0	0	0	2	0	0	0	0	2
Referral process	0	0	0	0	1	0	0	0	1
Transitions in care	0	0	0	1	0	0	0	0	1
Care Pathway	0	0	0	1	0	0	0	0	1
Total	**0**	**0**	**0**	**6**	**1**	**1**	**1**	**0**	**9**

Below is a summary of the actions identified:

Care planning

In-patient services should ensure that staff are aware of policy that the minimum standard for care planning would be to co-produce with the service user and copies should be offered to all service users and carers (where applicable).

Where it is indicated that a service user should access psychology and due to therapeutic reasons, there are long delays the community team should consider alternative options for therapeutic support.

The directorate should review the care pathway and treatment options for people with addictions and the support available to them including access to substance misuse services and specialist treatment

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.

Organisational systems

The investigators recommend that the Care Group reviews the need for a Trauma Informed Personality Disorder (TIPD) pathway Standard Operating Procedure/Guidance which aligns to existing Trust policies, particularly considering the move away from CPA to a personalised care and support programme.

The Psychiatric Liaison Team provides assessment and support to those who present either on the wards or Accident and Emergency pathway with a perceived mental health need. There are no exclusion criteria for those not deemed medically fit and support will be provided as required, based on an assessment of that individual's needs.

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.

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.

3) Care delivery (joint third):

Care delivery is new in the top three action themes. There were nine actions relating to care delivery. Where possible these have been grouped by broad sub-theme:

Figure 20 Care delivery - Subtheme by Care Group/BDU

	Barnsley Integrated Care Group		Adult and Older People Mental Health Care Group				Forensic Services Care Group	Trustwide support services	Total
Theme and Subtheme	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 Service	Trustwide Support Services	Total
Care planning	0	0	1	1	0	0	1	0	3
Communication with patient and/or family/carers	0	1	0	1	0	0	0	0	2
Roles and Responsibilities	0	0	0	1	0	0	0	0	1
Monitoring Physical Health Care	0	0	0	0	0	0	1	0	1
MDT working and meetings	0	0	0	1	0	0	0	0	1
Monitoring compliance	0	0	0	0	0	1	0	0	1
Total	**0**	**1**	**1**	**4**	**0**	**1**	**2**	**0**	**9**

Below is a summary of the actions identified:

Care planning

All restricted service users should have agreed specific recall thresholds and actions identified in their care and crisis and contingency plans.

Should a service user identify a specific drug they are prescribed as a means to harm themselves consideration should be taken at assessment to manage these drugs to reduce access and/or availability and this should be recorded.

Service users with a diagnosis of substance misuse must have a care plan to address this.

Communication with patient and/or family/carers

For the service to provide assurance that the involvement of service users, their families and supporters, is being actively sought both at the initial assessment stage and also as care plans are reviewed and changed, in line with Trust policy.

Where the Enhanced team becomes aware that the therapeutic relationship has broken down with a service user, consideration should be given to transferring the case to the other localities Enhanced Team.

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.

Monitoring Physical Health Care

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.

Completion of Actions

Between 1 April 2022 and 31 March 2023 there were 107 actions, arising from 18 completed serious incidents investigations. Figures 23 and 24 shows the progression with completion of actions at the date of extraction from Datix (05/06/2023):

- 81 actions had been completed (76%)
- 10 actions had not reached the due date at the time of preparing this report (9%)
- 10 actions had passed the due date (overdue) at the time of reporting (9%). Care Groups are asked for rationale for actions not completed in the timescale given and record this on Datix in the progress and monitoring section on Datix within the action record. Actions are reviewed and progress monitored at Care Group governance groups/SI subgroups. Overdue actions are also reported into the Trust Operational Management Group (OMG). All overdue risks are risk assessed by the Deputy Director of Nursing, and Quality Professions. Overdue actions are raised through Clinical Risk Report and chased by the Datix team.
- All overdue actions in each of the three Care Groups all related to an individual serious incident within that Care Group and either awaiting final approval or linked to an external provider.
- Many outstanding actions relate to Trust wide pieces of work, that the Care Group cannot action themselves.

Figure 21 Serious Incident actions from SI investigations completed during 2022/2023 by completion status and Care Group/BDU (at 05/06/2023)

Care Group	BDU	Completed within timescale	Completed over the timescale	Not yet due	Not yet completed overdue original timescale	Total
Barnsley Integrated Care Group	Barnsley Community Mental Health Services	4	2	0	0	6
	Barnsley General Community Services	0	1	0	2	3
Adult and Older People Mental Health Care Group	Calderdale Community Mental Health Services	1	3	4	0	8
	Kirklees Community Mental Health Services	12	32	6	0	50
	Wakefield Community Mental Health Services	3	3	0	0	6
	Mental Health Inpatient Services	2	10	0	0	12
Forensic Services Care Group	Forensic Service	2	8	0	5	15
Trust wide support services	Trust wide (Corporate support services)	2	2	0	3	7
Total		**26**	**61**	**10**	**10**	**107**

Figure 22 Serious Incident actions that are overdue completion from SI investigations completed during 2022/2023 by Care Group/BDU and time period overdue (at 05/06/2023)

Care Group	BDU	Working days overdue					Total overdue
		1 - 30 working days overdue	31 - 60 working days overdue	61 - 90 working days overdue	91 - 200 working days overdue	201-300 working days overdue	
Barnsley Integrated Care Group	Barnsley General Community Services	0	0	0	2	0	2
Forensic Services Care Group	Forensic Service	0	0	0	2	3	5
Trust wide support services	Trust wide (Corporate support services)	0	0	0	3	0	3
Total		**0**	**0**	**0**	**7**	**3**	**10**

Section 4 Learning from Healthcare Deaths

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 a 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 a number of 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 in order 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.

All deaths that are in scope are reported to Trust Board each quarter. The latest reports are published on the Trust website when approved.

Scope

The Trust has systems that identify and capture the known deaths of its service users on its electronic patient administration system (PAS) and on its Datix system where the death requires reporting.

The Trust introduced our Learning from Healthcare Deaths policy in 2017. Staff report deaths where there are concerns from family, clinical staff or through governance processes and where the Trust is the main provider of care. This is what we refer to as 'in scope deaths' (further details are available in the Learning from Healthcare Deaths policy). The policy has continued to be reviewed and updated to reflect national guidance.

Learning from Healthcare Deaths reporting

During 2022/2023, 2,812 deaths (row one in figure 23) were recorded on our clinical systems (figure correct at 12/4/2023). 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 through Business Intelligence software. This includes services such as end of life, district nursing and care home liaison services. The Trust was not the main provider of care at the time of death for a large number of cases.

Figure 23 Summary of 2022/2023 Annual Death reporting by financial quarter*

	2021/2022 total	2022/2023 Q1	2022/2023 Q2	2022/2023 Q3	2022/2023 Q4	2022/2023 Total
1) Total number of deaths reported on the Trust clinical systems where there has been system activity within 180 days of date of death	3609	812	710	754	536	2812
2) Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	404	95	87	97	100	379
3) Total Number of deaths which were in scope	307	68	55	62	68	253
4) Total Number of deaths reported on Datix that were not in the Trust's scope	97	27	32	35	32	126

*Data extracted from Business Intelligence Dashboards and Datix risk management systems. 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. Dashboard format and content as agreed by Northern Alliance group

Not all these deaths were reportable as incidents on Datix. Row 2 in Figure 26 shows that 379 deaths were reported on Datix in the year, with the quarterly breakdown. Row 4 shows those deaths that were not felt to meet the Learning from Deaths criteria. The second column of the table shows the comparative figures from 2021/2022. The total number of deaths reported has reduced this year, along with those in scope. The number of deaths reported that were not in scope has increased, however they have been reviewed to ensure this is accurate. No particular patterns or reasons have been identified.

All deaths reported on Datix are reviewed by the patient safety support team to ensure they meet the scope criteria. For 2022/2023, 253 deaths (a reduction on 2021/2022) were in scope and subject to one of the 3 levels of scrutiny the Trust has adopted in line with the National Quality Board guidance (figure 24):

Figure 54 National Quality Board Levels of mortality scrutiny

In scope deaths should be reviewed using one of the 3 levels of scrutiny:		
Level 1	Death Certification	Details of the cause of death as certified by the attending doctor.
Level 2	Case record review	Includes: (1) Managers 48-hour review (first stage case note review) (2) Structured Judgement Review
Level 3	Investigation	Includes: Service Level Investigation serious incident Investigation (reported on STEIS) Other reviews e.g., Learning Disability Review Programme (LeDeR), safeguarding.

Each quarter, there are a number of reported deaths that do not meet the Learning from Healthcare Deaths reporting criteria which receive no further review. These are not in scope and are not included in the data report, although the record remains on Datix.

For the purpose of this section, the date of reporting on Datix is used rather than the date of death. This is to ensure all deaths are systematically reviewed. The figures may differ from other sections of the report.

Figure 25 below shows a Statistical Process Control chart of all reported deaths (by reported date) between 1/4/2021-31/3/2023.

Figure 25 Statistical Process Control Report of all deaths reported 1/4/2021 – 31/3/2023 by date reported

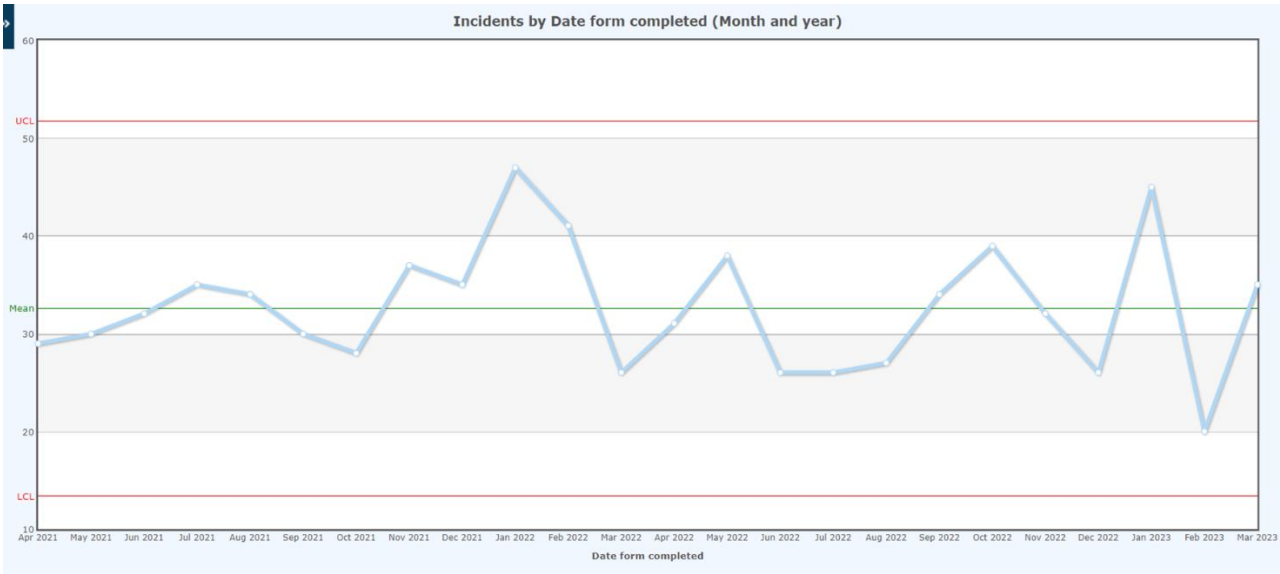


Figure 26 show the 253 in scope deaths reported by Care Group, and figure 27 by the review process followed in line with the National Quality Board levels of scrutiny, described earlier. These are reported against the financial quarter in which the death was reported.

Figure 26 In scope deaths reported by financial quarter and Care Group

Financial quarter - date reported	Barnsley Integrated Care Group	Adult and Older People Mental Health Care group	Learning Disability & ADHD / ASD Care Group	CAMHS and Childrens Care Group	Forensic Care Group	Total
Quarter 1	11	49	8	0	0	68
Quarter 2	11	40	3	1	0	55
Quarter 3	10	41	11	0	0	62
Quarter 4	13	45	9	1	0	68
Total	**45**	**175**	**31**	**2**	**0**	**253**

Figure 27 Learning from Healthcare Deaths during 2022/2023 by financial quarter and mortality review process

Financial quarter – date reported	Level 1	Level 2		Level 3				Total
	Death certified	Manager's 48-hour review	Structured Judgement Review (SJR)	Service Level Investigation	Serious Incident Investigation	Learning Disability Review (LeDeR)	Safeguarding review	
Quarter 1	34	15	6	1	4	8	0	68
Quarter 2	23	13	5	4	4	6	0	55
Quarter 3	27	15	6	1	0	12	1	62
Quarter 4	24	24	4	4	2	10	0	68
Total	**108**	**67**	**21**	**10**	**10**	**36***	**1**	**253**

*One learning disability death reported to LEDER was also subject to a Structured Judgement Review

Of the 143 deaths that were subject to a level 2 case note review (92) or level 3 investigation (51) [NB these also included an initial case note review] 108 have been completed (at the time of reporting 11/4/2022) and no problem in care was identified which directly resulted in those deaths. 35 cases remain under review at the time of reporting.

Deaths that were reported between 1/4/2021 and 31/3/2023 have been analysed using Statistical Process Control [SPC] to identify any areas of special cause variation. Data has also been interrogated to understand further details.

There are a number of factors that can affect death reporting figures when viewed over time. These include:

- The mortality data in this report is based on when deaths were reported, not when they occurred.
- The use of the date reported on Datix for reporting ensures no deaths that are retrospectively reported are missed, in line with other mental health trusts.
- Incidents reported may have occurred at an earlier date, but the report reflects when they were reported on Datix as teams became aware.
- Teams report deaths in line with the learning from deaths policy; reporting deaths irrespective of the cause of death where there is/has been a package of care given in the previous six months prior to death occurring.
- Teams report deaths of discharged patients, when they are informed/identified if they have provided care in the last six months prior to death, e.g., request for coroner's report for a discharged patient.

Learning disability deaths

Figure 26 above shows 31 deaths were reported by Learning Disability Services. However, any deaths of a person who has a Learning Disability is reportable on Datix, irrespective of the service they are under, in line with the Learning from Healthcare Deaths policy and national guidance.

This can be people who are under the care of teams other than Learning Disability Services; in this period this includes Paediatric Therapy, Epilepsy, Children's Speech and Language Therapy, Mental Health Liaison Team (figure 27 shows there were 36 deaths for review via Learning Disability Review Programme [LeDeR]. One further learning disability death was not reported because the age was below the threshold for LeDeR reporting (four years). When Learning Disability deaths are reviewed using SPC, reporting has remained within the normal range.

Over the period 1 April 2022 to 31 March 2023, of the 37 deaths of people with a Learning Disability, 31 deaths were under the care of Learning Disability services. Fourteen died in an acute hospital, 12 died at home, nine in residential care/nursing home and two in a hospice. Thirty-three deaths were confirmed to have been from physical health/natural cause (11 expected). Of the remaining deaths, cause of death has not been received, although one person was on end-of-life care.

Category of death

Figure 28 shows the reported deaths by Care Group and category.

Figure 28 Reported deaths by category and BDU reported during 2022/2023

Category	Barnsley Integrated Care Group	CAMHS and Children Care Group	Adult and Older People Mental Health Care group	Learning Disability & ADHD / ASD Care Group	Total
Death - confirmed from physical/natural causes	23	0	115	26	164
Death - cause of death unknown/ unexplained/ awaiting confirmation	16	1	22	4	43
Suicide (incl apparent) - community team care - current episode	4	0	17	0	21
Death - confirmed from infection	0	0	10	1	11
Suicide (incl apparent) - community team care - discharged	0	1	4	0	5
Death - confirmed related to substance misuse (drug and/or alcohol)	2	0	2	0	4
Death - confirmed as accidental	0	0	3	0	3
Apparent suicide - not Trust incident (for use by Patient Safety only) see notes	0	0	2	0	2
Total	**45**	**2**	**175**	**31**	**253**

Inpatient deaths

Figure 29 below shows that over the year 2022/2023, there were 21 inpatient deaths reported. There were no inpatient deaths relating to Learning Disability Services. It should be noted that inpatient deaths can include where a death has occurred within 30 days of discharge from the unit.

Figure 29 Trust wide Inpatient deaths in 2022/2023 by date reported

Care Group	Ward	Financial quarter - date reported				Total
		Q1 2022/2023	Q2 2022/2023	Q3 2022/2023	Q4 2022/2023	
Adult and Older People Mental Health Care Group	Poplars Unit, Wakefield	1	0	1	1	3
	Beechdale Ward, The Dales Unit	2	1	0	0	3
	Crofton Ward (OPS), Wakefield	2	2	0	0	4
	Willow Ward - Barnsley	1	0	0	0	1
	Ward 19 (OPS)	1	1	0	2	4
	Ashdale Ward	0	0	1	0	1
	Stanley Ward, Wakefield	0	0	0	1	1

Barnsley Integrated Care Group	Neuro Rehab Unit - Barnsley	0	0	3	0	3
	Stroke Unit, Barnsley	0	0	1	0	1
Total		**7**	**4**	**6**	**4**	**21**

Of the 21 deaths that occurred related to the Trust inpatient settings:

- Ten deaths occurred at the Trust inpatient wards, nine deaths occurred in an acute hospital setting and two deaths were in the patient's home (one person had been discharged from the ward, the other was on leave from the ward. Both died unexpectedly).
- None of the deaths were related to apparent suicide.
- Nine of the 21 deaths were expected. 12 were unexpected deaths from physical causes (some are awaiting confirmation).
- One death related to choking event occurred in care home setting but had recently been discharged from Trust inpatient care.
- Three deaths were related to COVID-19 infection.
- One of the deaths was reported as serious incident.

Location of deaths

Figure 30 below shows that the top three locations for where patients died were acute /general hospital setting (40%), patients own home (28%) and care/residential home (17%).

Figure 30 Location of deaths that were reported during 2022/2023

Location of death	Q1 2022-2023	Q2 2022-2023	Q3 2022-2023	Q4 2022-2023	Total
Acute Trust / General Hospital	27	22	23	30	102
Patient's home	18	20	21	14	73
Care/Residential Home	13	9	10	15	47
Inpatient facility (the Trust)	3	1	5	1	10
Unknown	1	0	2	4	7
Hospice	3	1	0	2	6
Public place	2	1	0	1	4
Other person's home	1	1	0	0	2
Other country	0	0	1	0	1
Other mental health provider (not the Trust)	0	0	0	1	1
Total	**68**	**55**	**62**	**68**	**253**

Where the location of death is unknown, this is often because we identify a patient has died from a third-party update on the clinical record.

Causes of death

In terms of causes of death, the table below shows the broad cause of death for the 253 patients who died. The highest type of cause of death recorded was from a physical cause, including expected and unexpected deaths.

Figure 31 Causes of death for in scope deaths recorded during 2022/2023 by geographical area (note this is not BDU)

	Barnsley Integrated Care Group	Adult and Older People Mental Health Care Group	Learning Disability & ADHD / ASD Care Group	CAMHS and Children Care Group	Total
Physical health related	16	94	19	0	129
Physical health related (end of life)	13	31	9	0	53
Unknown at time of reporting	9	22	2	0	33
Apparent suicide	4	22	0	1	27
Suspected overdose	2	1	0	0	3
unknown at time of reporting (end of life)	0	1	1	0	2
Accidental suspected	0	1	0	1	2
Choking (community setting)	0	1	0	0	1
Choking (acute hospital)	1	0	0	0	1
Choking (care home - recent discharge from the Trust inpatient ward)	0	1	0	0	1
Substance misuse	0	1	0	0	1
Total	**45**	**175**	**31**	**2**	**253**

Deaths reported as Serious Incidents

Of the 253 in scope deaths reported on Datix between 1 April 2022 and 31 March 2023, 9 were reported as serious incidents.

Please note this figure will not necessarily match those reported in the serious incident section of this report due to the use of different dates for different processes (serious incident reporting uses date reported on STEIS; mortality uses date reported on Datix).

Apparent suicides

The apparent suicides will be reported on further in the apparent suicide annual report which will be available separately. The figures will be based on the live data, so may not match figures in this report.

Next Steps

Our work to support learning from deaths continues, and includes:

- At the time of writing, the family liaison professional post has been advertised. The post will provide support to newly bereaved individuals, supporting the Care Groups and staff who have bereavement link roles in ensuring that bereaved families and carers are engaged and supported, by giving them the opportunity to raise questions and share any concerns they may have in relation to the quality of care received by their family member.
- Aligning our Learning from Deaths processes with the Patient Safety Incident Response Framework response methods and updating our policy accordingly.
- Development of Dashboards for data quality reviews throughout the year.
- Continued networking via regional mortality meetings to share best practice and learning in relation to the scrutiny, review and output from Learning from Deaths processes.

Section 5 – Learning from Experience 2022/2023

Learning takes place at different levels in the organisation – in Care Groups facilitated by Quality governance leads and Matrons, across services and across the entire Trust. The Patient Safety team support effective learning, embedding principles of a 'Just Culture' in the reporting and review of all incidents.

During 2022/2023, we have:

- Continued to host our Learning Network and increased the frequency to quarterly due to volume of content staff wished to share. The Learning Network is informal and open to all staff to attend or provide a presentation. Microsoft (MS) Teams has helped with broadening access. Learning examples are shared by Care Group colleagues and specialists' advisors. A recording of the event is shared on our intranet and through communication channels. This year, learning has included an allergy incident, under 18-year-olds on adult wards, safeguarding topics, medication management, learning from serious incidents, infection prevention and control learning, Ockenden report, consent for vaccinations and patient safety reports. A recording of the event is shared on our intranet and through communication channels.
- Continued to hold Learning Events as part of our serious incident Investigation process where staff involved are invited to hear the feedback and contribute to the action planning.
- We have held several Trust wide learning events to share learning from a thematic review into choking serious incidents and two learning events following the publication of Mental Health Homicides.
- Continued to share data on serious incidents action themes and incident equality data with policy authors so that learning can be incorporated into future policy revisions.
- Continued our complex case review group to ensure close overview of serious incidents, with direct reporting to Trust Board.
- Continued to share Blue Light Alerts across the Trust, in response to urgent learning where there are safety concerns identified either locally or nationally.
- Continued to share learning through the year through our Learning Library
- Presented our learning from serious incidents and other events.
- Undertaken a thematic analysis of three years serious incident investigations and Service Level Investigations to drill down to extract the experience of family and carers post loss of life to suicide. Themes condensed to key areas of focus and shared with the carers project lead/team which has been incorporated into carer training.

Learning from incidents presentation

Appendix 2 gives an illustration of our Learning presentation that brings together some of the learning from 2022/2023. The full set of slides are available here along with previous years learning.

Learning will be incorporated into our Quarterly Incident reports throughout 2023/2024.

Appendix 1 Demographic data for patients affected in all incidents reported between 1 April 2022 and 31 March 2023

In line with the Equality Impact Assessments in the incident reporting and management policy and investigating and analysing incidents policy, we have provided data for all incidents and serious incidents occurring during 2022/2023. This is to aid discussion in Business Delivery units to give insight into improvement opportunities. Further detail is available from patient safety support team or on Datix at local level.

Data relating to a limited number of protected characteristics for individuals involved in incidents (age, gender, ethnicity) is available on Datix for reported incidents. More recently, we have also started to collect data on sexuality. It should be noted that each person linked to an incident will have some level of demographic data recorded, but for the purposes of this report, we have focussed on the person affected. NHS England and Improvement are developing a new Learning from Patient Safety Events system (LFPSE) that will bring together patient safety incident reporting. The development of this system will hopefully strengthen data collection in a standardised format across the NHS. The collection of equality data cannot be mandated locally on Datix because information on any protected characteristics of the patients or staff involved in an incident may not be immediately available to the reporter (as identified by NHSE). Making its collection mandatory could act as a barrier to reporting and lead to fewer incidents being reported. As with the national position, we consider it is more important to collect incomplete information about risks to patients and staff than to potentially block reporting of that information by mandating the inclusion of information that reporters may not have or record inaccurately.

It is hoped that information collection on protected characteristics will be improved at the review/investigation stage of adverse events rather than incident reporting stage. As such, we have provided data related to serious incident investigations below. The new LFPSE system as a whole will improve safety for all patients and further developments in data linkage and collection should make it possible to identify any patient safety concerns that may disproportionately impact on groups with protected characteristics.

Staff are reminded through the above policies to ensure that the equality data fields on the incident report form are completed and when managers are checking for matching contacts in the database that this information is updated to that held in staff and clinical records.

For the purposes of analysing data that we do hold on Datix (age band, gender, ethnicity), we have provided data to breakdown the 14,352 incidents reported during 2022/2023 by the person/s affected by the incident - this has been separated into incidents affecting staff and those affecting patients. This accounts for 15021 affected contacts (please note this is not the number of unique individuals involved, i.e., one person may be linked to multiple incidents).

Person affected – patient

Figure 32 All incidents 2022/2023 where person affected was a patient, by gender and age band

	under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	Age not recorded	Total
Male	331	698	535	402	290	424	631	2422	5733
Female	496	329	213	233	307	318	830	2037	4763
Transgender	99	15	0	0	0	0	0	10	124
Person lives and works permanently in a gender other than that assigned at birth	57	2	5	1	1	0	0	22	88
Not stated unknown	7	1	4	3	2	1	1	47	66
Prefers not to say	7	0	0	0	0	0	0	8	15
Form not returned/left blank	0	0	0	0	0	0	0	7	7
Total	**997**	**1045**	**757**	**639**	**600**	**743**	**1462**	**4553**	**10796**

Figure 33 All incidents 2022/2023 where person affected was a patient, by ethnicity and age band

	under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	Age not recorded	Total
Any other ethnic group	12	2	1	0	0	1	1	15	32
Asian/Asian British - Any other Asian background	3	11	14	6	3	4	0	16	57
Asian/Asian British - Bangladeshi	0	8	0	0	0	1	0	11	20
Asian/Asian British - Chinese	1	0	0	0	0	0	2	1	4
Asian/Asian British - Indian	7	4	6	15	1	1	0	25	59
Asian/Asian British - Pakistani	25	69	85	33	13	2	5	274	506
Black/African/Caribbean/ Black British - African	12	14	20	2	0	0	0	42	90
Black/African/Caribbean/ Black British - Any other Black background	3	6	2	1	0	2	0	40	54
Black/African/Caribbean/ Black British - Caribbean	11	3	15	21	18	2	1	19	90
Form not completed/form left blank (Customer Services only)	3	0	1	2	1	1	2	29	39
Mixed/multiple ethnic group - white and black African	0	7	0	0	2	5	0	6	20
Mixed/multiple ethnic groups - white and Asian	8	14	1	0	0	2	0	13	38
Mixed/multiple ethnic groups - white and black Caribbean	5	8	2	0	1	1	0	16	33
Not stated	40	256	42	87	65	52	77	324	943
Other ethnic group - Arab	1	1	3	3	1	0	0	13	22
Other mixed	5	0	0	0	0	0	0	5	10

Prefers not to say	1	0	0	0	0	0	0	0	1
Unknown	20	65	22	22	29	70	18	179	425
White - any other white background	11	10	5	10	4	6	13	77	136
White - English/Welsh/Scottish/Northern Irish/British	829	566	537	434	461	593	1339	3414	8173
White - Gypsy or Irish Traveller	0	0	0	0	0	0	0	2	2
White - Irish	0	1	1	3	1	0	4	32	42
Total	**997**	**1045**	**757**	**639**	**600**	**743**	**1462**	**4553**	**10796**

Figure 34 All incidents 2022/2023 where person affected was a patient, by ethnicity and gender

	Female	Male	Transgender	Form not returned/left blank	Not stated unknown	Person lives and works permanently in a gender other than that assigned at birth	Prefers not to say	Total
Any other ethnic group	10	22	0	0	0	0	0	32
Asian/Asian British - Any other Asian background	15	42	0	0	0	0	0	57
Asian/Asian British - Bangladeshi	0	20	0	0	0	0	0	20
Asian/Asian British - Chinese	2	2	0	0	0	0	0	4
Asian/Asian British - Indian	30	29	0	0	0	0	0	59
Asian/Asian British - Pakistani	84	421	0	0	0	1	0	506
Black/African/Caribbean/Black British - African	25	65	0	0	0	0	0	90
Black/African/Caribbean/Black British - Any other Black background	34	20	0	0	0	0	0	54
Black/African/Caribbean/Black British - Caribbean	21	69	0	0	0	0	0	90
Form not completed/form left blank (Customer Services only)	33	6	0	0	0	0	0	39
Mixed/multiple ethnic group - white and black African	15	5	0	0	0	0	0	20
Mixed/multiple ethnic groups - white and Asian	18	20	0	0	0	0	0	38
Mixed/multiple ethnic groups - white and black Caribbean	20	12	0	0	1	0	0	33
Not stated	271	621	0	7	43	1	0	943
Other ethnic group - Arab	2	20	0	0	0	0	0	22
Other mixed	6	4	0	0	0	0	0	10
Prefers not to say	1	0	0	0	0	0	0	1
Unknown	161	243	0	0	18	2	1	425
White - any other white background	77	59	0	0	0	0	0	136
White - English/Welsh/Scottish/Northern Irish/British	3930	4017	124	0	4	84	14	8173
White - Gypsy or Irish Traveller	2	0	0	0	0	0	0	2
White - Irish	6	36	0	0	0	0	0	42
Total	**4763**	**5733**	**124**	**7**	**66**	**88**	**15**	**10796**

Figure 35 All incidents 2022/2023 where person affected was a patient, by Care Groups and age band

	Under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	Age not recorded	Total
Adult and Older People Mental Health Care Group	610	581	344	380	324	418	472	2657	5786
Barnsley Integrated Care Group	123	71	101	114	183	277	976	794	2639
CAMHS and Children's Care Group	147	1	3	0	0	0	3	34	188
Forensic Service	82	177	296	125	69	43	0	722	1514
Learning Disability and ASD/ADHD Care Group	32	213	10	17	18	3	10	330	633
Trustwide support services	3	2	3	3	6	2	1	16	36
Total	**997**	**1045**	**757**	**639**	**600**	**743**	**1462**	**4553**	**10796**

Figure 36 All incidents 2022/2023 where person affected was a patient, by Care Groups and sexuality

	Heterosexual	Not stated	Prefers not to say	Unknown	Form not returned/left blank	Total
Adult and Older People Mental Health Care Group	126	14	1	56	5589	5786
Barnsley Integrated Care Group	8	0	0	0	2631	2639
CAMHS and Children's Care Group	1	0	0	0	187	188
Forensic Service	59	0	0	0	1455	1514
Learning Disability and ASD/ADHD Care Group	1	0	0	0	632	633
Trustwide support services	0	0	0	1	35	36
Total	**195**	**14**	**1**	**57**	**10529**	**10796**

Person affected – staff (includes the Trust employees, local authority staff, bank, agency staff, volunteers, and student's trainee on placement)

Figure 37 All incidents 2022/2023 where person affected was a staff member, by gender and age band

	Under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	Age not Recorded	Total
Female	95	158	115	141	140	12	4	2306	2971
Male	14	51	53	57	59	5	7	944	1190
Not stated unknown	1	1	2	0	0	1	0	55	60
Prefers not to say	0	0	0	0	0	0	0	2	2
Form not returned/left blank	0	0	0	0	0	0	0	2	2
Total	**110**	**210**	**170**	**198**	**199**	**18**	**11**	**3309**	**4225**

Figure 38 All incidents 2022/2023 where person affected was a staff member, by ethnicity and age band

	18 to 24 years	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	Not recorded	Total
Any other ethnic group	0	0	0	0	0	0	0	4	4
Asian/Asian British - Any other Asian background	5	1	0	1	0	0	0	11	18
Asian/Asian British - Bangladeshi	0	0	0	0	0	0	0	1	1
Asian/Asian British - Chinese	0	0	1	0	0	0	0	0	1
Asian/Asian British - Indian	0	3	3	1	0	0	0	32	39
Asian/Asian British - Pakistani	6	8	4	0	2	0	0	54	74
Black/African/Caribbean/Black British - African	3	4	5	10	2	0	0	296	320
Black/African/Caribbean/Black British - Any other Black background	0	0	0	1	0	0	0	45	46
Black/African/Caribbean/Black British - Caribbean	0	0	1	2	0	0	0	34	37
Form not completed/form left blank (Customer Services only)	0	0	0	0	0	0	0	2	2
Mixed/multiple ethnic group - white and black African	0	0	0	0	0	0	0	7	7
Mixed/multiple ethnic groups - white and Asian	3	0	0	0	0	0	0	5	8
Mixed/multiple ethnic groups - white and black Caribbean	0	2	2	0	0	0	0	9	13
Not stated	15	43	26	29	23	2	0	727	865
Other ethnic group - Arab	0	0	2	1	0	0	0	7	10
Other mixed	0	0	0	0	0	0	0	2	2
Prefers not to say	0	9	1	2	0	0	0	30	42
Unknown	4	6	5	2	2	1	0	189	209
White - any other white background	1	4	5	2	3	0	0	21	36
White - English/Welsh/Scottish/Northern Irish/British	73	130	115	145	162	15	11	1825	2476
White - Irish	0	0	0	2	5	0	0	8	15
Total	**110**	**210**	**170**	**198**	**199**	**18**	**11**	**3309**	**4225**

Figure 39 All incidents 2022/2023 where person affected was a staff member, by ethnicity and gender

	Female	Male	Form not returned/left blank	Not stated unknown	Prefers not to say	Total
Any other ethnic group	4	0	0	0	0	4
Asian/Asian British - Any other Asian background	14	4	0	0	0	18
Asian/Asian British - Bangladeshi	1	0	0	0	0	1
Asian/Asian British - Chinese	0	1	0	0	0	1
Asian/Asian British - Indian	16	22	0	1	0	39
Asian/Asian British - Pakistani	58	16	0	0	0	74
Black/African/Caribbean/Black British - African	138	182	0	0	0	320

Black/African/Caribbean/Black British - Any other Black background	14	32	0	0	0	46
Black/African/Caribbean/Black British - Caribbean	26	11	0	0	0	37
Form not completed/form left blank (Customer Services only)	0	0	1	1	0	2
Mixed/multiple ethnic group - white and black African	3	4	0	0	0	7
Mixed/multiple ethnic groups - white and Asian	8	0	0	0	0	8
Mixed/multiple ethnic groups - white and black Caribbean	12	1	0	0	0	13
Not stated	601	220	0	43	0	864
Other ethnic group - Arab	5	5	0	0	0	10
Other mixed	1	1	0	0	0	2
Prefers not to say	29	13	0	0	0	42
Unknown	115	80	1	13	1	210
White - any other white background	31	5	0	0	0	36
White - English/Welsh/Scottish/Northern Irish/British	1885	588	0	2	1	2475
White - Irish	10	5	0	0	0	15
Total	**2971**	**1190**	**2**	**60**	**2**	**4225**

Figure 40 All incidents 2022/2023 where person affected was a staff member, by Care Groups and age band

	Under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	Not Recorded	Total
Adult and Older People Mental Health Care Group	54	88	65	93	94	7	2	1400	1803
Barnsley Integrated Care Group	9	25	24	31	27	5	9	119	249
CAMHS and Children's Care Group	2	7	17	6	4	0	0	42	78
Forensic Service	31	66	39	37	30	4	0	1128	1335
Learning Disability and ASD/ADHD Care Group	13	18	11	15	31	0	0	587	675
Trustwide support services	1	6	14	16	13	2	0	33	85
Total	**110**	**210**	**170**	**198**	**199**	**18**	**11**	**3309**	**4225**

Figure 41 All incidents 2022/2023 where person affected was a staff member, by Care Group and sexuality

	Heterosexual	Not stated	Unknown	Form not returned/left blank	Total
Adult and Older People Mental Health Care Group	3	2	1	1797	1803
Barnsley Integrated Care Group	0	1	0	248	248
CAMHS and Children's Care Group	0	0	0	78	78
Forensic Service	19	0	0	1316	1334
Learning Disability and ASD/ADHD Care Group	0	0	0	675	675
Trustwide support services	2	0	0	83	83
Total	**24**	**3**	**1**	**4197**	**4225**

Serious Incidents- Demographic data

The tables below give a breakdown of the patients affected involved in serious incidents.

Figure 42 Demographic data for patients affected in serious incidents reported between 1/4/2022 and 31/3/2023, by Geographical, gender and age band (as recorded on Datix)

	Under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	Total
Barnsley	**0**	**0**	**0**	**0**	**2**	**0**	**2**	**4**
Female	0	0	0	0	1	0	1	2
Male	0	0	0	0	1	0	1	2
Calderdale	**0**	**1**	**0**	**2**	**0**	**0**	**0**	**3**
Male	0	1	0	2	0	0	0	3
Kirklees	**0**	**2**	**1**	**0**	**0**	**0**	**0**	**3**
Female	0	1	1	0	0	0	0	2
Male	0	1	0	0	0	0	0	1
Wakefield	**1**	**0**	**0**	**1**	**0**	**1**	**0**	**3**
Female	1	0	0	1	0	0	0	2
Male	0	0	0	0	0	1	0	1
Total	**1**	**3**	**1**	**3**	**2**	**1**	**2**	**13**

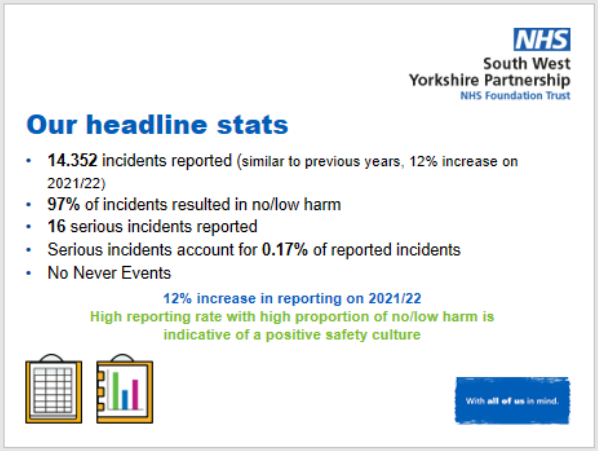
Figure 43 Demographic data for patients affected in serious incidents reported between 1/4/2022 and 31/3/2023, by Geographical, ethnicity and age band (as recorded on Datix)

	Under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	Total
Barnsley	**0**	**0**	**0**	**0**	**2**	**0**	**2**	**4**
White - English/Welsh/Scottish/Northern Irish/British	0	0	0	0	2	0	2	4
Calderdale	**0**	**1**	**0**	**2**	**0**	**0**	**0**	**3**
White - English/Welsh/Scottish/Northern Irish/British	0	1	0	2	0	0	0	3
Kirklees	**0**	**2**	**1**	**0**	**0**	**0**	**0**	**3**
White - English/Welsh/Scottish/Northern Irish/British	0	0	1	0	0	0	0	1
Asian/Asian British - Pakistani	0	1	0	0	0	0	0	1
Not stated	0	1	0	0	0	0	0	1
Wakefield	**1**	**0**	**0**	**1**	**0**	**1**	**0**	**3**
White - English/Welsh/Scottish/Northern Irish/British	0	0	0	1	0	1	0	2
Black/African/Caribbean/Black British - African	1	0	0	0	0	0	0	1
Total	**1**	**3**	**1**	**3**	**2**	**1**	**2**	**13**

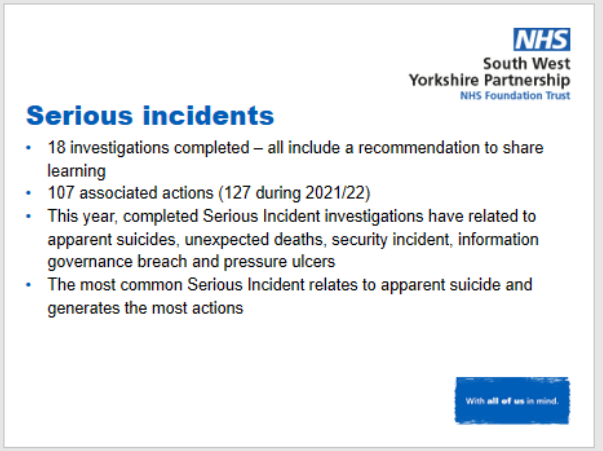
Appendix 2 – Learning from Experience slides

Below is an illustration of our Learning presentation that brings together some of the learning from 2022/2023. The full set of slides are available here along with previous years learning.

1

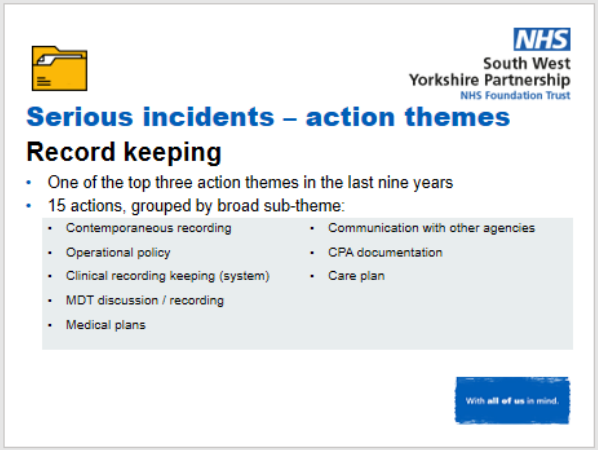


2



3

4



5

6

NHS South West Yorkshire Partnership NHS Foundation Trust

Serious incidents – action themes

Care Delivery

- In the top three action themes in the last three years
- 9 actions, grouped by broad sub-theme:

- Care planning
- Communication with patient and/or family/carers
- Roles and responsibilities
- Monitoring compliance of clinical record keeping
- MDT working and meetings
- Monitoring compliance

With all of us in mind.

7

NHS South West Yorkshire Partnership NHS Foundation Trust

Serious incidents – action themes

Care Pathway

- In the top three action themes in the last three years
- 9 actions, grouped by broad sub-theme:

- Care planning
- Organisational systems
- Referral process
- Transitions in care
- Care Pathway

With all of us in mind.

8

NHS South West Yorkshire Partnership NHS Foundation Trust

Serious incidents – action theme

Team/service systems, roles & management

- In the top three action themes in the last three years
- 9 actions, grouped by broad sub-theme:

- Risk assessment and management
- Standard operating procedures
- Operational policy
- Supervision
- Access to clinical information
- MDT working and meetings
- Team building and staff development

With all of us in mind.

9

NHS South West Yorkshire Partnership NHS Foundation Trust

Learning and improvement

Some key examples of lessons learned and action outcomes from across our geographical areas, Care Groups and Specialists.

With all of us in mind.

10

NHS South West Yorkshire Partnership NHS Foundation Trust

Learning from Serious Incidents – Risk Assessment

Outcomes from Serious incident investigations highlighted;-

Learning from the National Confidential Inquiry for Suicide (NCISH) identified risk assessments tools should not be used as a means to predict suicide and that the aims for mitigation of risk in suicide lie in the collaboration with the individual, for example with thoughts of suicide, building a therapeutic relationship, the active involvement and engagement of people who are close to the person (family/carer or significant others).

https://sites.manchester.ac.uk/ncish/reports/the-assessment-of-clinical-risk-in-mental-health-services/

With all of us in mind.

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NHS South West Yorkshire Partnership NHS Foundation Trust

Learning from Serious Incidents – Risk Assessment continued

Individuals bereaved through suicide are at a greater risk of loss of life through suicide, Information previously shared through the Trust Learning Library had identified that the Trust's own review into apparent suicides (March 2020-April 2021) demonstrated that out of 61% of people experiencing several life events, bereavement had been one of the key themes. There is learning to share across all teams in ensuring the impact of the loss on the meaning and purpose of the bereaved person's life is captured within the risk assessment process and active referral for bereavement support (in particular for suicide bereavement) is undertaken.

Bereavement and Suicide

With all of us in mind.

12

NHS South West Yorkshire Partnership NHS Foundation Trust

Learning from Serious Incidents – Risk Assessment continued

Risk assessment information should be recorded within the FIRM risk assessment document on SystmOne, as well as progress notes. The absence of full risk assessment information and formulation within the risk assessment documentation could impact on future decision making in care and treatment and increase risk.

The Trust FIRM risk assessment training is available to staff to support an understanding that it is a framework to record clinical judgements about risk that inform management and care plans.

With all of us in mind.

13

NHS South West Yorkshire Partnership NHS Foundation Trust

Learning from Serious Incidents – Record Keeping

Outcomes from Serious incident investigations highlighted;-

- The importance of contemporaneous record keeping, in particular discussions with service users, families/carers, medication and care plans.
- Telephone calls made from family/carers in respect to service user progress should be robustly recorded and be used to consider wider family connections as part of assessment, evaluation and care planning.
- Multi-disciplinary team meeting discussions should be documented with outcomes added to SystmOne records.
- Level of access to information/records held by external partnership organisations requires a joined up approach for service users that present to different organisations, with the nature of involvement accurately recorded.

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NHS South West Yorkshire Partnership NHS Foundation Trust

Learning from Serious Incidents – Record Keeping continued

- As a part of the safety planning process in the community, consideration should be given to the discussion and documentation of access to means. Although access to means in the community cannot be eliminated, it is advisable to document that it has been asked for removal.
- Should a service user identify a specific drug they are prescribed as a means to harm themselves consideration should be taken at assessment to manage these drugs to reduce access and/or availability and this should be recorded.

With all of us in mind.

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NHS South West Yorkshire Partnership NHS Foundation Trust

Learning from Serious Incidents – Team systems, roles, management

Outcomes from Serious incident investigations highlighted;-

- Supervision should be planned in advance and recorded accurately to represent the practice of each supervision.
- Completion of Cardiopulmonary Resuscitation/Basic Life Support/Immediate Life Support training for all in-patient services, in line with Trust policy (regardless of completion at another NHS organisation).
- Each ward/team should have the appropriate Emergency Response Procedure for that area attached to/within their emergency bag/AED for staff to follow/consult in an emergency.
- A robust induction for staff, to be signed off by staff and manager.

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NHS South West Yorkshire Partnership NHS Foundation Trust

Learning from Serious Incidents – Care Pathway

Outcomes from Serious incident investigations highlighted;-

- Service users, their families and/or carer involvement is actively sought both at the initial assessment stage and also as care plans are reviewed and changed throughout the service users care journey.
- Improved joint-working arrangements between exercise therapy and dietetics that provide an integrated approach to weight management in secure services.
- Service users with a diagnosis of substance misuse must have a care plan to address this.

With all of us in mind.

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NHS South West Yorkshire Partnership NHS Foundation Trust

Learning from Serious Incidents – Discharge/transfer

Outcomes from Serious incident investigations highlighted;-

- Advice provided by Trust services is based on an assessment of the service user's clinical record and that this advice is shared and understood with other NHS organisations, particularly that of observation levels.
- Trust governance processes have been reviewed to capture good practice identified where service users will remain within the current team caseload until they are able to transfer to the agreed team for onward management.
- A review of the formal and informal links between general and secure services was recommended, particularly where service users with conditions that must stay under the care of secure services are identified.

With all of us in mind.

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Learning from Serious Incidents – Pressure ulcer care

Adherence to the Wound Care Policy for the Prevention and Management of Pressure Damage and Treatment and Management of All Wounds 2018 – 2023, particularly in relation to;-

- An assessment of risk of developing pressure damage to be conducted on the first visit.
- Risk of developing pressure damage re-assessed following changes in condition (at least weekly for service users with existing ulcers).
- Liaison with the SystmOne team to introduce automatic alerts when Waterlow risk assessments have not been completed.
- Stronger working relationships with care homes from hospital discharge to rehabilitation.

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Learning from Serious Incidents – Physical Health

- Where a service user has physical health concerns as well as mental health concerns, a multi-agency approach should be adopted to ensure that a holistic approach to care is provided.
- Consideration should be given to safeguarding concerns that need raising after a service user has a fall.

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#allofusimprove and be outstanding Learning Library

Below is a summary of learning that has been shared through our Learning Library:

- Ockenden report
- The Myth of Invisible Men
- Learning from serious incidents
- Parental consent to vaccination
- Private ambulance
- Administering medicines to a patient on an acute mental health ward
- Learning from a homicide
- Virginity testing
- Care planning for Missing patient
- Carers and suicidality
- Risk of using toaster bags
- Recording escapes from wards
- Sexual safety
- Deaths where Clozapine was prescribed
- Safer discharge from hospital
- Inpatient ligature incident
- Children's therapy – allergy risk
- Under 18 pregnancy
- Adrenaline accident during training

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#allofusimprove and be outstanding Learning Network

Below is a summary of learning that has been shared at our Learning Network forum:

- Learning from apparent suicides
- Cuckooing
- Medication safety
- Parental consent to vaccination
- Ockenden report
- Sharing previous years:
  - Incident annual report
  - Learning report
  - Apparent suicide report
- Infection Prevention and Control themes
- Me and my medicine
- Learning from serious incidents
- Medication management on a ward
- Honour based violence
- Under 18 admission on a ward
- Children's therapy – allergy risk

We have also held several Trust wide learning events to share learning from a thematic review into choking serious incidents and two learning events following the publication of Mental Health Homicides.

Bluelight Alert

Sharing urgent safety information and learning from incidents

- Safe batteries
- Ligature risk from piano door hinge
- Ligature risk from collapsible shower rails
- Using chlorine based solutions to decontaminate blood and body spills
- Key fault
- Shower head used as a fixed ligature with Blu tack
- E-burn e-cigarette fire risk
- Countersigning of medicines administration on electronic prescribing and medication administration system (EPMA)
- Oxygem concentrator and emergency cylinders
- F-sized oxygen safety incidents
- Suspended ligature from door closure with a corridor area

Greenlight Alert

Sharing medication safety information

- Medicines in cars – checking formulations
- Adrenaline in the community
- Chlordiazepoxide, rescue medication

In November 22 the pharmacy team also sent out Top Tips for medicines in the community and administering meds on EPMA (not Greenlights)

With all of us in mind.

NHS
South West
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NHS Foundation Trust

Learning from healthcare deaths

An overview of themes identified from reviews and investigations that have been completed during 2022/23. Where appropriate, comparative data for previous periods is included.

With all of us in mind.

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Learning from Structured Judgement Reviews

Assessment of care overall

- **63%** of 167 reviews completed to date rated this as good or excellent.
- Over time, we are seeing less poor or adequate care identified.

Quality of the service user record in enabling good quality of care to be provided

- **59%** of 167 reviews completed rated this good or excellent.
- This continues to show an improvement over time.

With all of us in mind.

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NHS Foundation Trust

Learning from Structured Judgement Reviews

Phases of care (reviewed where relevant)

Risk assessment

- **52%** of 162 reviews completed rated this as good or excellent.
- This percentage has increased slightly from the last year (51%).
- In 2019 this was 35% which shows an improvement in the quality of risk assessment recording, and corelate with this no longer appearing in the top 3 themes from Serious Incidents

Allocation / initial review

- **66%** of the 154 reviews completed rated this as good or excellent.
- This is an improvement compared to this time last year (62%)

With all of us in mind.

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NHS Foundation Trust

Learning from Structured Judgement Reviews

Phases of care (reviewed where relevant)

Ongoing care

- **62%** of the 159 reviews completed rated this as good or excellent.
- Improvement on last years position (59%)

Care during admissions (where applicable)

- **73%** of the 55 reviews completed rated this as good or excellent.
- Same position as last year, but more cases reviewed (73%)

With all of us in mind.

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NHS Foundation Trust

Learning from Structured Judgement Reviews

Phases of care (reviewed where relevant)

Follow-up management / discharge:

- **62%** of the 114 reviews completed rated this as good or excellent.
- This is the same position to previous analysis (59%).

End of life care

- **100%** of the 4 reviews completed rated this as good or excellent.
- This has remained consistent.
- There are no new cases that featured end of life care in 2022/23.

With all of us in mind.

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NHS Foundation Trust

Learning from Structured Judgement Reviews

Themes from actions for improvement

Action theme	Number of actions
Risk assessment	4
Care pathway	2
Record keeping	1
Care delivery	1
Carers/family	1
Care coordination	1
Staff education, training, and supervision	0
Total	**10**

There are less actions arising from Structured Judgement Reviews this year compared with last year (20) which shows improvement

With all of us in mind.

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Learning from Service Level Investigations (SLI) and Significant Event Analysis (SEA)

NHS South West Yorkshire Partnership NHS Foundation Trust

Themes from actions for improvement

	Local review	SLI	SEA	Total
Record keeping	0	15	3	18
Risk assessment	0	6	1	7
Staff education, training and supervision	0	5	1	6
Carers/family	0	5	0	5
Care delivery	0	5	0	5
Communication	0	3	1	4
Medicine management	1	2	0	3
Environmental	0	3	0	3
Discharge/follow up	0	0	3	3
Care coordination	0	3	0	3
Team service systems, roles and management	0	1	0	1
Policy and procedures, not in place	0	1	0	1
Policy and procedure - in place but not adhered to	0	1	0	1
Care pathway	0	1	0	1
Grand Total	**1**	**51**	**9**	**61**

With all of us in mind.

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Continuing to develop how learning is shared

NHS South West Yorkshire Partnership NHS Foundation Trust

Well designed patient safety information systems, including:

- Reporting into the National Reporting and Learning System (NRLS) and is replacement Learn From Patient Safety Events.
- Serious incident investigations routinely followed by a learning event for the individual teams or services involved, led by the lead serious incident investigator
- The Patient Safety Support Team support and monitor the Serious Incident process, giving information to the Clinical Governance and Clinical Safety Committee and Trust Board.
- Our Internal learning systems

The Patient Safety Support Team also work closely with a range of external agencies including the CQC, ICBs, and regional networks.

With all of us in mind.

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NHS South West Yorkshire Partnership NHS Foundation Trust

How we share learning at all levels

Our methods of sharing learning from incidents at all levels:

- Learning library
- Bluelight alert system
- Greenlight alerts
- Learning Network
- SBAR tools

With all of us in mind.

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Areas to develop in 2023/24

NHS South West Yorkshire Partnership NHS Foundation Trust

We are preparing to transition to the new Patient Safety Incident Response Framework (PSIRF) from Autumn 2024, we are:

- Analysing our patient safety data from a wide range of sources including serious incident themes to identify our patient safety priority areas
- Assessing our capacity for responding to patient safety incidents
- Considering which Learning Response type will be appropriate for our priorities (see image) →
- Developing safety improvement plans for change
- We will adapt our method of sharing learning in line with our developments.

Implementing Learn From Patient Safety Events (LFPSE)

- A new national system for learning linked to local systems

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NHS South West Yorkshire Partnership NHS Foundation Trust

Thank you for supporting a patient safety culture

Contact the patient safety team: patientsafety@swyt.nhs.uk

With all of us in mind.

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NHS South West Yorkshire Partnership NHS Foundation Trust

With **all of us** in mind.

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South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2023
Agenda item 10.2

Private/Public paper:	**Public**		
Title:	**Care Quality Commission (CQC) inspections – initial feedback**		
Paper presented by:	Darryl Thompson, Chief Nurse and Director of Nursing, Quality and Professions		
Paper prepared by:	Darryl Thompson, Chief Nurse and Director of Nursing, Quality and Professions		
Mission/values:	The report demonstrates the Trust's commitment to be honest, open and transparent, and to improve and aim be outstanding.		
Purpose:	Presented to Board today are the two letters of written feedback received following the inspections of mental health in-patient and forensic in-patient services in May 2023.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	This report aligns to all areas of the BAF. CQC inspections cover all aspects of care including whether a service is well led. The regulatory oversight paper identifies areas of concern and areas of strength identified within the CQC inspection framework.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Understanding our performance against the CQC framework allows a benchmark of our service and care delivery locally and nationally. It allows us to internally assure ourselves of the care we deliver and provide this assurance to our stakeholders, partners and communities. The CQC inspection provides an opportunity to test this assurance, learn and develop.		
Any background papers / previously considered by:	Clinical Governance and Clinical Safety Committee receives a regular paper with updates around all CQC or other regulatory contact. These two letters from the CQC were reviewed in the private section of Clinical Governance Clinical Safety Committee on 13 May.		
Executive summary:	On the 16 May 2023, the CQC undertook unannounced inspections of two core services: acute mental health inpatients and psychiatric intensive care units (PICU), and forensic inpatient services. The inspectors were on site for a period of three days during working hours and visited one ward during the evening to witness handover and night processes. Following the visits some initial verbal feedback was provided to the Trust. Two letters with initial written feedback were subsequently sent to Mark Brooks, chief executive.		

	These attached letters contain the initial feedback received from the inspectors. They do not constitute the report, which will be received within 50 working days of the inspection. Following receipt of the report a factual accuracy check will be completed and returned to the CQC for their consideration before the report is published. On receipt of the service ratings, this may potentially have an impact on the overall Trust rating. Points to particularly note in each letter are as follows: **Acute Mental Health and PICU wards:** • The inspectors observed positive and caring interactions between staff and patients on all the acute/PICU wards visited. • Patients told inspectors that staff treated them with kindness and respect. • The wards were safe, clean and free from avoidable hazards such as unmitigated ligature risks. • Medicines were well-managed, and staff told inspectors that the new electronic prescribing and medicines administration system (EPMA) was very beneficial. • Staff felt valued. • Inspectors identified some areas where people's specific needs were not always fully taken into account, e.g. access to person-centred psychological support and meeting cultural needs. • Use of a non-bedroom area at Kendray Hospital for admissions. • All wards impacted by staffing pressures, which in turn impacted on such as activities and supporting service user leave off the ward. • Inspectors did not identify any concerns about culture on the wards. **Forensic services:** • Not all wards had an up-to-date ligature risk assessment and staff were not always aware of ligature risks on the wards or how they were locally managed. • Some staff told inspectors that they felt unsafe because blind spots were not always mitigated effectively. • There was a lack of activities across a number of the wards. • Inspectors observed some positive interactions between staff and patients and received lots of positive feedback regarding permanent staff. • Patients told inspectors that some staff really cared about them. • EPMA was seen as a really effective tool. • Clinic rooms were generally well maintained, but some out of date and un-checked equipment was found by inspectors. • Fridge temperatures (where medication is stored) were not always checked on some wards. • Inspectors were unclear about the kind of security checks [of the environment of the ward] that were being undertaken. • Staff were positive about some of the training being offered. **Initial response from the Trust:** • Out of date and unchecked equipment was addressed immediately.

	• A refreshed ligature risk management process is now in place across all wards. • The induction process, both for substantive and temporary staff, has been reviewed to ensure ligature awareness. • Pharmacy colleagues have overseen our response to fridge temperatures. • All the data requests subsequently received by the Trust were responded to as required. • The inspected services have reviewed any learning and taken action to ensure improvement is made where this is required. **Risk appetite** Compliance risks: Failure of the Trust to comply with its licence, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation. Risk appetite Minimal / low Cautious / moderate Risk target 1-6 • Risk of failing to comply with NHS England requirements impacting on the Trust's licence. • Risk of failing to comply with CQC standards and potential of compliance action. • Risk of failing to comply with health and safety legislation. • Risk of failing to comply with Fire Safety (England) Regulations 2022. • Risk of failing to comply with data security protection toolkit standards, including meeting cyber essentials standards. • Risk of failing to comply with our statutory responsibilities under the Equality Act 2010, especially the Public Sector Equality Duty (PSED) and the Health and Social Care Act 2022
Recommendation:	**Trust Board is asked to RECEIVE this executive summary and the CQC response letters.**

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

Our reference: INS2-14937029681

Mr. Mark Brooks
Chief Executive/
South West Yorkshire Partnership Foundation Trust
Fieldhead
Ouchthorpe Lane
Wakefield
West Yorkshire
WF1 3SP

Date: 23/05/2023

CQC Reference Number: RXG – Forensics wards

Dear Mr. Brooks

Re: CQC inspection of South West Yorkshire Partnership NHS Foundation Trust/ Fieldhead Hospital

Following your feedback meeting with Sionadh Curtis, Hannah Schofield and Rachel Unsworth on 18/05/2023. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to Darryl Thompson at the feedback meeting.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed back on 18/05/2023 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied into this letter.

An overview of our feedback

The feedback to you was:

Not all wards had an up to date ligature risk assessment, several wards had ligature risk assessments that had been completed in December but not ratified. We found inconsistent ligature risks across all wards. Staff were not always aware of ligature risks on wards. Several managers found it difficult to locate the ligature risk

assessments. It was not always clear how ligature risks were mitigated locally, when ligature risks stated that risks were locally managed.

Some staff told us they felt unsafe because blind spots were not always mitigated effectively.

There was a lack of activities across a number of the wards. A lot of activities were stopped prior to Covid and have not started again, particularly those based on the wards. A number of rooms were being used for hydration stations which was impacting on patient space, particularly on smaller wards such as Priestly ward. Patients were unable to use kitchens due to infection control unless they were on a one to one with an OT, this was highlighted by staff and patients as limiting patient activities, particularly on wards where patients did not have any leave. Activities across wards appeared inconsistent with some wards providing a range of activities and some wards providing very few activities.

We noted that there was issue with confidentiality on Priestly ward, discussions in the therapy room can be overheard.

We observed some positive interactions between staff and patients and received lots of positive feedback regarding permanent staff. Patients told us that some staff really cared about them.

The new meds system, EPMA was seen as really effective tool, it had reduced medication errors kept everything in one place.

Clinic rooms were generally well maintained, however the clinic room and dispensary on Johnson ward had a range of equipment that was out of date. The red bag on Johnson ward had not been checked since March. Fridge temperatures on several wards had not always completed and Johnson ward had a different form which did not record maximum and minimum temperatures. One ward recorded maximum fridge temperatures of 13 and it was not obvious that any action had been taken in response to this.

We found that some call alarms had been deactivated, one of these was due to patient behaviour and this had not been reviewed.

Security checks appeared to be taking place weekly and we were unclear what kind of daily security checks were taking place and whether these are recorded.

We spoke to staff who were positive about some of the specialist training being offered which included the Oliver McGowan training, curious conversations and Mary Seacole training.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Margaret Kitching at NHSE.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Sheila Grant

Deputy Director of Operations

c.c. Marie Burnham – Chair of Trust
Margaret Kitching – Chief Nurse for Yorkshire, NHSE
Angela Clark – CQC Regional Communications Manager

Care Quality Commission
Citygate
Gallowgate
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NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

Mr. Mark Brooks
Chief Executive
South West Yorkshire Partnership NHS
Foundation Trust
Fieldhead Hospital
Ouchthorpe Lane
Wakefield
West Yorkshire
WF1 3SP

Date: 23/05/2023

CQC Reference Number: INS2-14937029681

Dear Mr. Brooks

Re: CQC inspection of South West Yorkshire Partnership NHS Foundation Trust

Following the feedback meeting with Julia Zebelys on 23/05/2023 we are writing to give written feedback as highlighted at the inspection and given to Carmain Gibson-Holmes and Carol Harris at the feedback meeting.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed back on 23/05/2023 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied into this letter.

An overview of our feedback

We observed positive and caring interactions between staff and patients on all the acute/PICU wards we visited. Patients generally spoke highly of the support they were receiving from staff and we did not identify any concerns about culture on the wards.

The wards were safe, clean and free from avoidable hazards such as unmitigated ligature risks. We saw evidence of learning from incidents being implemented to improve the safety of the wards.

Medicines were well managed and staff told us that the new EMPA electronic prescribing system was very beneficial in supporting them with medicines management.

We did not identify any concerns about the overuse of restraint, seclusion or other restrictive practices on any of the wards we visited. Patients told us that staff treated them with kindness and respect.

Staff at all levels generally spoke positively about their experience as an employee of the trust. Staff felt valued and did not complain of unmanageable levels of work-related stress.

We identified some areas where people's specific needs were not always fully taken into account in the provision of care to them on the acute/PICU wards. Examples were access to person-centred psychological support and meeting cultural needs.

Similarly, we identified some issues with the care environment not meeting people's individual needs, for example accessibility for wheelchair users, ensuring privacy and dignity and balancing the management of environmental risks with the principle of least restriction.

There had been several occasions recently when a patient had been admitted to a non-bedroom area at Kendray Hospital, for example the quiet lounge or the extra care area. Staff and patients raised concerns about the impact of this both for the individual concerned and the ward more generally. Beamshaw ward was at over 100% occupancy when we visited and staff told us it was common practice to admit to the beds of people on longer term section 17 leave.

All the acute/PICU wards had been impacted by staffing pressures, particularly in relation to qualified nurses. We were told that at times this was impacting on patient care, for example the ability of staff to facilitate activities and section 17 leave for people.

We found it reassuring that the vast majority of the issues we identified had already been picked up by managers through the trust's governance processes and action was being taken to address them. However, there were some cases where this work was not fully embedded to provide assurance of ongoing monitoring to prevent similar issues recurring.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Margaret Kitching at NHSE.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

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NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Sheila Grant

Deputy Director of Operations

c.c. Marie Burnham – Chair of Trust
Margaret Kitching – Chief Nurse for Yorkshire, NHSE
Angela Clark – CQC Regional Communications Manager

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2023
Agenda item 10.3

Private/Public paper:	**Public**		
Title:	**Trust PAM (Premises Assurance Model) submission 2023**		
Paper presented by:	**Adrian Snarr – Director of Finance, Estates and Resources**		
Paper prepared by:	Cecilia Crump – Specialist Compliance Manager		
Mission/values:	To ensure the Trust makes best use of resources and provides a safe environment for staff, service users and visitors		
Purpose:	To appraise the Board on the Premises Assurance Model submission and to seek Board approval for the latest submission to be uploaded to the NHS England portal in line with guidance from NHSE.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work		
BAF Risk(s):	No BAF risks have been noted around PAM		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The annual PAM submission is a mandatory submission for all NHS Trusts. At the integrated Care Board level it gives an understanding of how well the estate across the whole footprint is being managed. In doing this it can aid decisions on where funding on estate related issues may need to be prioritised.		
Any background papers / previously considered by:	N/A		
Executive summary:	The Trust estate and its related services are integral to the delivery of high-quality clinical care. Therefore, it is essential that the Trust provide a safe, high quality, efficient and effective estate. The NHS Premises Assurance Model (PAM) is a mandatory national Estates and Facilities benchmarking tool designed to be used by NHS organisations for Board reporting, and externally to provide assurance to Regulators and Commissioners. NHS PAM is a complex spreadsheet developed by NHS England, that can be used to collect a snapshot of Estates and Facilities performance to ensure Estates and Facilities services are “fit for purpose based on national best practice and the current regulatory requirements”. It does this through a series		

	of Self-Assessment Questions (SAQ's) to produces a summary report that can be used to demonstrate that robust systems are in place to assure that Trust premises and associated services are safe. This report provides a high-level summary overview of the NHS PAM process undertaken throughout the 2022/23 financial year and details the results of the self-assessment exercise. The self-assessment exercise is wholly reliant on evidence of compliance being included in the PAM submission to ensure that the grading sele3cted can be proven. This evidence is sent in with the submission for review and audit purposes. This report builds on the previous and first PAM submission to Board showing that improvements have been made in subsections of the report whilst maintaining the same score of "good". Within Hard FM improvements have been made within the subset of questions with some areas moving to "outstanding" from "good" The report gives an overall assurance rating of "Good".
Recommendation:	**Trust Board is asked to:** • **NOTE the content of the report** • **NOTE that the overall score is "good".** • **NOTE the improvement to "outstanding" in some areas across the submission.** • **AGREE that the submission of the formal PAM return to NHS England.**

South West Yorkshire Partnership NHS Foundation Trust

ESTATES & FACILITIES DEPARTMENT

Premises Assurance Model (PAM)

Summary Report for 2023 Submission

Produced by Cecilia Crump
Specialist Compliance Manager

South West Yorkshire Partnership NHS Foundation Trust

Contents

NHS
South West
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INTRODUCTION

This report has been produced by Cecilia Crump specialist compliance manager in estates and facilities. It summaries each section of the PAM Report indicating the scoring of each section. The scoring matrix is:

1. Outstanding
2. Good
3. Requires Minimal Improvement
4. Requires Moderate Improvement
5. Inadequate

Executive Summary

A new section has been added which bring the total to 20 sections within Hard FM and all questions have maintained their ratings of Good with 2 improving from Good to Outstanding. One question has been removed and 2 questions are not applicable to the Trust.

There were 14 additional questions added to the Soft FM section this year under SS1 catering. These pertain to Food Standards and 6 new questions under SS4 Cleanliness & Infection Control. The Telephony questions were replaced and extended, and all have scored a rating of Good.

All questions within Patient Experience have maintained their rating as Good.

There was an additional question added to Efficiency and this has been rated Good and all previous questions have maintained their rating as Good.

Within Effectiveness all questions have maintained their ratings of Good with two improving from Good to Outstanding.

All questions within Governance have maintained their rating as Good.

A new Question set labelled Maturity has been added. This pertains to Asset Management, Data Security & Quality. This section has been rated Outstanding as Estates & Facilities have a robust Asset Register that now contains assets for both Estates and Facilities.

A new question set has been added that pertains to Organisational Contact Details. This has been rated as Outstanding.

A new Section has been added for Helipads which is not applicable to the Trust.

South West Yorkshire Partnership NHS Foundation Trust

Hard FM

There are 20 sections within Hard FM each with either 7 or 8 qualifying questions.

Section 1 - With regard to the Estates and Facilities Operational Management – 3 questions rated Outstanding and 5 good. No change from 2022

Section 2 - With regard to the Design, Layout and Use of Premises - 4 questions rated Outstanding and 4 good. This has improved from 2022 where 3 were rated as Outstanding.

Section 3 - With regard to Estates and Facilities Document Management – 1 question rated Outstanding and 7 good. No change from 2022

Section 4- With regard to Health & Safety at Work - 3 questions rated Outstanding and 4 good. No change from 2022

Section 5- With regard to Asbestos - 7 questions rated Outstanding. This has improved from 2022 where 2 were rated as Good.

Section 6 - With regard to Medical Gas Systems – This section is not applicable to the Trust.

Section 7 - With regard to Natural Gas and specialist piped systems - 2 questions rated Outstanding and 6 good. No change from 2022

Section 8 - With regard to Water Safety Systems- 3 questions rated Outstanding and 5 good. No change from 2022

Section 9 - With regard to Electrical Systems - 2 questions rated Outstanding and 6 good. No change from 2022

Section 10 - With regard to Mechanical Systems and Equipment - 2 questions rated Outstanding and 6 good. No change from 2022

Section 11 - With regard to Ventilation, Air Conditioning and Refrigeration Systems - 1 question rated Outstanding and 7 good. No change from 2022

Section 12 - With regard to Lifts, Hoists and Conveyance Systems - 1 question rated Outstanding and 7 good. No change from 2022

Section 13- With regard to Pressure Systems - 1 question rated Outstanding and 7 good. No change from 2022

Section 14 - With regard to Fire Safety - 3 questions rated Outstanding and 7 good. No change from 2022 with the exception of the new questions being rated as Good.

Section 15 - With regard to Medical Devices and Equipment - 4 questions rated Outstanding and 4 good. No change from 2022

Section 16 - With regard to Resilience, Emergency and Business Continuity Planning - 3 questions rated Outstanding and 4 good. No change from 2022

Section 17- With regard to the reporting of safety related issues and actioning of safety related alerts for estates and facilities issues - 1 questions has been removed and1 question improved its rating. 5 are now rated Outstanding and 2 good.

Section 18 - With regard to ensuring estates and facilities services are safe and suitable when the organisation is not directly responsible for providing these services - 1 question rated Outstanding and 7 good. No change from 2022

Section 19 - With regard to Contractor Management for Soft and Hard FM services - 1 question rated Outstanding and 7 good. No change from 2022

Section 20 - With regard to Healthcare Safety Investigation Branch- Medical Gas Pipeline System – This is a new section and is not applicable to the Trust.

Soft FM

There are 10 sections within Soft FM each with either 7 or 8 qualifying questions.

Section 1 - With regard to Catering Service - 1 question rated Outstanding and 21 good. Ratings for questions from 2022 remain the same and additional questions all rated as Good.

Section 2 - With regard to Decontamination Processes - 0 questions rated Outstanding and 8 good. No change from 2022

Section 3- With regard to Waste and Recycling Management - 2 questions are rated Outstanding and 6 good. This has improved from 2022 as one question moved from Good to Outstanding,

Section 4- With regard to Cleanliness and Infection Control applying to Premises and Facilities - 1 question rated Outstanding and 13 good as new questions have been added.

Section 5- With regard to Laundry and Linen Services - 2 questions rated Outstanding and 6 good and improvement on 2022 as two questions moved from Good to Outstanding,

Section 6- With regard to Security Management - 0 question rated Outstanding and 8 good. No change from 2022

Section 7 - With regard to Transport Services and access arrangement - 0 questions rated Outstanding and 8 good. No change from 2022

Section 8- With regard to Pest Control - 1 question rated Outstanding and 7 good. No change from 2022

Section 9- With regard Portering Services - 0 questions rated Outstanding and 8 good. No change from 2022

Section 10 - Estates IT and Building Information Management (BIM) systems- 0 questions rated Outstanding and 8 good. This question set has changed since 2022 but all have rated as good.

Patient Experience

There are 6 sections within Patient Experience each with between 3 and 9 qualifying questions.

Section 1 - With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff- 1 question rated Outstanding and 5 good. . No change from 2022

Section 2- : With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory - 3 questions rated as good. . No change from 2022

Section 3 - With regard to ensuring that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory - 1 question rated Outstanding and 3 good. . No change from 2022

Section 4 - With regard to ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitor - 3 questions rated as good. . No change from 2022

Section 5- With regard to providing a high quality and supportive environment for patients, visitors and staff in relation to Grounds and Gardens - 3 questions rated as good. . No change from 2022

Section 6 - How does your organisation/site ensure that NHS Catering Services provide adequate nutrition and hydration through the choice of food and drink for people to meet their diverse needs - 9 questions rated as good. . No change from 2022

Efficiency

There are 5 sections within Patient Experience each with between 3 and 10 qualifying questions.

Section 1 - With regard to having a well-managed approach to performance management of the estate and facilities operations - 3 questions rated as good. . No change from 2022

Section 2- With regard to having a well-managed approach to improved efficiency in running estates and facilities services - 10 questions rated as good. . No change from 2022

Section 3- With regard to improved efficiencies in capital procurement, refurbishments and land management – There has been an additional question added and all 6 questions rated as good.

Section 4- With regard to having well-managed and robust financial controls, procedures and reporting relating to estates and facilities services - 3 questions rated as good. . No change from 2022

Section 5- With regard to ensuring Estates and Facilities services are continuously improved and sustainability - 7 questions rated as good. . No change from 2022

Effectiveness

There are 4 sections within Patient Experience each with between 4 and 8 qualifying questions.

Section 1 - With regard to having a clear vision and a credible strategy to deliver good quality Estates and Facilities services - 7 questions rated as good. . No change from 2022

Section 2- With regard to having a well-managed approach to town planning - 5 questions rated as good, and one has improved and is now rated as Outstanding.

Section 3 - With regard to having a well-managed robust approach to management of land and property- 4 questions rated as good. . No change from 2022

Section 4 - With regard to having a suitable Sustainability approach in place and being actioned - 7 questions rated as good, and one has improved and is now rated as Outstanding.

Governance

There are 3 sections within Patient Experience each with between 4 and 12 qualifying questions.

Section 1 - With regard to ensuring the Estates and Facilities governance framework has clear responsibilities and that quality, performance and risks are understood and managed - 10 questions rated as good. No change from 2022

Section 2- With regard to ensuring the Estates and Facilities leadership and culture reflects the vision and values, encourages openness and transparency and promoting good quality estates and facilities services - 12 questions rated as good. No change from 2022

Section 3 - With regard to ensuring that the Organisations Board has access to professional advice on all matters relating to Estates and Facilities services - 4 questions rated as good. No change from 2022

Maturity

There are 15 questions all of which have been scored as Outstanding.

Helipads

This section is not applicable to the Trust.

Contacts

This section has no scoring matrix, but details are complete.

Conclusion

Peer review has been expanded and now includes Doncaster & Bassetlaw Teaching Hospitals, Sheffield Health & Social Care and Derbyshire Community Health Services NHS Foundation Trust

The Trust still maintained its minimal scoring as 'Good' and in certain sections improvements were made advancing the question to a score of Outstanding.

Overall improvement being that Hard FM has increased to outstanding in 8 areas from the score of good last year. Soft FM has increased from good to outstanding in 3 areas.

The submission provides strong assurance to the Board that the area of Estate and Facilities management is being undertaken in a safe and effective manner and continues to improve.

Recommendation

Trust Board is asked to :-

- Note the content of the report.
- Note that the overall score is "good."
- Note the improvement to "outstanding" in some areas across the submission.
- Agree that the submission of the formal PAM return is made to NHS England.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2023
Agenda item 10.4

Private/Public paper:	**Public**		
Title:	**Data Security & Protection Toolkit (DSPT) Submission 2022/23**		
Paper presented by:	**Adrian Snarr – Director of Finance, Estates and Resources**		
Paper prepared by:	Rachael Smith, Information Governance Manager/ Data Protection Officer		
Mission/values:	Respectful, honest, open and transparent. Relevant today and ready for tomorrow.		
Purpose:	To obtain Board approval to publish the final submission with a status of 'standards exceeded'		
Strategic objectives:	Improve Health		
	Improve Care	✓	
	Improve Resources		
	Make this a great place to work		
BAF Risk(s):	Risk 2.1 - The increasing demand for strong analysis based on robust information systems means there is insufficient high-quality management and clinical information to meet all of our strategic objectives		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Exceeding the standards of the annual DSPT demonstrates to commissioners, health and social care partners, suppliers, service users, carers and the general public that the Trust is compliant with the National Data Guardian's 10 Data Security Standards, which are designed to protect sensitive data and critical services. Partners and organisations will have confidence in our systems when entering into contracts or data sharing arrangements with the Trust, and individuals can be assured that their personal and sensitive data is protected when receiving treatment and care from Trust services.		
Any background papers / previously considered by:	Progress reports towards the final submission has been presented at the Digital TAG and Improving Clinical Information Group meetings since December 2022 Presented at Digital TAG 13/06/2023		
Executive summary:	Organisations that process health and social care data must undertake an annual self-assessment against the National Data Guardian's 10 Data Security Standards, which are designed to protect sensitive data and critical services. In addition, the latest Data Security & Protection Toolkit (DSPT) submission will allow NHS England to monitor compliance with the National Data Opt-Out policy, which became mandatory in July 2022.		

	An interim submission was made on 27 February 2023 to assess the position and formulate an action plan. The deadline for the final submission is 30 June 2023. The final submission requires completion of 36 mandatory assertions (113 evidence items); however, as the Trust has been re-accredited for Cyber Essentials Plus (CE+) an exemption was automatically applied to 29 evidence items. All evidence gathered from Trust services by the Information Governance Manager was approved by an appropriate assistant director or head of service. NHS England selected 13 assertions (47 evidence items) for internal audit review, of which 8 evidence items were immediately validated based on the CE+ exemption. For the third consecutive year the audit output is: • Overall classification for each of the assertions assessed: **substantial** • Overall risk assessment across all 10 data security standards: **substantial** • Confidence level in the veracity of the self-assessment: **high**. Two low-risk findings were reported around social media passwords and the business continuity exercise and an action plan has been agreed, but the corresponding assertions were validated by internal audit so the final DSPT submission will not be affected. Four non-reportable observations were communicated by internal audit and action is being taken to contextualise the issues and implement improvements. All mandatory evidence items are currently completed and some non-mandatory items have also been completed. The Trust was able to evidence it's compliance with the National Data Opt-Out policy for the past two DSPT submissions; however, this item only became mandatory for the latest submission. The Information Governance Manager and Deputy Director of Corporate Governance met on 12 June 2023 to review each completed evidence item and finalise the assertions. The Trust achieved a status of 'standards exceeded' in the past two DSPT final submissions. If the latest submission were to be made, standards would again be exceeded.
Recommendation:	**It is recommended that the Trust Board APPROVES the Trust's submission of the final assessment of the DSPT with "standards exceeded".**

South West Yorkshire Partnership NHS Foundation Trust

Data Security & Protection Toolkit 2022/23

1. Introduction

The current Data Security & Protection Toolkit (DSPT) was released on 12 December 2022. An interim submission was made on 27 February 2023 to assess the position at that time. The final submission deadline is 30 June 2023.

The DSPT allows organisations to self-assess their performance against the ten data security standards recommended by the National Data Guardian (NDG). To ensure this self-assessment is considered and evidenced the final assessment submission is subject to review by internal audit. Internal audit have completed remote fieldwork to assist the Trust with action planning to achieve full compliance, as well as ensuring the self-assessment is based on robust and evidenced grounds.

The standards are clustered under three leadership obligations to enable peer support and cascade lessons learned:

- **Leadership obligation 1: People**
  Ensure staff are equipped to handle data respectfully and safely, according to the Caldicott Principles.

  Data Security Standard 1: Confidential, person-identifiable data

  All staff ensure personal, confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes.

  Data Security Standard 2: Staff responsibilities

  All staff understand their responsibilities under the NDG's Data Security Standards, including their obligation to handle data responsibly and their personal accountability for deliberate or avoidable breaches.

  Data Security Standard 3: Training

  All staff complete appropriate annual data security and protection training and pass a mandatory test, which is linked to the current DSPT.

- **Leadership obligation 2: Process**
  Ensure the organisation proactively prevents data security breaches and responds appropriately to incidents or near misses.

Data Security Standard 4: Data access management

Personal, confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal, confidential data on IT systems can be attributed to individuals.

Data Security Standard 5: Process reviews

Processes are reviewed at least annually to identify and improve processes that have caused breaches or near misses, or which have forced staff to use workarounds that compromise data security.

Data Security Standard 6: Incident responses

Cyber-attacks against services are identified and resisted and CareCERT security advice is responded to. Action is taken immediately following a data breach or near miss, with a report made to senior management within 12 hours of detection.

Data Security Standard 7: Continuity planning

A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum with a report to senior management.

- **Leadership obligation 3: Technology**
  Ensure technology is secure and up to date.

  Data Security Standard 8: Unsupported systems

  No unsupported operating systems, software or internet browsers are used within the IT estate.

  Data Security Standard 9: IT security

  A strategy is in place for protecting IT systems from cyber threats, which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually.

  Data Security Standard 10: Accountable suppliers

  IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the NDG's Data Security Standards.

The DSPT assertions have been updated since the previous submission to include the following:

- Minor changes to a number of evidence items for Data Security Standard 1 following user feedback,
- Wording of evidence item 3.2.1 (95% staff training target) has been updated to allow a calculation over the preceding 12 months, rather than a rolling target.

For the current DSPT assessment the data security standards are broken down into 36 assertions, which are further divided into 113 mandatory evidence items. 29 evidence items have an exemption as the Trust has been re-accredited for Cyber Essentials+ (CE+).

The mandatory implementation deadline of the National Data Opt-Out Policy was 31 July 2023 and NHS England will monitor compliance via DSPT submissions. The policy gives everyone the ability to stop health and adult social care organisations from sharing their confidential patient information for reasons other than providing their individual care and treatment. The Trust has been compliant for the past two submissions as there is an appropriate solution in place to remove data from extracts that are not to be used for health care purposes where the individual has opted out.

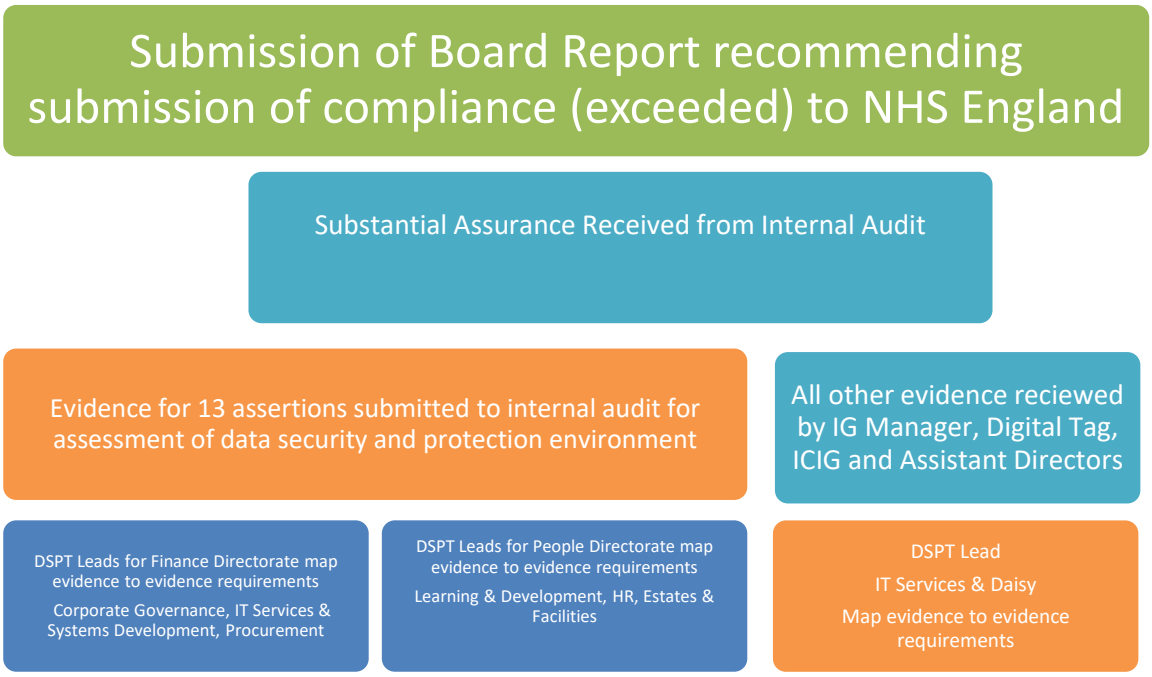
NHS England selected 13 assertions (47 evidence items) for internal audit review. 8 evidence items were immediately considered met and validated as they are within the scope of the CE+ exemption.

It should be noted that, whilst it has been approved for use by NHS England, the DSPT is a beta release and is subject to ongoing review and development

2. Evidence gathering

Documents and information provided as evidence to the Information Governance Manager were overseen by the appropriate assistant director or head of service

The full structure for evidence provision, assessment and sign off is below. This is a comprehensive and robust structure that provides strong assurance that the evidence compiled is solid and subject to review by the right people across the organisation.



3. Internal audit review

The draft internal audit report was shared with the Information Governance Manager on 12 June 2023.

For the third consecutive year, the audit assessment is as follows:

- The overall classification for each of the assertions assessed is **substantial**.
- The overall risk assessment across all ten data security standards is **substantial**.
- The confidence level in the veracity of the self-assessment is **high**.

It should be noted that the criteria for assessment of evidence is extremely specific and does not provide any real margin for interpretation. In addition, the evidence requested for the latest audit was more detailed than in previous years, for example, whilst it has previously been acceptable to provide written confirmation that the Trust has a proportionate monitoring solution to detect cyber events, this year evidence that the Trust's solutions and processes are implemented and operational was requested and provided.

Two low-risk findings were reported in respect of the following:

- Social media passwords (data security standard 4): the Trust has a comprehensive password policy; however, whilst social media passwords were explained to the auditors and it was confirmed they are included in the policy, this is not explicitly referenced. If social media passwords are not managed in line with the password policy there is a risk that unwanted individuals may gain access to the Trust's social media accounts. The Information Governance Manager is working with the Digital Communications Manager and IT Services to update the password policy.
- Business continuity exercise (data security standard 7): the Trust has carried out a tabletop exercise and resulting actions have been identified and recorded, with owners assigned; however, not all actions had a due date set and it was not clear if some had been completed. If actions are not SMART then there is a risk that actions are not completed in a timely manner or at all. Therefore, the identified risk is not mitigated. The Information Governance Manager is working with IT Services to ensure that all actions are assigned due dates and, once actions are completed, this is recorded appropriately.

Once deadlines have been confirmed for completion of these actions the final report will be shared with the Deputy Director of Corporate Governance and the Assistant Director of IT Services & Systems Development for approval. The actions will be followed up via the online tracker, which will include providing documentary evidence to demonstrate that they have been implemented.

Four non-reportable observations were communicated to assist in contextualising issues and implementing improvements:

- Senior Information Risk Owner responsibility (data security standard 1): the SIRO is the Director of Finance, Estates and Resources, and the job description clearly states this; however, the job description lacks further reference to data security and protection. It should be noted that, in previous years, provision of the job description evidencing assignment of SIRO responsibility was acceptable but this year reference to the

accountabilities was requested. Further references to data security and protection should be included in the job description as a point of best practice.

- Digital services that are attractive to cyber-criminals (date security standard 6): the Trust does not currently have digital services which are attractive to cyber criminals. The Trust could strengthen the assessment of new projects in this area by including a requirement to consider fraud in the Data Protection Impact Assessment.
- Open Web Application Security Project vulnerabilities (data security standard 9): although OWASP vulnerabilities do not apply to the staff app, penetration testing on the app was completed by Claranet Cyber Security and two issues were identified. Completion of the remediation actions should be recorded and reported through information governance channels.
- List of suppliers (data security standard 10): the Trust records its list of suppliers and can isolate those who have access to personal data. It is not clear from the spreadsheet itself which suppliers these are, and the spreadsheet should be updated so that it is clear which suppliers have access to what information.

Action is being taken to implement these improvements.

No key issues on governance, risk management and control were identified.

4. Action Plan

The findings in respect of social media passwords and the business continuity exercise are low-risk and internal audit confirmed they have been validated, so the assertions can be completed in the DSPT and the final submission will not be affected.

The evidence items that are within scope of the CE+ exemption and those in scope of the audit are all completed in the DSPT.

All other mandatory evidence items are completed and some on-mandatory items have also been completed.

5. Final Reviews

A summary report was presented at the Digital TAG on 14 June 2023.

The Information Governance Manager and Deputy Director of Corporate Governance met on 12 June 2023, to review each evidence item and complete each assertion. If the submission were to be made, it was confirmed that the standards would be exceeded.

Conclusion and Recommendation

The Trust has made excellent progress in its completion of the DSPT and currently has evidence of full compliance with all of the mandatory standards plus a number of non-mandatory standards.

The Trust exceeded the standards of the DSPT for 2020/21 and 2021/22 and will retain this status in the current submission.

It is recommended that the Trust submits the final assessment of the DSPT with “standards exceeded”.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 27 June 2023
Agenda item 10.5

Private/Public paper:	**Public**		
Title:	**Annual report on Safe Working Hours Doctors in Training (April 2022–March 2023)**		
Paper presented by:	**Prof.Subha Thiyagesh - Chief Medical Officer**		
Paper prepared by:	Dr.Richard Marriot - Guardian of Safe Working		
Mission/values:	The Trust is meeting its duties and requirement to have a Guardian of Safe Working. Caring for the wellbeing of our staff and provision of safe clinical care is essential to support the Trust's mission in helping people to reach their potential and live well in their communities. The training of the next generation of substantive psychiatrists is of strategic importance for not only the Trust's succession planning but to ensure provision of a highly trained medical workforce within the wider mental health system.		
Purpose:	To provide assurance to the Board that we are meeting our responsibilities in relation to the monitoring of safe working hours within the new Doctors in Training contract. Trust Board is asked to note the report.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Risk 2.2 - Failure to create a learning environment leading to lack of innovation and to repeat incidents. Risk 2.3 - Increased demand for services and acuity of service users exceeds supply and resources available leaving to a negative impact on quality of care. Risk 4.1 - Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user and staff experience and the inability to sustain safer staffing levels Risk 4.2 - Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively Risk 4.3 - Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies		
Contribution to the objectives of the	There remains continued joint working, support and shared learning across the integrated care systems in terms of training of medical workforce.		

Integrated Care System/Integrated Care Board/Place based partnerships	There remains high level of engagement and initiative from various senior medical and people directorate colleagues, to work closely with other regional stakeholders on this important aspect.
Any background papers / previously considered by:	Briefing paper presented to Trust Board on 25 April 2017 Quarterly reports presented to Trust Board from Q1 onwards. Annual board reports presented annual since 2017-18 onwards. Paper presented to People and Remuneration Committee on 23 May 2023
Executive summary:	The introduction of the 2016 contract for Doctors in Training impacted on the Trust in February 2017 with new employees moving onto the contract at that point. In order to protect the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training, the role of Guardian of Safe Working was established. 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 that doctors' working hours are safe. The Trust appointed Guardian of Safe Working is Dr Richard Marriott. The 2022/23 Annual Report highlights the following: • There is confidence that all generic work schedules include rota patterns are compliant with the terms and conditions of the junior doctors' contract. • The Postgraduate Medical Education Lead has implemented processes Trust-wide to ensure that trainees doing extra shifts have signed the European Working Time Directive (EWTD) waiver and that the number of shifts they do remains within safe limits. The structures of the new contract offer an opportunity to develop better systems to ensure both patient safety and better training experiences for our junior medical staff. • As with previous years, there have been very few exception reports generated. This is not unusual compared to other Trusts providing mental health services and where issues arise, these have been directed to appropriate managers to address the difficulties. • Access to training experience in the assessment of patients presenting with self-harm, had to be put on hold due to the pandemic. Initial attempts to restart this across the trust, stalled due to the pressure of other commitments but a new rota has been devised to try to address these issues. • The roll out of Electronic Prescribing and Medicines Administration (EPMA) has been extremely helpful with a positive impact on workload.
Recommendation:	**Trust Board is asked to RECEIVE, REVIEW and CONFIRM their assurance that the Trust has met its statutory duties.**

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board: 27 June 2023
Agenda item 10.5

Annual Report on Safe Working Hours:
Doctors in Training (April 2022 - March 2023)

Introduction

The 2016 junior doctors' contract introduced stronger safeguards to prevent junior doctors from having to work excessive hours. The safety of patients is of paramount concern for the NHS and significant staff fatigue is a hazard both to patients and to the staff themselves. In this respect, the new contract introduced the role of Guardian of Safe Working Hours (GoSW). The GoSW is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The GoSW will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe.

The Guardian is independent of Trust management and the Guardian's main roles are to:

- Champion adherence to safe working hours.
- Oversee safety-related exception reports and monitor compliance with the system.
- Escalate issues for action where not addressed locally.
- Request work schedule reviews to be undertaken where necessary.
- Intervene as required to mitigate safety risks.
- Intervene where issues are not being resolved satisfactorily.
- Provide assurances on safe working and compliance with TCs.
- Submit a quarterly and an annual report to the Trust Board on the functioning of the contract and exception reporting.

This report outlines:

- Challenges
- The Junior Doctors' Forum
- The number and distribution of doctors in training across the Trust
- A summary of exception reports (ERs) submitted by doctors in training
- Fines
- Work schedule reviews
- Rota gaps and cover arrangements
- Locum Work carried out by Trainees / Medical Bank
- Issues of concern
- Actions taken
- Summary

High level data

Number of doctors in training (total):	64
Amount of time available in job plan for Guardian to do the role:	1 Programmed Activity (PA)
Admin support provided to the Guardian:	Ad hoc
Amount of job-planned time for educational supervisors:	0.125 PAs per Trainee

Challenges

1) **Trainee and Clinical Supervisor Engagement**: There are varied levels of understanding about the contract amongst all grades of doctors, many of whom have expressed confusion regarding its implications. To introduce the GoSW role and Exception Reporting System, presentations have been undertaken at the Induction Programme for each cohort of new junior doctors. As well as the Junior Doctors' Forum, the GoSW attends the Medical Education Trust Action Group, which has oversight of all issues to do with Medical Education within the Trust. The GoSW contacts clinical supervisors to support them in completing all reviews of ERs.

2) **Trainee concerns**: Trainee Surveys carried out by the GoSW both in 2021 and in previous years, suggest that some trainees remain anxious about the exception reporting process. A number of Foundation trainees report that ERs completed in acute trusts have not been dealt with, reducing their faith in the system. The GoSW meets all the new trainees and describes how positively the trust views exception reporting and assures trainees that they will be supported when they complete ERs.

Junior Doctors' Forum

The setting up of a Junior Doctors' Forum is a key requirement of the new contract. The forum meets quarterly. The role of the forum is to advise the Guardian in all aspects of the role.

All junior doctors within the Trust are invited to the forum with around 40 attending the last meeting in February. Particular efforts have been made to ensure that representatives of all the Care Groups and rotas are able to attend. The other key attendees are the Associate Medical Director for Postgraduate Medical Education, The Postgraduate Medical Education Lead, The Champion of Less Than Full-Time Training, the Local Negotiating Committee Chair or representative and the People Directorate Business Partner. The local British Medical Association representative has also attended most of the meetings.

The Champion of Less Than Full-Time Training has been proactive, arranging drop-in sessions for Less Than Full-time Trainees and a WhatsApp group for them to stay in touch and raise any concerns they have.

Few of the issues raised at the forum have related to hours of working. Where hours are raised, the main area of concern has been the Wakefield rota, the largest site with the greatest volume of work for trainees. Various options to manage this have been discussed and the roll out of Electronic Prescribing and Medicines Administration (EPMA) has had a positive impact on workload. There is no easy solution to other issues such as the travel time to The Poplars inpatient site, which means that the trainee is away from the Fieldhead site for prolonged periods of time. Trainees have been encouraged repeatedly to complete ERs if they work beyond their contracted hours but as yet, there have been very few related ERs.

In Calderdale, the chief concern for trainees relates to rota administration. Due to a combination of staff sickness and changes, there have been problems with the organisation of rotas. It is envisaged that new appointments will address these issues.

Distribution of Trainee Doctors within SWYPFT

The Trust covers a wide geographical area and receives Trainees from a number of different rotational training schemes (Foundation Programme, General Practice Vocational Training Schemes, Psychiatry Core Training Schemes and Psychiatry Higher Training Schemes). Approximately half of the Trainees are employed by the Trust, with the remainder employed by other organisations.

Each locality (Barnsley, Calderdale, Kirklees and Wakefield) has a 1st on-call rota staffed by junior doctors. These are trainees from the local Core Psychiatry Scheme, the Foundation Year 2 Scheme or GP Vocational Training Scheme, although Barnsley's 1st on-call rota also includes non-training Specialty Doctors. The 2nd on-call rotas for each locality and at Newton Lodge are staffed partly by Higher Trainees and partly by non-training Specialty Doctors, the latter whose contracts are subject to different terms and conditions.

Tables shown in the appendix demonstrate the breakdown of the different grades of Trainees in each locality, also noting the areas where there are vacancies. Recruitment to the Foundation and GP training programmes have generally been good but we have had some vacancies more recently. Recruitment to core training posts in Psychiatry has improved over the last couple of years. The 3 training schemes in West Yorkshire were merged as of August 2020. This has largely reduced the number of vacancies within SWYPFT, but in the latest rotation in February, a number of vacancies, especially on the Core Training scheme affected Calderdale. Expansion of Core and Foundation training has started with additional posts over the last 12 months and more promised for August.

The main current concern in recruitment relates to Higher Training with vacancies across most psychiatric specialties. This has an immediate impact on middle tier rotas but is also of concern for consultant recruitment over the next few years. Hopefully the improvement in Core Training recruitment will feed through to improve this over the next few years. However, Yorkshire is reducing its number of Higher Training Posts in Old Age Psychiatry.

Exception Reports (with regard to working hours)

The Exception Reporting (ER) system is the main safeguard in the new junior contract that ensures junior doctors are not being forced to work excessive hours and are able to meet the training requirements of their contract. The hours and rest rules are complicated and a helpful factsheet covering the key features can be found at: Rota-rules-at-a-glance_0.pdf (nhsemployers.org)

Each Trainee receives a work schedule prior to commencement of their post, which outlines the rota pattern, hours and pay arrangements for that post. If a Trainee is required to work beyond those hours, or if work commitments prevent them from attending required training, the Trainee is encouraged to complete an ER. This details the circumstances of the 'exception'. The report goes to the Trainee's clinical supervisor. If the clinical supervisor agrees an ER regarding additional hours, the options are for the Trainee to be given time off in lieu or to be paid for the extra time.

There have only been a few ERs completed in SWYPFT since the introduction of the new contract (~50). This is to some extent reassuring, although there does appear to be a degree of reluctance amongst trainees to complete ERs. The results of a survey of trainees in 2021 shows that for most trainees, this is because there had been nothing for them to report. However, others report various concerns; these include uncertainty as to how to complete the report or what would constitute an exception. Others were concerned that exception reporting would not achieve anything and might lead to them being seen as causing trouble. At a recent meeting arranged by HEE, trainees related experiences in other trusts, where they were actively discouraged from exception reporting or even explicitly told that they must not do so whilst in a particular department. There has never been any reports of such behaviour within this trust but does make it understandable that trainees experiencing such behaviour in other trusts might be reluctant to use the system. In order to address these concerns, the GoSW now has longer sessions with new trainees at induction and has produced more detailed information about exception reporting in their induction pack. Admin staff also follow-up the emails sending the login details for the Allocate system, to ensure that trainees have received them and understand how to access the system.

Exception Reports By Area				
Area/Care Group	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Barnsley	0	0	0	0
Calderdale	0	8	8	0
Kirklees	0	4	4	0
Wakefield	0	5	5	0
Forensic	0	1	1	0
Total	0	18	18	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	11	11	0
F2	0	5	5	0
GPVTS	0	0	0	0
CT1-3	0	1	1	0
ST4-6	0	1	1	0
Total	0	18	18	0

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	2	0	9	0
F2	0	4	1	0
GPVTS	0	0	0	0
CT1-3	0	0	1	0
ST4-6	0	0	1	0
Total	2	4	12	0

For the exceptions noted in the tables above, the actions were:

1) In 5 cases, Trainees working additional hours were given time off in lieu. In one of these cases, the ER related to missed Personal Development time and the trainee was given protected time to catch up on the time missed.
2) In 13 cases payment for additional work was agreed.

There were issues with response time, partly due to consultant annual leave and lack of familiarity with the IT system used. All clinical supervisors have addressed the ERs once prompted. However, some delays have been prolonged, in part due to difficulties organizing payment for trainees hosted by the trust but employed by neighbouring trusts.

Fines

A fine will be incurred should certain of the hours and rest rules under the new contract be broken, with a penalty hourly rate paid to the doctor and the remainder of the fine paid to the Guardian to be used to improve training within the Trust. None of the ERs received so far have resulted in a fine. Despite no fines being levied at this stage, a decision has been made to identify an account and a member of finance personnel to support audit of any funds, should fines be levied.

Work schedule reviews

The new contract requires that generic work schedules, detailing work patterns and pay, be sent to trainees prior to commencement of the post and this was achieved. Trainers have also been asked to specify in trainees' timetables, an hour a week for work on their training portfolio. On occasion, there have been issues relating to the responsibilities of the employing trust and the host trust to send this information to the trainees, but these have been addressed. Following commencement of the post, the generic work schedule should be used to develop a personalised work schedule according to the doctor's learning needs and training opportunities within the post. The Work Schedule Review is the process whereby concerns about a doctor's working hours or access to training are reviewed. There were no work schedule reviews required during this period.

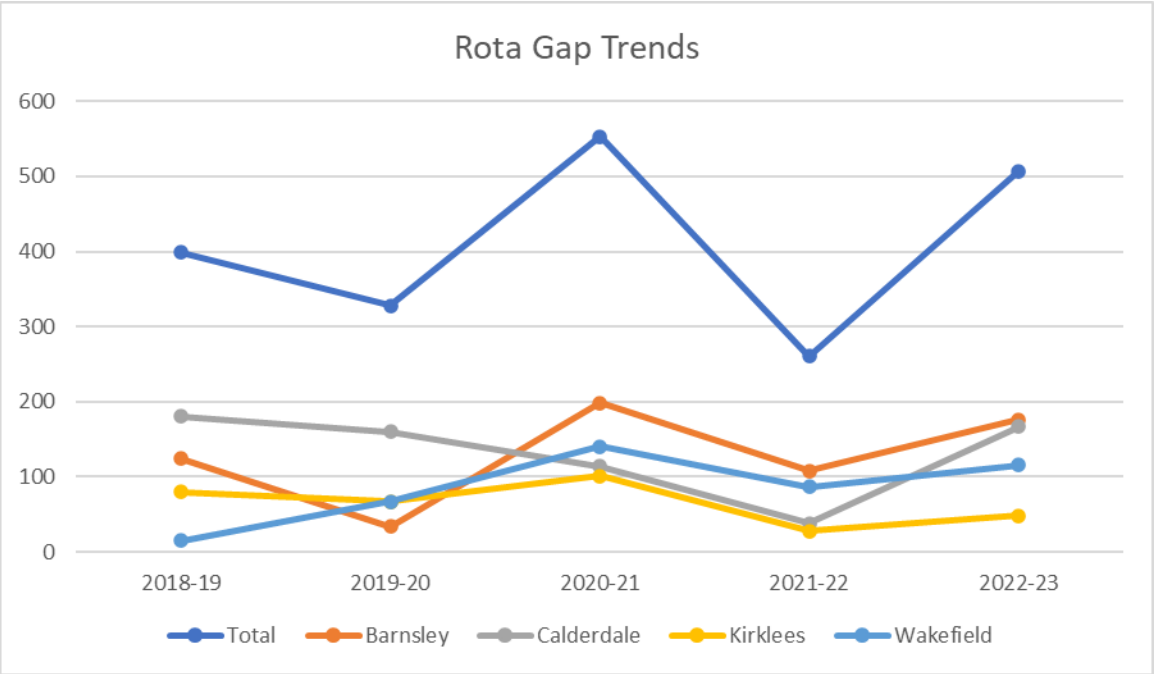
Rota gaps and cover arrangements

COVID-19 had a significant impact on rotas. The combination of shielding and requirements for self-isolation massively increased the number of gaps on rotas during 2020-21 (nearly 70% increase in gaps). The figures for 2021-22 were much improved. Despite the impact of COVID remaining low the number of gaps has risen again this year (See graph below), affecting all areas but especially Barnsley and Calderdale. The following table details rota gaps by area and how these have been covered. There were only 3 shifts where it was not possible to obtain junior doctor cover.

Gaps by rota April 2022 – March 2023					
Rota	Number (%) of rota gaps	Number (%) covered by Medical Bank	Number (%) covered by agency / external	Number (%) covered by other trust staff	Number (%) vacant
Barnsley 1st	176 (28%)	176 (100%)	0	0	0
Calderdale 1st	167 (27%)	166 (99%)	0	0	1 (1%)
Kirklees 1st	48 (13%)	48 (100%)	0	0	0
Wakefield 1st	116 (18%)	114 (98%)	0	0	2 (2%)
Total 1st	507 (20%)	504 (99%)	0	0	3 (0.5%)

Colleagues in Postgraduate Administration have been able to capture some information about the financial cost to the Trust of covering rota gaps. They have also tried to record the costs directly attributable to COVID-19.

Costs of Gaps by rota April 2022 – March 2023				
1st On-Call Rotas	Shifts (Hours) Covered by Bank	Cost (£) of Shifts Covered by Bank	Costs Directly attributable to COVID-19	Shifts (Cost (£)) Covered by Agency
Barnsley	176 (1706)	59,710.00	700.00	0
Calderdale	166 (1571.25)	55,344.50	0	0
Kirklees	48 (832)	29,800.00	0	0
Wakefield	114 (1067)	47,802.75	5,535.10	0
Total	504 (5176.25)	192,657.25	6,235.10	0



Locum work carried out by Trainees / Medical Bank

The Trust is largely reliant on the current trainees to do locum shifts to fill the gaps on the rota. However, a number of doctors who have worked with the Trust previously have joined the Medical Bank. Since this was set up, a greater number of shifts have been covered without the need to employ agency. This should be safer for patients as well as being slightly cheaper for the Trust, given the higher hourly rate charged by agencies.

Postgraduate administrators and the Medical Bank staff ensure that trainees doing locum shifts, sign the European Working Time Directive (EWTD) waiver. This allows trainees to work up to an average of 56 hours a week instead of the usual 48 hours a week. Postgraduate administrators then monitor to ensure that individual doctors are not taking on excessive additional hours / shifts.

Issues of Concern

1) **Rates of Pay:** Trainees raised concerns in August 2022 that rates of locum pay had not risen for a prolonged period of time and were not competitive with neighbouring trusts. A review has taken place and a small increase has been agreed for junior trainees on resident rotas and for Higher Trainees. A comprehensive benchmarking exercise was undertaken and rates were revised and agreed to a higher level in the region amongst MH trusts for resident rotas and for Higher Trainees. The process has been very slow but it is hoped that these new rates can be implemented soon.

2) **Recruitment:** Recruitment to training posts, including core training posts in Psychiatry has been improving and there are plans to expand Foundation and Core training. Unfortunately gaps on the various schemes have increased vacancies within SWYPFT at the last couple of rotation points. Recruitment to Higher Training in Psychiatry, remains a concern, especially following news about a loss of Higher Training numbers in Old Age Psychiatry across Yorkshire. This has short-term implications for trainees and rotas but longer-term concerns about the effect this may have on already difficult to fill consultant posts. However, it is likely to continue to be the quality of the experience we offer to medical students and Foundation doctors that is most likely to lead to trainees choosing to train and work in Psychiatry in this Trust in the long term.

Actions taken to resolve issues

There have been no significant actions arising out of trainees' working hours. All ERs were dealt with appropriately and they did not require there to be fines or work schedule reviews.

Work to try to improve the on-call experience for trainees in Wakefield is on-going. The roll out of EPMA has been extremely helpful.

Access to training experience in the assessment of patients presenting with self-harm, had to be put on hold due to the pandemic. Initial attempts to restart this across the trust, stalled due to the pressure of other commitments but a new rota has been devised to try to address these issues.

Summary

There is confidence that all generic work schedules include rota patterns that are compliant with the terms and conditions of the new junior doctors' contract.

The Postgraduate Medical Education Lead has implemented processes Trust-wide to ensure that trainees doing extra shifts have signed the EWTD waiver and that the number of shifts they do, remains within safe limits. The structures of the new contract offer an opportunity to develop better systems to ensure both patient safety and better training experiences for our junior medical staff.

As described above, there have been very few ERs generated. This is not unusual compared to other Trusts providing mental health services and where issues arise, these have been directed to appropriate managers to address the difficulties.

Recommendation

Trust Board is asked to RECEIVE, REVIEW and CONFIRM their assurance that the Trust has met its statutory duties.

Appendix – Trainee distribution as at March 2022

Distribution of Trainees by Locality

Barnsley

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	3	1.8	Sheffield Health and Social Care Trust
GP Trainee	1	1	Barnsley Hospital NHS Foundation Trust
CT1-3	5	4.6	Sheffield Health and Social Care Trust
LAS	0	1	South West Yorkshire Partnership NHS FT
FY2 FY1	1 2	1 2	Barnsley Hospital NHS Foundation Trust

Calderdale & Kirklees

Grade of Trainee	**Number Expected**	**Number in Post (WTE)**	**Employer**
ST4-6	3	2.8	South West Yorkshire Partnership NHS FT
GP Trainee	7	5	Calderdale and Huddersfield NHS FT
CT1-3	11	7.4	South West Yorkshire Partnership NHS FT
LAS	0	1	South West Yorkshire Partnership NHS FT
FY2 FY1	4 3	4 2.8	Calderdale and Huddersfield NHS FT Calderdale and Huddersfield NHS FT

Wakefield

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	5	2.8	South West Yorkshire Partnership NHS FT
GP Trainee	4	3.4	Mid Yorkshire NHS Trust
CT1-3	8	8	South West Yorkshire Partnership NHS FT
LAS	N/A	2	South West Yorkshire Partnership NHS FT
FY2 FY1	2 3	2 3	Mid Yorkshire NHS Trust Mid Yorkshire NHS Trust

Forensic: Newton Lodge /Bretton /Newhaven

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	5		South West Yorkshire Partnership NHS FT
ST4-6	1		Sheffield Health and Social Trust

CAMHS / LD

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6 CAMHS	1	1	South West Yorkshire Partnership NHS FT
ST4-6 LD	1	0	South West Yorkshire Partnership NHS FT

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2023
Agenda item 10.6 – Assurance from Trust Board Committees

Audit Committee

Date	26 June 2023
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	Verbal update to be provided in the meeting.
Approved Minutes of previous meeting/s for receiving	11 April 2023 minutes to be presented to July Board.

Collaborative Committee	
Date	5 June 2023
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Assure** The Committee continues to receive reporting across the following areas from both collaboratives ○ Finance – only Period 1 data presented. No significant issues highlighted. ○ Contracting – as noted previously work is ongoing to conclude 22/23 contracts by December 23 ○ Quality – significant focus on continued activity from the Commissioning hubs to provide quality assurance through regular monitoring and follow up activity ○ Risk – actions taken have resulted in closure of a number of risks and reduction in the scoring of others The regular report from the SY Commissioning Hub on the SY collaborative has been enhanced to specify what actions are being taken (have been taken) to move from partial to full assurance in those areas highlighted by the hub. This will provide committee members with further assurance going forward. The Committee received its first report on WY PC's where the Trust is a partner (Adult Eating Disorders/Children and Young People's MHS). Challenges regarding admissions has led to increases usage of out of area beds in both collaboratives. **Alert** Quality monitoring continues to highlight specific areas of concern but positive progress is being made The Committee will be asked at a future meeting to approve the community pathway for the WY Adult Secure PC. This is a complex area and will require appropriate scrutiny at a clinical level before approval by the Collaborative Committee

	Arrangements for the integration of the Phase II collaborative into the Collaborative Committee workplan/reporting have yet to be concluded **<u>Advise</u>** As previously advised Committee members are to set up visits to services with a focus on those provided by the independent sector and/or where quality issues have been highlighted Whilst there has been progress, further work is needed to harmonise performance reporting across the two Phase1 collaboratives; this will also need to address the integration of Phase II. Performance reporting received currently covers • Bed occupancy • Referrals • Admissions • Out of area • Discharge rates/delayed discharge • Length of stay
Approved Minutes of previous meeting/s for receiving	4 April 2023 (presented in private)

Clinical Governance and Clinical Safety Committee	
Date	13 June 2023
Presented by	Nat McMillan Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	**<u>Alert:</u>** Issues being raised through Freedom to Speak Up around Horizon and from a visit by the Chair around the behaviours and the leadership. The Trio are aware and are working in a focussed way with Horizon to understand the issues and ways to address the concerns. They will continue to have oversight and report into GCCS as part of their regular report. There is not assurance that the issues are resolved but assurance around the process. The impact of staffing issues on staff-wellbeing continues to be a concern and ongoing mitigation and management of the risk associated with this and the impact on the quality of care. There continues to be a backlog of complaints although this had reduced to 26 the day before the committee meeting (i.e. 13th May). The committee will continue to receive an update on the position and actions being taken. **<u>Advise</u>** The committee heard about the work taking place around the Triangle of care being led by Gillian Conwey. The aim is to gain level 3 accreditation and continue to show our commitment to supporting carers. Tees, Esk and Wye Valley report to come to committee as a deep dive and then to board. QMV and feedback around how these are planned and timetabled to ensure that Non Executive Directors can attend and are seen as essential rather than optional.

	The committee received and discussed the draft Quality Account. This will have final sign off at Board in June. **<u>Assure</u>** Recent events around seclusion rooms being damaged and not available have been escalated previously and assurance that these are now back in use with the exception of one, The reality of the damage to seclusion rooms was seen first hand by the Chair of CGCS and recognition of the hard work to turn this around and have them back in use. The committee queried the use of mechanical restraint which it was reported as being used once. The Trio confirmed that the process was followed with approval from a director. The committee were assured that this was related to use of a ski pad and was the exception to enable a service user to be transferred. It was agreed to include the use of mechanical restraint to the quarterly RRPI report for further and ongoing assurance. The improvement work around Care Planning continues with 85% achieved and being reported to the committee. An update report is coming to the meeting on 13th June. The committee received the Apparent Suicide report. The committee received the annual Mental Health Survey which showed the trust benchmarked well across the metrics although this is with the caveat of a low response rate of 17% (which we were informed does tend to be typically low). The committee received and recommended the IPC BAF to the board for approval.
Approved Minutes of previous meeting/s for receiving	16 May 2023

Equality, Inclusion and Involvement Committee	
Date	12 June 2023
Presented by	Marie Burnham, (Chair of Committee)
Key items to raise at Trust Board	**<u>Alert:</u>** There will be a focus on a senior diverse workforce with the Trust looking into the number of people who are in a grade Band 7 and above. This will take place over the next 12 months for each protected characteristic to identify any gaps and improvements. An Equality Diversity and Inclusion (EDI) improvement plan has published by NHS England. The content of this document will be appraised and reviewed by EMT to ensure the Trust are in line with national guidelines. National and regional update picked up a significant number of guidance documents which maintain a focus on understanding the impact of digital access with more work to be done to capture and understand this information to address inequality of access. **<u>Advise:</u>**

	Care Group update: Forensics, Learning Disability (LD), attention deficit hyperactivity disorder (ADHD) Autistic Spectrum Disorder (ASD) Care Groups. Sue Threadgold reported on the work of 2 care groups to demonstrate EII is embedded and a golden thread through services. The groups reported on their plans to re-engage carers through a carers group and dedicated post. The support they have received from Yorkshire and Humber Involvement colleagues to improve involvement and build on the cultural competency work which has taken place. A guidance document has been developed to support staff in the management of hate crime / challenging incidents and this is further supported by work to increase cultural awareness through artwork and religious and faith celebrations. Improving access to information for people with a learning disability including access to friend and family to provide feedback and improving reach into communities for Forensic CAMHS as well as fully complete Equality Impact Assessments (EIAs) provided significant assurance. A focus on the REACH staff network achievements and progress was presented by Iffath Hussain, lead for staff networks. The presentation provided an overview of the achievements of the staff network, which included an increase in membership, progress to recruit to key roles. Key messages were to ask for continuing network support whilst the transition period from the old steering group to the new one, is progressed. This included support for staff to attend network meetings. It was also suggested that staff network numbers could be mapped against Trust equality data to ensure it was reflective. An update on the Trust social responsibility and sustainability strategy was presented by Tony Wright which demonstrated progress on this agenda. A framework and metrics are now in place and the first report demonstrated progress. Staff engagement in the work and communication channels are established and the first meeting of a steering group will take place. The committee suggested ideas to strengthen the role of procurement which Tony is already picking up. The report was well received. **Assure:** The EII exception and highlight report provided assurance that the Trust continues to deliver on the Trust wide strategy action plans 2023/2024 for both equality and involvement – with a request to move the deadline for census data 2021 update as there were still external barriers to receiving all the information required. National, local, and regional updates which include legislation and publications are presented at every EIIC. The Committee remain assured that the Trust is embedding any recommendations, good practice and policy or legislative changes through the action planning process and wider Trust. Progress on the Equality dashboard and metrics continues using case studies to evidence the use of the data to identify areas of improvement. The workforce data focuses this quarter on Ethnicity shows the Trust workforce total is 11.2% against the population average of 14.8% so we are not reflective of our communities. 14% of BAME staff entering a formal disciplinary process and training figures were higher at 16% for mandatory and 17% for non-mandatory (excluding medics).

	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. A 360 review of sustainability audit outcome resulted in significant assurance, with 2 proposed and agreed medium risk actions identified (impact and likelihood 3x3). The report provided assurance to the committee with the report and content noted. **Risks discussed:** Risk register was reviewed, and updates included. All updates were agreed as providing assurance on risks assigned to the Committee. **New risks identified:** No new risks identified
Approved Minutes of previous meeting/s for receiving	14 March 2023

Finance, Investment & Performance Committee	
Date	19 June 2023
Presented by	David Webster, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert:** Nationally agreed pay award is in excess of budget, which creates a £2.5m cost challenge, which will need to be found through savings. Initial review suggests this should be able to be covered in 23/24 through non-recurrent items, less certain longer term. **Advise:** Capital training will be carried out for NEDs in July Agency continues to be overspent, however, the working group focussed on this has been confirmed to be feeding into People & Remuneration Committee Mostly on track with Cost Improvement Programmes to date, which now all take into account an equality impact assessment National costing collections have been delayed, including prior year's information. Waiting list report was shared for the first time at the committee following transfer of performance (but not clinical safety element) from Clinical Governance and Clinical Safety Committee. **Assure:** Despite the increasing financial pressures, the current in year risk remains at an acceptable level based on mitigations and plans and is reflected as such on the risk register. Future years carries a higher risk, and this is being reviewed as to whether this is covered and monitored appropriately alongside a longer-term resource plan which is being developed.
Approved Minutes of previous meeting/s for receiving	20 March 2023

Mental Health Act Committee	
Date	16 May 2023
Presented by	Kate Quail (Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert:** Possible strike action by consultants and the potential for more nurse strikes which could be relevant when talking about changes to receiving Section papers. **Advise:** Legal briefing on Liberty Protection Safeguards - the government have decided to further delay progressing Liberty Protection Safeguard (LPS) plans to allow them time to deal with social care reforms. Noted although we have already done a lot of the preparation work, none of it has been in vain and has been useful, quality improvement work. Mental Health Act Committee **(**MHAC) has Commissioned further work on ethnicity an use of MHA – o the use of the MHA over the last 2 years broken down by ethnicity, age and place of residence. o re the number of people of black ethnicity in Forensic services – ie where individuals are being detained from, ie the community or criminal justice system and if there are any actions for us as an organisation. MHAC Plan to understand more about the experience of young people detained in adult beds. Service user experience work in Forensics services – in September 2021 MHAC had asked for Forensic services to be involved in a piece of work with service users about their experience of being detained. 'Discovery Interview' approach. for produced a 'You said, we did' and an information animation for service users to view before or on admission. Approached by other Trusts interested in similar. **Assure:** Code of Practice group - agreement that Nurse Associates can receive Section papers Long Term Segregation – and improvement programme on Horizon. Performance Monitoring information Q1 – Overall, good assurance of compliance. Assurance from Mandatory Training compliance (standard is 80%). Mental Capacity Act (MCA) and DoLS training for non-clinical staff is 100% and 90.9% for clinical staff, which are both above target. The MHA training for all clinical staff was above target at 92%. Care Quality Commission MHA visits actions & updates – Assurance that actions and recurring themes have an action plan or improvement workstream with improvement work and action taking place. CQC visits and thematic review - overview of visits and themes over last. Years

	Discussion and review of Risk Registers – reviewed Organisational Risk Register (ORR) risks identified as having a potential impact on the application of the MHA. Noted impact of staffing pressures on use of the MHA. Currently no risks on Mental Health Act Committee risk register.
Approved Minutes of previous meeting/s for receiving	7 March 2023

Members' Council	
Date	9 May 2023
Presented by	Marie Burnham, Chair (Chair of Committee)
Key items to raise at Trust Board	**Key points** Members' Council received the update to the Trust annual report unannounced / planned visits. Members' Council received the Care Quality Commission (CQC) action plan. Members' Council approved the Associate Non-Executive Director appointments. Members' Council approved the deputy lead governor appointment. Members' Council received assurance from Members' Council groups and Nominations Committee. Members' Council received the review of the Audit Committee terms of reference. Members' Council received the outcome of the governor elections. Members' Council received the Integrated Performance Report (IPR). Members' Council discussed the governor feedback of the Chair's appraisal.
Approved Minutes of previous meeting/s for receiving	24 February 2023

People and Remuneration Committee	
Date	23 May 2023
Presented by	Mandy Griffin - Chair
Key items to raise at Trust Board	**Alert:** Appraisal compliance still not met, currently 71.8%. The committee received data by care group which highlighted some areas below 30% compliance. Challenges around agency spend is still ongoing but actions are in place to mitigate this. Governance around the agency scrutiny group will be reviewed.

	Industrial action and impact still a risk. With Junior Doctors strike ready to go ahead 14th-16th June 2023. CPR and RRPI compliance is still below target. A new approach was discussed. **Advise:** Spotlight on recruitment was a really useful insight into all the on-going activity. The report highlighted the positive work that was being undertaken. Great success with International recruitment, the trust now needs to think about the on-going strategy and how this is managed. The Government has ceased the lifetime allowance for pensions and increased the annual allowance for pensions. This has helped the trust in terms of retention, particularly senior medics. Flowers settlement (holiday pay) has now been ratified. Guardian of safe working report provided an insight into the good will and support from staff to plug gaps on the rota. Great place to work strategy delivery plan was presented showing good progress. It was noted that it might be useful to consider how Governors could support this work. Health Roster and Safe Care roll out plans were presented for consideration. Both plans will be discussed and approved at EMT. The recruitment timeline for the Director of Strategy and Change. Interim arrangements were also shared **Assure:** Discussion around the IPR and KPI's including appraisal compliance. IPR now showing care group level data giving an extra level of assurance Assurance was provided regarding the staff survey and devolving this into care groups. Workforce Equality report provided excellent data and was a really useful report. The trust had seen an improvement of absence figures in both Forensics and Estates and facilities **Risk Register**: It was agreed the industrial action risk would remain at 16. The committee confirmed they are assured that the scoring of all risks were appropriate.
Approved Minutes of previous meeting/s for receiving	21 March 2023

West Yorkshire Mental Health Learning Disability and Autism (WYMHLDA) Committee in Common	
Date	26 April 2023
Presented by	Brodie Clark (Chair) (BC)- Chair, Leeds Community Healthcare NHS Trust
Key items to raise at Trust Board	**Alert:** Nil **Advise:** There are challenges around the PMH transformation due to static financial flow and some lack of understanding of the NHSE expectations. **Assure:** Stakeholder and provider collaborative workshops are taking place to explore the future MHLDA operating model. The MHLDA Collaborative is connecting with Primary Care for ED and Physical Health Monitoring. PMH EOI has been completed and will be presented to the NHSE panel, this recommends LYPFT to be the Lead Provider. There is an expectation that the MHLDA Collaborative bank will be launched once re-procurement has taken place. International recruitment has been successful for some psychiatrist roles.
Approved Minutes of previous meeting/s for receiving	Combined public/private meeting notes are presented in Private board

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

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee meeting held on Tuesday 16 May 2023
Microsoft Teams meeting

Present:	Nat McMillan (NM) Darryl Thompson (DT) Marie Burnham (MB) Dr Subha Thiyagesh (STh) Kate Quail (KQ)	Non-Executive Director (Chair of the Committee) Chief Nurse / Director of Quality and Professions (Lead Director) Chair of the Trust Chief Medical Officer Non-Executive Director
Apologies:	Carmain Gibson-Holmes (CGH) Carol Harris (CH)	Deputy Director of Nursing, Quality and Professions Chief Operating Officer
In attendance:	Gillian Cowell (CW) Yvonne French (YF) Gemma Hinchliffe (GH) Chris Lennox (CL) Sarah Millar (SM) Naomi Sutcliffe (NS) Julie Williams (JW)	Carers Project Management Officer/ Family and Friends Practitioner (for agenda item 6) Assistant Director of Legal Services Assistant Director of Nursing Quality & Professions Director of Services (deputising for Carol Harris PA to Chief Medical Officer (author) Serious Incidents Investigator (for agenda item 15) Assistant Director of Corporate Governance & Risk

CG/23/99 Welcome, introduction and apologies (agenda item 1)
The Chair, Nat McMillan (NM) welcomed everyone to the meeting. Apologies were noted as above, and the meeting was deemed to be quorate and could proceed.

NM outlined the Microsoft Teams meeting protocols and etiquette.

CG/23/100 Declarations 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 2023 or subsequently.

CG/23/101 Minutes from previous Clinical Governance and Clinical Safety Committee meeting held 11 April 2023 (agenda item 3)
The minutes were approved as an accurate record.

It was RESOLVED to APPROVE the minutes of the Clinical Governance and Clinical Safety Committee meeting held on 11 April 2023 as a true and accurate record.

CG/23/102 Matters arising from previous Clinical Governance and Clinical Safety Committee meeting held 11 April 2023 and action log (agenda item 4)
The action log was reviewed and updated as follows:

- CG/23/78 Review of Committee Related Risks – Darryl Thompson (DT) and Julie Williams (JW) agreed that it would be helpful to review all the risks with regards to which committee might require oversight of a risk that is owned by another committee, and it was noted that this is a wider piece of work than the Committee action. JW added that her team is looking at cross-referencing risks across committees and an update will be taken to Board.

NM asked for the action log to be shared ahead of papers going out so that updates can be added and for the progress column to be clearer on whether the action is complete.

Action: Darryl Thompson

It was RESOLVED to NOTE the changes to the action log and AGREE to close all actions with updates for 11 April 2023.

CG/23/103 Review of Committee related risks including focus on Covid 19 related risks for Committee – update following Board discussion (agenda item 5)

DT reported that the likelihood score of seclusion rooms being unavailable would be reduced as they are all now repaired apart from the one on an empty ward which has structural damage and remains out of action.

CG/23/104 Staff / Team Story – Gillian Cowell - The equality and involvement team 'commitment to family, friends and carers' (agenda item 6)

DT raised that this was an opportunity for Clinical Governance and Clinical Safety Committee (CGCSC) to hear more about Gillian Cowell's (GC) work, the robust focus on support for carers and the framework approach to that. DT added that GC was an award winner at the recent Trust Excellence Awards.

GC advised that there had been a lot of work over the last 18 months to address some of the issues raised by carers including looking at robust models of care for inclusion in the patient's journey. The Triangle of Care model stood out as the best one and the Trust is applying for membership of that as an external governance form of benchmarking.

GC referred to the six key standards, the first of which is that carers and the essential role they play are identified at first contact with our services. GC went on to say that we are changing our systems to ensure that at first contact, staff are able to document carer involvement and make people aware of what is available such as carers' passports, carers' assessments, etc.

The second standard talks about staff being trained in carer engagement and a training programme has been developed over the last 18 months. It was launched in April and is now on the Learning and Development calendar. GC advised that the training incorporates everything our staff need to support our carers, including staff who are carers. Policies and practice protocols and information sharing are also in place and included in the training.

GC indicated that standard 4 refers to having defined posts responsible for carers in place and as well as the Carers Project Management Officer (CPMO) there are carer leads and carer champions. It was noted that the aim would be to have these roles in all areas of the Trust.

Standard 5 talks about a carer introduction to the service and GC advised that there are welcome events as well as all the information available to carers.

The final standard is about having a range of carer support services available and GC referred to Cloverleaf, Making Space and the Friends and Family team who are all willing to be part of the Triangle of Care. GC advised that we would be aiming for a 3 star accreditation rating as an integrated Trust and having critical friends able to evaluate the services from the point of view of the carers would be really positive.

GC indicated that the 6 standards have either been implemented or are ready to go and the team are keen to apply for membership as soon as possible. Work is ongoing to have the Directors of Services and Matrons sign up to the Triangle of Care principles and a proposal is going to Operational Management Group (OMG). The All of Us Improve team are also supporting.

NM asked if there was anything Committee or Board could do to support the application and GC advised that everything should be in place to apply for accreditation in about 6 months' time. GC added that it would be more meaningful to have our carer involvement externally governed rather than doing something similar internally.

Kate Quail (KQ) referred to doing her own benchmarking and deep dive into carer involvement in 2019/20 and noted the immeasurable progress that had been made since then. KQ thanked GC and colleagues for that and agreed that the Triangle of Care was a good accreditation to get. KQ added that it should also help with other issues such as collaborative care planning.

NM thanked GC for joining the meeting and acknowledged that the significant progress had been as a result of the commitment from GC and Sarah Whiterod, noting the difference that the personal passion, drive and leadership had made.

CG/23/105 Chief Nurse - Update Paper (update on verbal items) (attached) Inc update of topical & legal risks, Issues from IPR, Covid-19, escalations, QIA/EIA reviews / escalations, QIA / Quality Account (agenda item 7)

DT highlighted the key points:

- A summary of the system-wide independent investigation into the safety and quality of CAMHS services at Tees, Esk and Wear Valleys Trust (TEWV) will be taken to Executive Management Team (EMT) on 18 May and then submitted to Committee.
- The backlog of complaints responses was down to 26 as of yesterday. There is a strong flow through and robust processes in place.
- There are plans to step down some of our PPE use (personal protective equipment in response to COVID-19).
- The first draft of the Quality Account will be taken on the agenda today.
- There was a summary from other recent Place Quality Committees and it was noted that there are similar conversations happening at Place as in our own committees.

NM referred to the report from TEWV and wanted to be clear on the role of Committee and Board so there was no duplication. It was agreed that CGCSC would carry out a deeper dive and then give an overview to Board with some assurance from NM and DT.

It was RESOLVED to RECEIVE the update.

CG/23/106 Approval of Quality Accounts (agenda item 8)

DT advised that the draft Quality Account would be shared with our partners for consultation at the end of the week and Board would have final sign off before it is published on the Trust's website. DT noted that there was still some more information to be added when figures

become available, however asked Committee to consider if the content felt like it fitted with discussions at previous meetings and accurately reflected our awareness of the quality of the organisation. NM agreed that it does feel like it resonates with the work at Committee although we need to assure ourselves about CGCSC's role around quality priorities.

Marie Burnham (MB) indicated that the Quality Account read very well indeed and an external perspective would help to provide further assurance as part of the development of future quality accounts. As part of this, MB suggested that DT have informal conversations with peers at other organisations in case there is anything we may have missed when it is in earlier draft stages.

JW queried how the quality priorities link to the Trust strategic priorities and DT referred to page 23 of the Quality Account where this is set out. JW suggested having it as more of a thread throughout all the organisational annual reports although NM felt that page 23 with the visual was sufficient and that we are generally good as an organisation at referencing the strategic priorities. Subha Thiyagesh (STh) agreed that the document reads well and clearly sets out the quality priorities and how they link with the strategic priorities. JW suggested that it could maybe be brought in earlier to set the scene.

KQ asked if the National Quality Board is reviewing the format of the Quality Account for next year and if we could have early sight of that. DT indicated that we have been told for the last 2 years that the format would change but it has not done so yet. JW added that it would be coming out for consultation with the NHS Code of Governance so the work is not done twice.

KQ queried if the Quality Account reflect enough about our improvement work in Forensics, Learning Disability services and the Horizon Centre. DT took an action to check and make sure it is included.

Action: Darryl Thompson

DT added that we want to accurately capture the quality elements but also reflect where we have quality risks.

DT advised that Sarah Whiterod was the lead author and that the Quality Account had been a team effort from across the Trust. NM asked for thanks to be passed on from the Committee.

It was RESOLVED to RECEIVE the Quality Account.

CG/23/107 Quality Improvement (agenda item 9)

CG/23/107a Quality and Regulatory Oversight Paper (agenda item 9.1)

DT noted that the paper provided Committee with an update and assurance regarding the Trust's approach to CQC concerns, inspections and our own internal process for assuring ourselves of the quality of our services.

The following was noted:

- There was a summary of feedback from two recent Quality Monitoring Visits (QMVs) on the Horizon Centre and Elmdale Ward. It was noted that Elmdale Ward is also mentioned in the care group quality and safety report later in the agenda.
- The Quality Improvement (QI) team continues to visit Care Groups to deliver CQC presentations.
- There was an update on the CQC's four stage plan for delivering new ways of working.
- There are changes to our CQC inspectors who will be replaced by one person, with senior CQC manager oversight staying the same.

- There was feedback from quality aspects of a Mental Health Act inspection to the Ryburn Unit at the Bretton Centre.

NM raised that the paper still reads like a lot of information rather than someone analysing the information and sharing themes with committee. NM went on to say that it would be helpful to be given a level of assurance at this meeting that themes have been identified and actions are being taken to address them. NM asked how we know what we are doing and whether it is having an impact.

DT wondered whether that should be for this paper or reflected more in the care group quality and safety report with headlines of themes. DT added that he is trying to balance the content of this report, the care group quality and safety report and the chief nurse report. MB agreed that the themes coming out of the visits should be reflected in the care group quality and safety report.

MB raised that the QMV reports do not provide assurance to committee on actions or mitigations and that people who have been part of the visits do not know what improvements have been made. MB referred to a specific issue on the Horizon Centre and was unaware if that had been tackled or not. DT was confident that the Director of Services was dealing with it in as fair and equitable a way as possible. MB indicated that concerns had been raised 2 months ago and the Non-Executive Directors (NEDs) or governors do not get follow up or assurance from the QMVs they are involved in.

DT indicated that there are processes in place across the Care Groups and also in central meetings that concerns from QMVs are being actioned. DT added that there have been senior unannounced visits during the night as part of the issue that MB referred to above. NM suggested that NEDs being 'buddied' with areas of concern could be another way of providing assurance.

KQ raised the need for a NED or governor to be present at all QMVs. MB noted some issues with the quality team thinking the NEDs and governors have the same role and going ahead with a QMV that clashed with Members' Council. KQ also referred to raising some points that had not been included in the formal report or action plan. DT assured committee that the team were aware of the diffeeernces between a NED and a governor, and will ask the team to link with corporate governance in terms of dates to avoid, and acknowledged that whilst the roles of the NED and governor are different, they bring an independent view to a visit.

It was RESOLVED to RECEIVE the Quality and Regulatory Oversight update report.

CG/23/107b CQC Action Plan (agenda item 9.2)
DT advised that the CQC action plan and summary of unannounced visits had been to Members' Council as part of their annual work plan and was here today for noting. The CGCSC annual work plan will be updated to ensure that the papers come to this meeting first next year.

It was RESOLVED to NOTE the report.

CG/23/107c Unannounced and Planned CQC Visits (agenda item 9.3)
This was covered at item 9.2.

It was RESOLVED to NOTE the report.

CG/23/108 Care Group Quality and Safety Report (agenda item 10)

Chris Lennox (CL) highlighted the key points from the report:

- There had been rapid improvement work on safe seclusion and almost all seclusion rooms were now up and running. CL noted this to be better for service users and reducing the pressure in the system. The risk of likelihood would, therefore, be lowered. There had also been some learning from that work that would feed into the ongoing seclusion review.
- A review session in relation to the recent junior doctor industrial action had taken place on 20 April. It had been noted that the quality and safety of services had been maintained but at the cost of pressure into the system. There had been some learning points taken from the experience of managing the industrial action which could be used for future episodes, which was an uncertain position for us at the moment.

CL asked if DT had anything to add in relation to the Horizon Centre and DT advised that there was enhanced support and oversight from an Associate Director of Nursing, Quality and Professions which was distinct from the routine oversight to ensure that the change is sustained. Emma is maintaining a link with the Freedom to Speak Up Guardian in case any further issues come to light.

NM asked what keeps the executive trio (the Chief Medical Officer, Chief Operating Officer and Chief Nurse / Director of Quality and Professions) awake at night and DT advised the Horizon Centre and staffing, not just for mental health inpatient units but also Barnsley community staffing. CL added that there are also staffing issues in mental health community services. STh noted a couple of things in addition to what DT had said. The consultants are being balloted for strike action up until the end of June and there are no government conversations happening which is clearly worrying. STh had joined a Royal College of Psychiatry session yesterday and raised issues around workforce, the establishment review, new roles and a lack of connection between what Health Education England (HEE) are doing and what is needed on the ground. It was noted that new services are being developed which has an impact on us retaining our experienced staff and maintaining our inpatient acute pathways.

STh also referred to a recent executive trio talk at Kendray Hospital where front line colleagues had mentioned that Trust communications do not always reach them. STh added that we need to ensure we keep everyone connected and identify ways of doing that. MB raised that extended EMT meetings need to be reflective of people who have authority across the organisation and attendance at those meetings is key to then communicate effectively with their staff.

MB referred to CL's comment in relation to mental health community staffing and queried if the issues were clinical or managerial. CL indicated that there was growing pressure to meet service user need and cope with the change in landscape and workforce challenges. CL gave the example that Wakefield SPA have an establishment of 13.4 and currently have only 4 Whole Time Equivalent (WTE) colleagues, which was unprecedented.

MB raised that as an organisation we need to be clear what our actual capacity is and from what CL described, it sounds like the quality is being tested because of the sheer volume and acuity of patients presenting. MB suggested that this is discussed with EMT colleagues to clearly set out what we are contracted to do and what we can do without compromising safety.

KQ referred to the point about mechanical restraint which had been raised at the last Committee meeting. KQ indicated that the CQC guide to mechanical restraint says all instances should be reported to Board and if mechanical restraint is used, Board level agreement should be sought to ensure it is the least restrictive option.

DT confirmed that Board level approval is always in place and that requests come to the trio during working hours or to the out of hours director on call. CL advised that the specific incident previously discussed had been outside of process and subject to investigation. The process for use of mechanical restraints had been reviewed subsequent to that and found to be robust, with Board level approval for each individual need for restraint.

KQ asked if a regular update could come to Committee as well as Board, even just giving the number of instances of mechanical restraint. STh suggested it could be added to the quarterly RRPI report and DT took an action to pick this up with his team.

Action: Darryl Thompson

NM noted that KQ had raised this as an exception at the last meeting although it had not been specifically highlighted to Committee. It had then led to some scrutiny so there may be some learning around ensuring that reporting is robust enough, with exceptions clearly highlighted.

CL referred to some issues in relation to professional boundaries within Forensic services and advised that training on how to maintain professional boundaries is being prioritised and reviewed as necessary, supported by the Nursing, Quality and Professions directorate with some external input.

NM thanked the executive trio for the report which helpfully brought the current key issues together. NM added that the report provides a lot of assurance and noted the visibility of the executive trio across the Trust.

It was RESOLVED to NOTE the information provided.

CG/23/109 Care Planning and Risk Assessment Improvement Update (agenda item 11)

This item was deferred to the June meeting to allow for a further update to go to EMT. DT raised that time would be needed to ensure that changes are embedded although there has already been an 85% step change improvement up to at the current time in relation to care planning.

NM noted that this had been discussed at Board as part of the Integrated Performance Report and thanked DT for the verbal update.

CG/23/110 Safer Staffing Report (agenda item 12)

NM advised that the report had already been to Board and was for committee to note. It remains a work in progress and whilst it is much more condensed and focused than previously, there is still an ambition to help it be even more focused.

NM indicated that there is now a clear process in place, including escalation points, to ensure delivery of the paper to committee first, for next time.

It was RESOLVED to NOTE the report.

CG/23/111 IPC BAF (agenda item 13)

DT reported that the National Infection Prevention and Control (IPC) board assurance framework (BAF) is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others.

It was noted that COVID-19 had dominated thoughts around IPC in recent years although this goes beyond that and is for all things IPC. DT referred to the attached spreadsheet and the detailed piece of work being undertaken by the IPC team. DT advised that we are compliant with all but one aspect in relation to laboratory diagnostic reports. DT went on to say that whilst we are compliant with our own process in relation to external ICE (the electronic pathology system) access, work is ongoing to ensure more global access and for the process to be more seamless.

NM noted the assurance for committee that the self-assessment feels accurate for our organisation and the recommended work was underway.

It was RESOLVED to RECEIVE the report and APPROVE for recommendation to Trust Board.

CG/23/112 Community Mental Health Survey (agenda item 14)

It was noted that this item had been deferred from the last meeting. DT reported that given the significant pressures in community mental health teams and some of our most experienced staff moving on, it was remarkable that we had still reported reasonable scores, at least in line with other organisations. There had been a positive increase in 12 out of 24 questions and where areas for improvement had been identified, there have been conversations in Care Groups about our learning and response. DT referred to the actions in the executive summary and asked committee to note the benchmarking aspects and how we compare to similar providers.

NM agreed that our quality metrics by and large stand up despite all the pressures we know about, although noted that the response rate was low so was unsure how representative it was. NM asked how we triangulate this source of information with existing workstreams, etc and queried how we will know if things have improved without waiting another year to find out. DT advised that this is just one source of information along with complaints, incidents, engagement with staff, workforce surveys, hotspots etc that help to guide the themes in the care group quality and safety report.

DT highlighted that the question 'Would you know who to contact out of the office hours within the NHS if you had a crisis?' had decreased again. DT raised that given the work we are undertaking around sharing care plans, the contact information should be on there so people would be able to confidently say they know who to contact. NM noted that we should, therefore, see an improvement for next year. DT added that it can sometimes be about language and connecting the focus of the question.

It was RESOLVED to NOTE the report and the planned response.

CG/23/113 Apparent Suicide Report (agenda item 15)

DT welcomed Naomi Sutcliffe (NS) to the meeting as the author of the report, to give a summary and be available for any questions. NS highlighted the following:

- The executive summary gives an overview of the statistical differences noted in 21-22.
- Overall, as a Trust we have noted for the last 3 years no real difference in the number of suicides.
- The report goes into detail of the nature and manner of how people are dying by suicide and the report seeks to put some context behind the numbers.
- Out of 26 individual cases, key themes included bereavement, relationship difficulties or challenges, significant levels of drug or alcohol use, domestic abuse and long term health conditions. Financial distress is also a factor but it was not possible to drill down

further as to why the person was in financial distress. The personal impact of COVID-19 also featured as a theme.

- We have tried to cross reference our own data against the The National Confidential Inquiry into Suicide and Safety in Mental Health (**NCISH**) report and what that means for us as an organisation in relation to clinical risk.
- We have tried to align ourselves regionally across South Yorkshire and West Yorkshire. At the time of writing the report, South Yorkshire had come to the end of their 3 year specific funding from NHSE so were working collaboratively across partner organisations. West Yorkshire is now in the same position so there are some changes in regional work.
- The rest of the report breaks down the data, looks at population and how many people had contact with our services, received our care and then tragically died.

KQ referred to the groups or people most likely to die by suicide, for example those experiencing domestic violence and asked, given that we know that, what we are doing to identify and target those individuals. NS advised that we have regional and national connections to work taking place where we know there is an increased risk of suicide. Through that, we have started to pick up individuals where suicide or homicide is more likely and we are taking forward what we can learn from that and what we can do with partner organisations to reduce suicide.

KQ also referred to the NCISH report and the toolkit, 10 ways to improve safety and asked how SWYPFT uses that. NS advised that we have benchmarked our organisation against the 10 steps although we could review that as part of the apparent suicide strategy work.

NM suggested that NS join a future CGCSC meeting for a more in depth discussion and NM/DT will agree a date for that.

Action: Nat McMillan and Darryl Thompson

MB thanked NS for a great report and agreed that a further discussion would be helpful. MB asked NS to consider, before joining a future meeting, whether or not having a dedicated Accident and Emergency (A&E) department for people presenting with mental health needs would make a difference to suicide rates. MB asked CL to also consider if we could create an A&E in mental health service provision. CL advised that this had been discussed regionally and nationally.

It was RESOLVED to RECEIVE the report.

CG/23/114 Reports from Formal Sub-Committees (agenda item 16)

CG/23/114a Drug & Therapeutic TAG (agenda item 16.1)
There was no update for this item.

CG/23/114b Infection, Prevention and Control (agenda item 16.2)
There was no update for this item.

CG/23/114c Joint Safeguarding (agenda item 16.3)
There was no update for this item.

CG/23/114d Reducing Restrictive Physical Interventions (agenda item 16.4)
There was no update for this item.

CG/23/114e Improving Clinical Information Governance Group (agenda item 16.5)
The updated was received and noted.

CG/23/114f Clinical Governance Group (agenda item 16.6)

There was no update for this item.

CG/23/114g Clinical Ethics Advisory Group (agenda item 16.7)
There was no update for this item.

CG/23/114h QUIT (agenda item 16.8)
The updated was received and noted.

CG/23/114i Safer Staffing (agenda item 16.9)
This was included at item 12.

CG/23/114j Physical Health (agenda item 16.10)
There was no update for this item.

CG/23/115 Issues and Items to be brought to the attention of Trust Board / Committees (agenda item 17)
NM will share the triple A update with CGCSC members if anyone wants to comment before it goes to Board.

CG/23/116 Risk Register review (agenda item 18)
There were no further updates for this item.

CG/23/117 Work Programme (agenda item 19)
The updated Work Programme was noted.

CG/23/118 Date of next meeting (agenda item 20)
The next meeting will be held on 13 June 2023.

Minutes of Equality, Inclusion and Involvement Committee held on
14 March 2023
Via Microsoft Teams

Present:	Marie Burnham (MBu)	Chair of the Trust (Chair of Committee)
	Salma Yasmeen (SY)	Director of Strategy (Lead Director)/Deputy Chief Executive
	Mike Ford (MF)	Non-Executive Director
	Erfana Mahmood (EM)	Non-Executive Director
	Mark Brooks (MB)	Chief Executive
	Greg Moores (GM)	Chief People Officer
Apologies:	Darryl Thompson (DT)	Director of Nursing, Quality & Professions
In attendance:	Rachel Irwin (RI)	PA to Director of Strategy/Deputy Chief Executive (author)
	Dawn Pearson (DP)	Communications, Engagement, Equality and Inclusion Lead
	Sue Threadgold (ST)	Deputy Director
	Aboobaker Bhana (AB)	Equality & Involvement Manager
	David Webster (DW)	Non-Executive Director
	Mike Garnham (MG)	Health Intelligence Analyst/Information Manager
	Darren Dooler (DD)	Governor
	Zahida Mallard (ZM)	Equality & Engagement Manager
	Chris Lennox (CL)	Deputy Director of Operations
	Elaine Shelton (ES)	Disability network Chair & Staff Side Chair/Covid Lead
	Gillian Cowell (GC)	Carers staff network Chair/Carer Support Worker
	Donna Somers (DS)	LGBT+ staff network Chair/Ward Manager
	Nomagugu Ndhlovu (NN)	Associate Quality and Governance Lead
	Paul Brown (PB)	HR Business Partner
	Paul Cartwright (PC)	Head of Marketing and Communication
	Iffath Hussain (IH)	Diversity Inclusion & Belonging Lead
Apologies Attendees:	Catherine Musagedi (CM)	Staff Side Lead for Equalities
	Carmain Gibson-Holmes (CGH)	Deputy Director of Nursing, Quality and Professions
	Tony Wright (TW)	Sustainability Change Manager

Section 1 – Standing Opening Items

EIC/23/01 Welcome, introductions and apologies (agenda item 1)
The Chair, Marie Burnham (MBu), welcomed everyone to the meeting. Apologies were noted.

EIC/23/02 Declarations of Interest (agenda item 2)
None.

EIC/23/03 Minutes of previous meeting held on 14 December 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 14 December 2022.

EIC/23/04 Matters arising from previous meeting and action log (agenda item 4)
Mike Ford (MF) commented that he was impressed that so many actions had been closed and so few remained open and thanked all involved.

EIC/22/78 Commitment to Carers – action closed. Aboobaker Bhana (ABB) confirmed that a connection had been made with the ICB lead for South Yorkshire and Gillian Cowell (GC) was meeting with them on 22 March. MBu felt it would be useful to receive feedback. ABB advised that any progress would be included in the annual update paper in December.

Mark Brooks (MB) wasn't convinced some of the actions were for him i.e., possible change to risk register to ensure agency policies for bank staff aligned with ours. MBu confirmed she had reassigned to Greg Moores (GM), which he was happy to pick up.

EIC/23/05 Actions from Trust Board (agenda item 5)
No specific actions raised at Trust Board.

EIC/23/06 Review of Committee related risks and any exception reports as required (agenda item 6)
Salma Yasmeen (SY) drew Committee's attention to Risk 1689 (risk that the Trust cannot evidence that it has mitigated against or addressed health inequalities in both the provision and restoration of services). It had been agreed to review this month given the substantial amount of work undertaken over the last 2 years. Recommendation was to reduce the risk score from 12 to 9 – unable to reduce further as there are a series of ongoing actions but will continue to monitor and review this every quarter. Committee had no objection to this.

With regard to the other two risks, there are significant controls in place and also a comprehensive work programme to help to try and reduce these down and again they will be reviewed quarterly. GM confirmed there will be a discussion at EMT Time Out in April around diversity and leadership roles which will help support the risk around lack of diversity above Band 7.

The Committee DISCUSSED and COMMENTED on the current Trust wide corporate/organisational level risks relevant to this Committee and AGREED to reduce the risk score for Risk 1689.

EIC/23/07 Context report – National, ICS and Trust level (agenda item 7)
Dawn Pearson (DP) thanked Zahida Mallard (ZM) and the team for pulling the report together and aligning with the improving health, improving care, improving resources and great place to work themes. This insight is fed back to OMG, care groups, relevant service leads and taken into account when action planning.

Highlights included: -

- Children and young people – sharp increase in 1 in 6 young people having a mental health problem rising to 1 in 4.
- Learning disability: -
  - The CQC has published its 'Who I am Matters' report highlighting the experiences of being in hospital for people with a learning disability and autistic people.
  - No wrong door - a vision for mental health, autism and learning disability services in 2032 for people of all ages in England.
- Action to address the over representation of Black people and those living in deprived areas in mental health inpatient facilities and also a report around rising restraints for this group.

- HMIP thematic review - making and sharing of food together can build trust between people in prison and staff.
- Focus on ethnicity and vaccination levels and links to structural and institutionalised racism.
- Report on racism and medicine – 47% of our doctors are from ethnic or diverse backgrounds and some of the issues they face.
- Racism strategy by Joan Saddler launched – good information around how to address system leadership to tackle racism.
- Workforce information including how we might support older people and their health so they can continue working.
- Menopause.
- LGBTQ+ and mental health, particularly support to students.
- Podcast on sustainability.

Erfana Mahmood (EM) asked who the audience was – internal or external. DP advised that this was internal but there was no reason it couldn't be shared more widely and externally if Committee thought it would be useful. EM also mentioned the Covid 19 enquiry currently being carried out and the focus on inequalities and how different communities had been impacted and that we needed to be mindful there will be impacts and outcomes which may come via this Committee.

MB mentioned that the report highlighted rising restraints for Black people in inpatient settings and wondered how we compared as a Trust to the national trend. MB also mentioned access to children and younger people services i.e., CAMHS. Receiving lots of complaints from families and carers around access to CAMHS and so need to work out how we respond to this in order that we give the appropriate access to treatment.

MF mentioned a report requiring Mental Health Trusts to appoint a board member responsible for improving racial equality and also to draw up a patient and carer race equality framework by March 2024. MF asked if we were taking appropriate action. SY confirmed the patient and carer race equality framework and recommendations had been reviewed and there had been a paper into subcommittee and EMT and we had a shared leadership approach with regard to how we drive equality. SY also advised that the Covid 19 enquiry had been picked up in previous reports and there was an action plan which feeds into EMT on a regular basis and will ensure the inequalities aspect is an integral part of this. With regard to the use of restraints, data is captured on how we use restraints but not with regard to the ethnicity of the people who are restrained and felt this was an action for Darryl Thompson (DT) to pick up. ZM confirmed that some work had started on restraint and ethnicity with Sarah Whiterod.

Action: Darryl Thompson

MBu asked whether we could add a front sheet to this report in future clearly showing it was an internal report, its purpose and detailing some of the highlights. MBu also felt it might be useful to have a Trust Board report along the same lines.

The Committee NOTED the contents of the context report.

Section 2 – Insight, feedback, and programme updates

EIC/23/08 Insight Report (agenda item 8)

DP had provided a couple of reports on how we use and collect insight from a range of sources across the system – quarter 3 (including responses from our senior leads) and quarter 4 (themes to agree). These reports are to give Committee an idea of what people are saying in the system as a collective voice and what key areas and themes we are going to focus on.

MF felt the Clinical Governance Committee should also be looking at this report as there were a number of different issues raised. He assumed it was fed through to the Exec Trio to pick up and that we were receiving this to demonstrate involvement and how we were responding to our service users, staff and carers. DP confirmed that it was also shared with governors so they had the insight when out and about in the communities we serve.

MF asked if there was an update on the Dales. MB confirmed they had just had some Mental Health Act visits from the CQC which had identified some good areas of practice but also some challenges. The Exec Trio will be overseeing the work to address the points the CQC had raised. MB confirmed it was a challenging ward due to staffing and the environment itself - issues with substance misuse and how other services interact with people with substance misuse, communication with families and carers and younger people to adult transition. The themes we are picking up from the insight are consistent with the areas we are picking up internally. DP confirmed that she also met quarterly with Healthwatch colleagues and they were assured by what we are doing.

The Committee NOTED the insight reports, the themes for quarter three and four and AGREED the themes for quarter four.

EIC/23/09 Staff Network Update (agenda item 9)
Paul Brown (PB) and Iffath Hussain (IH) had provided a general update on all four networks. Focus for this meeting was on the LGBT+ network with Donna Somers (DS) providing a presentation.

LGBT+ Network Presentation
DS confirmed that at the last meeting, MBu had set a challenge to get to 100 members and the network now has 104, a lot of this via the welcome events (62 identifying as LGBT+, 38 identifying as allies and 4 people did not disclose). Overall, the welcome events are going well but she sometimes feels there are a lot of people from different countries and cultures coming to the Trust and not sure how they feel about the LGBT+ stall.

Successes

- Full members meeting, facilitated by Liz Twelves, in September 2022.
- Increased network membership.
- The network provides a safe space.
- Increased members of steering group – now 4 and group is developing and will start to look at elections towards the end of the year.
- Improvements seen on Datix and reporting.
- Recognising micro-aggressions and how to challenge - undertaking some work with GM with regard to this.
- Policy development – asked to be involved in this but usually just a read through rather than actual involvement.
- Funding for 4 pieces of inclusive artwork around the Trust.
- Gender neutral toilets now installed.
- Pledges of rainbow badge/lanyard showing support of LGBT+.
- Regular communication with members.
- Supportive organisation.

- Impact of lobbying – act as advisers, having a collective voice.

Aspirations

- Full members meeting on 18 April 2023 being held in Barnsley - will provide an opportunity to clarify what members want from the network and the Trust.
- Staff have the opportunity to be involved in working with an artist to develop 4 pieces of artwork, representing inclusivity and diversity.
- Network to continue to grow and make positive change.
- Working with the people directorate on how to improve LGBT+ staff members experience of working for the Trust and ways they can report instances of homophobia and homophobic micro-aggressions outside of the Datix incident reporting process.

MBu thanked DS for her presentation and commented that the network had really started to develop and evolve and didn't think there was anything in the aspirations that couldn't be achieved. MF mentioned the development of a toolkit to help clear up myths and questions and to help people reflect more on what they are saying. MF felt it was really important to help people understand issues and the impact of their own beliefs and views and would be happy to get involved in this. MF also asked what specific improvements had been made on Datix. DS advised that previously you couldn't report anything homophobic as it was more about racism but now includes gender and sexuality and this gets discussed at the risk panel.

The Committee NOTED the staff network update and presentation.

EIC/23/10 Care Group Highlight Report (agenda item 10)
Chris Lennox (CL) presented a paper on Adults and Older People.

Equality Impact Assessment (EIA) actions in progress
CL detailed the actions and how teams are working towards these and connecting the priorities in terms of addressing health inequalities and broader inequalities.

CL mentioned the Datix incident reporting – have seen an increase where race has been a factor of abuse but have not looked at the other ones in detail – undertaking some drill down from other areas in the care group to understand these incidents and to inform service changes.

Continuing to ensure that venues and locations are accessible to those with any disabilities and other protected characteristics, reporting and making improvements where possible. An evaluation of all sites is underway and action plans are in place.

Equality Impact Assessments (EIAs) and training compliance
Work still to do – had included new tracker which was produced in partnership with colleagues.
Training compliance is generally in a positive position.

Equality highlights: -

- Sessions/workshops held for staff to offer wellbeing support around the rise in racial abuse from service users.
- Information on work to address physical health challenges and reduce health inequalities – introduction of physical health monitoring machines in community teams Trust wide.
- Calderdale and Kirklees Talking Therapies (formally IAPT) – specifically for older people - there has been the development of bespoke accessible promotional material approved through experts by experience; bespoke training for teams focusing on reasonable adjustments to working with an older adult population; and re-establishing links in the local community and attendance at events with University of the Third Age.

- Older people inpatient wards improvement plans. An increased level of input from the Chaplains employed by the Trust to meet religious/spiritual needs of patients at specific times of observance.
- Older people inpatient wards improvement plans. Contact made with local religious leaders to come along and attend a ward staff meeting to allow time for Q&A sessions around religious sensitivity/education/understanding and how this translates to our patients on the ward.
- Older people inpatient wards improvement plans. A piece of quality improvement work is underway around service users with dementia and oral hygiene. This is being led by a Speech and Language Therapy practitioner with input from Quality Improvement.
- Older people community teams. Improving communication. Team information/booklet has been produced explaining the CMHT service offer for both service users and carers.

Involvement highlights: -

- Moving on from Care Programme Approach - Work being planned with service users and carers to gain their views and thoughts around CPA being removed, including linking with events planned at Integrated Care Board and regional level.
- Older People Inpatient Transformation - Consultation process is planned and in preparation for this Summer.
- Recovery college – currently working with the long-term conditions steering group to see how we can better support and provide self-management for long term conditions such as cardiac disease, diabetes, and smoking cessation. Aware of a gap in our reach to BAME communities and our college population not being reflective of our local population. Taking steps to address this e.g., recently started working with a local mosque to understand and improve reach, accessibility and delivery.
- Family & Friends Tests - Distributed on a regular basis by all teams for completion. In the care group, exceeded the performance target every month.
- Carers offered a passport to assist them in accessing services they need.

Next steps: -

- Developing workforce strategy building diversity into roles and recruitment and local and in partnership at place recruitment plans.
- Prioritising better understanding of local populations and use of data – feedback from teams is that increasing numbers of people are interrogating the availability of the data on the intranet and quality and governance leads are leading sessions around this.
- Trauma Informed Pathway - reviewing our commissioned pathways and offers in place to ensure we can meet the needs of older people.

MBu thanked CL and the team for the report which had provided an excellent overview. MB felt it was very encouraging to see how we are using data and picking up on things to improve services for everyone in terms of accessibility. MB mentioned the recent staff survey and that it had shown an increase in racial abuse to staff from service users so felt it might be worth adding to the agenda at this Committee or subcommittee in future to look at our approach as an organisation. MB also mentioned venue access and wanted to know what feedback we had received from service users, friends and families as part of our assessment to make sure they are accessible - whatever we can do with respect to recovery colleges in improving accessibility would be very welcome.

The Committee NOTED the contents of the Care Group highlight report.

EIC/23/11 All of You campaign (agenda item 11)
Paul Cartwright (PC) shared his presentation: -

The campaign encourages staff to declare their personal characteristics – able to do so via ESR so that we can ensure the support we provide matches the needs of our workforce. Service users are also asked if they will declare their characteristics so we can ensure services and accessibility needs are met, via SystmOne.

The approach we take is all about creating inclusive and supportive language, making sure people understand whatever they bring to their work as an experience is valued and respected. The All of You campaign has been co-produced with groups of staff, staff networks and equality and inclusion team colleagues to showcase all the different types of people who work for the Trust and the things they bring i.e., their experiences and viewpoints. Have focused on individuals sharing stories and experiences of events and celebrations, national awareness days, plus religious celebrations and have worked closely with Spirit in Mind (developed a cultural and spiritual calendar).

We monitor the effectiveness of the communication channels through a number of interactions and impressions and then ultimately in the % of staff who have recorded their equality data. PC just awaiting to hear back from HR about the updated staff figures, however, the service user has gone up from 59% at the start of the campaign to now just over 70%.

Ongoing plans include: -

- Continuing to share staff and volunteer stories in their own words.
- Supporting service users, carers and volunteers who may want to share their lived experiences.
- Events and celebrations linked to awareness days and religious holidays.
- Sharing experience and stories from people with no religious faith.
- Establishing strong links with our local and community groups and individuals who want to get involved.
- Building on our support for and the involvement of our staff networks.

EM asked how comms gets to Wetherby Youth Offenders, Urban House and other hard to reach communities. PC advised that we try to use as many different comms channels as possible – internally via the staff app (big increase in uptake recently) and having nominated individuals in each area responsible for sharing information at meetings/briefings and printing resources. For public messages, we use printed materials, social media and local radio stations but it would be difficult to include everything so PC was more than happy to speak to Wetherby Youth Offenders and Urban House to see if they could offer any other suggestions. EM suggested PC also accompany NEDs on visits. SY confirmed that we also used our operational management structure i.e., OMG plus The Brief but another area of potential are the 200 voluntary and community sector organisations we partner with.

MBu felt it would be good to link all the campaign themes together – All of You, All of Us etc., which PC agreed to action. DP thanked PC and the team for all their work collating the stories, increasing visibility and creativity.

Action: Paul Cartwright

The Committee NOTED the presentation.

Section 3 – Strategy and Policy

EIC/23/12 Equality, inclusion and involvement annual action plans (agenda item 12)

DP advised that the actions had been co-created, presented at Committee in December and progressed through subcommittee, staff networks, staff groups, OMG and EMT.

DP advised that in future there will be an additional column for national priorities (NP) which will be aligned with our own Trust priorities (TP) to show where we are delivering on some of these.

The highlight report will also include these in future. MB commented that they were very comprehensive and to reflect whether or not as a Trust we were trying to do too much in one year. MBu felt we needed to be sure that our operational teams could deliver the change as detailed in all the action plans and that there may be some things we could cease doing. MF advised that he would have another look at the plans from this perspective.

The Committee NOTED the action plans and APPROVED them.

EIC/23/13 Human Rights policy (agenda item 13)
GM advised that the policy was being provided for information only - it had been through EMT and the usual consultation process and was something we are required to have as an organisation. EM was concerned about slavery and our relationships with third parties when procuring goods and services and asked if we got a statement from them. GM confirmed that this was pretty well embedded from a procurement perspective. MB advised that if we had a statement, we need to ensure it is visible on our intranet/website.

MF asked how the policy was communicated to teams and whether we had a modern slavery act policy statement – GM confirmed we did. MBu advised that GM and PC need to ensure the policy is communicated effectively for Committee to feel assured. MF noted that we didn't mention our freedom to speak up guardian process to raise a concern about human rights. GM will ensure this is picked up as part of the comms messaging.

The Committee NOTED the policy.

Section 4 – Performance Reports
EIC/23/14 Equality dashboard (agenda item 14)
SY advised that the dashboard continues to evolve and we are now at a stage where we can do deep dives into particular areas, using the approach in a more meaningful way in co-production with staff.

Workforce
GM advised that there had been a focus this month on LGBT. GM apologised for an error on the slide regarding the LGBT total – should be 4.2% and not 8.4%. This compares to a national average of 3.7%. Slightly above our places in terms of proportion of our workforce which come from a LGBT background. We are recruiting even more – 6.1%. Training – 5% of our training is accessed from people from an LGBT background. Disciplinary – no staff have gone through a formal disciplinary over the last 12 months. With the different approach we are now taking, have seen a significant drop in overall disciplinaries. Abuse/harassment of staff – 16 are related to LGBT and are responding to these.

EM mentioned about capturing data around social mobility and whether we had made any inroads into this. SY advised that the slide set contained data collected over the last 2 years and the two indicators we look at are BME and depravation index and we are getting people from the most deprived neighbourhoods accessing our services. SY advised that we were trying to create flash cards for services to stimulate conversation and action planning using EIAs and then we should see some of this feeding back into future EI&I Committees.

MF felt it was very positive that we were starting to collect the data but wanted to know what it was telling us in some cases and how to interpret it i.e., waiting times on ethnicity – BME patient being seen before a non BME patient. Mike Garnham (MG) advised that it was only shown to advise what sort of level of information could be provided and to encourage what is happening at team level to drill down into it. We have really good data that we are advising people to look at around waiting times, referrals, ethnicity and depravation and there are also a lot more metrics we can also look at and build in. Length of staff on a ward is currently in development.

MG advised MF to look at the case studies as examples of how we think a service might want to use the data. Have developed a tool to encourage people to look at what inequality data they might have or want to be looking at for a particular service.

DP advised that there are still some gaps and more work to do to ensure we have good quality data people can use and hopefully by June will have some more progress on how we are going to start working with teams to support them to use this data in a way that enables them to do the case studies. MF would like stories on how the data has been used and how the outcome has changed through using the data to demonstrate an improvement in inequalities. SY advised that we should be able to bring back case studies to future meetings and that impact and outcomes will follow later. MG confirmed that they had chosen ethnicity and depravation as they already had really good quality data on this but were aware this wasn't the case with some of the other metrics i.e., digital inclusion.

The Committee NOTED the development of the dashboard.

EIC/23/15 Equality, Involvement, Communication and Membership strategy implementation action plan highlight report (agenda item 15)

DP advised the report covered whether we were delivering against the action plans shared with Committee last year and what we have carried forward into next year where we didn't quite achieve, together with some highlights. Two areas which had to be moved forward were the census and procurement of the data interpretation service.

Delivered on 105 Trust wide actions.

In terms of the involvement action plans for last year, started to do work but have not progressed as much as would have liked and have carried forward into next year - one which is outstanding is the audit of our partners which was due to take place in Autumn but there was already another audit taking place so didn't want to duplicate.

In terms of the work being undertaken, we are recording equality data and starting to clear the EIAs.

Equality and diversity mandatory training – very positive.

Training compliance actions for service/team – no issues this quarter.

Equality highlights: -

- Delivered on the FLAIR survey - 1082 responses (23% of our staff) looking at racial bias within our system and starting to look at the data and will produce a report for EMT on the early findings.
- Continuing with lunch box exercises (films delivered by communities) – available on the intranet.
- Now have Trust wide mental health EIA.
- Delivered on EDS2.
- ZM and ABB have been undertaking some work around hate crime awareness week.
- Progressing Race Forward under the umbrella of All of You.
- Lots of work around cultural awareness and cultural awareness training taking place.

Involvement highlights: -

- Working closely with Patient Knows Best to think about how we roll out digitally, ensuring we involve staff and people who use our services.

- Worked in partnership with the corporate team to look at the membership database – now identified those who want to be involved further in the Trust.

EM mentioned the recruitment of governors and where responsibility lies for this. DP confirmed that John Laville had developed an action plan which she had incorporated into the involvement action plan. DP confirmed that they always promote being a governor but have identified that they need to do more pre-election.

The Committee NOTED the report and APPROVED the recommendations.

EIC/23/16 Equality Delivery System 2 (EDS2) update on grading (agenda item 16)
ZM had provided a presentation to stakeholders in January for goals 1 and 2 – we had ourselves as developing but the participants graded us as achieving. ZM apologised for the mistake in the paper which had the overall final grading for the Trust as developing when it should have stated achieving – ZM will ensure when uploading to NHSE/I that it will say achieving.

With regard to next steps, have commenced some internal work with teams and services to prepare for the new system coming in and have already had two meetings – one in December and one in January.

DP apologised for the mistake in the document. The presentation put together by the team was comprehensive and a partnership co-produced approach and it will inform the work we are doing around improving services to people with a learning disability.

The Committee NOTED the final Trust grading for all goals and the emergence of EDS2023.

EIC/23/17 Equality Standard update (WRES & WDES) (agenda item 17)
GM confirmed that the action plans had been agreed and published at the end of October. Work on the plans continues.
Highlights: -

- Good and diverse response to our face to face and virtual recruitment events.
- Good partnership working between people directorate and facilities in terms of diversity around recruitment.
- Employment scheme at Kendray successfully recruited 6 people. Hoping to extend offer to Wakefield.
- Starting to embed Race Forward into an ‘All of You’ programme approach with working group focus that aligns other work streams into a system wide change programme to address racial equity.
- Following the national WRES report published 22 February 2023, the Trust will do a comparison report to present to EMT in late April 2023. IH will be getting involved in this work and will be interrogating the data – at present, doesn’t look like any one Trust nationally has managed to achieve all 9 WRES indicators.

MBu asked if we had a group of Trusts to compare ourselves against. IH felt it would be good to benchmark ourselves with other Mental Health Trusts – Leeds is one which is performing well on WRES data together with Coventry and Warwickshire Foundation Trust but IH happy to receive any suggestions about which to particular deep dive into. MB confirmed we could share the model hospital data which compares ourselves with like for like organisations but wasn’t sure the WRES and WDES data was on it so would have to individually tailor their benchmarking but we have plenty of other relationships with organisations where we can share

results. GM confirmed that there was not only a performance element to this but also a learning element.

ABB asked about our plans in terms of our organisational development to look at staff from all protected groups and certainly those underrepresented in terms of opportunities to develop their skills. GM confirmed that some options and approaches would be prepared for EMT Time Out in April after reviewing what we have done previously. MBu mentioned that at the last Trust Board they had discussed the lack of BAME representation in the management structure in the Trust. SY confirmed this and advised there was a comprehensive plan in place but this had been paused whilst the FLAIR survey was undertaken and she was hopeful this survey would provide the data we needed to have discussions with various talent groups about what inclusive leadership, an inclusive organisation and an inclusive workforce should look like. IH confirmed that she herself had been through the BAME talent pool and Moving Forward programmes and that a robust evaluation was required in order to learn lessons and look at what we need to do more effectively. EM advised that we were well informed about the challenges people with protected characteristics have to deal with on a daily basis and asked if we could have an action plan, fully co-produced with a long-term strategy. SY advised that we had external input and expertise to help with this and that the planning and some of the actions were well underway.

The Committee NOTED the update.

EIC/23/18 Internal Audit Reports (agenda item 18)
Nil.

Section 5 – Annual Items
EIC/23/19 Annual Items (agenda item 19)
Nil.

Section 6 – Governance
EIC/23/20 Committee annual report (agenda item 20)
The Committee REVIEWED AND APPROVED the annual report and work programme for 2023/2024.

EIC/23/21 Committee membership and Terms of Reference (agenda item 21)
The Committed NOTED the updated Terms of Reference.

EIC/23/22 Annual review of Committee effectiveness (agenda item 22)
MF mentioned there would be an email being sent shortly from himself with a request for these reports in future to have a narrative highlight section by the Chair of each Committee as part of the overall effectiveness approach covering what we have achieved throughout the year, any areas we need to further improve, any lessons we have learnt and possibly the inclusion of our annual governance statement. SY advised that we had already provided a comprehensive annual report set against the objectives of the strategy and that a further report wasn't required. MB advised that for each Committee, the corporate governance team work with Lead Directors and Chairs each year to look at the overall Committee effectiveness report and draw out any highlights. Some Committees (like this one) already produce an annual report. In terms of the annual governance report, the format is pretty prescriptive and we have a tried and trusted process we follow to pull out key items which MB was happy with. MB was however happy to have a conversation with MF outside the meeting together with Andy and Julie about what the expectations are for the summary.

Action: Mark Brooks, Mike Ford, Andy Lister & Julie Williams

MF mentioned the survey feedback. SY advised that the Committee had evolved and changed and as the subcommittee had strengthened, there had been a lot of new people (Network Chairs and General Managers) and that this was the reason for some of the comments in the report. MF felt that in future the surveys should be more tailored to the work of each individual Committee i.e., specific questions around health inequalities for this Committee rather than questions around finance/audit. MB agreed that some of the questions needed updating and that Julie and Andy should discuss with each Committee Chair and Lead Director to ensure the questions are tailored for the requirements of each Committee in future.

Action: Andy Lister & Julie Williams

The Committee NOTED the annual review of effectiveness.

Section 7 – Standard Closing Items

EIC/23/23 Review of risks (agenda item 23)

No further risks identified.

EIC/23/24 Work Programme (agenda item 24)

The work programme was approved.

EIC/23/25 Items to bring to the attention of Trust Board or other Committees (agenda item 25)

MBu detailed items to be included in the assurance form: -

- Context report.
- Inpatient wards – use of restraint in terms of differentiation between BAME colleagues and other colleagues.
- All of You campaign.
- Statement around Human Rights policy.
- Issue around CAMHS access.
- Exception and highlight report.
- Equality, inclusion and involvement action plans 2023/2024.
- FLAIR survey.
- Completion of 2022/2023 action plans.

EIC/23/26 Any Other Business (agenda item 26)

ABB mentioned that we are seen as a beacon organisation for the work we have done supporting unpaid carers and staff carers but we may get left behind if we don't invest further to support this work. SY mentioned that discussions around GC's role and future funding was in progress.

EIC/23/27 Date of next meeting (agenda item 27)

The next meeting will be 14 June 2023.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Minutes of the Finance, Investment & Performance Committee held on 17 April 2023 (Virtual meeting, via Microsoft Teams)

Present:	David Webster Kate Quail	Non-Executive Director (Chair of the Committee) Non-Executive Director
Apologies	Natalie McMillan Julie Williams	Non-Executive Director (Deputy Chair of the Committee) Deputy Director of Corporate Governance
In attendance:	Nick Phillips Adrian Snarr Rob Adamson Carol Harris Mel Wood	Associate Director of Estates & Facilities Director of Finance, Estates & Resources Deputy Director of Finance Chief Operating Officer Head of Performance and Information (Item 10)

FIP/23/01 Welcome, introduction, and apologies (agenda item 1)

The Chair of the Committee, David Webster (DW) welcomed everyone to the meeting. Apologies were noted as above, and the meeting was deemed to be quorate and could proceed.

DW informed attendees that the meeting was being recorded for administration purposes, to support minute taking, and once the minutes had been completed the recording would not be retained.

FIP/23/02 Declaration of interests (agenda item 2)

There were no further declarations of interests to declare.

FIP/23/03 Minutes from the meeting held on 20 March (agenda item 3)

It was RESOLVED to APPROVE the minutes from the Finance, Investment & Performance Committee meeting held on 20 March SUBJECT to one amendment, which was Action 147 is to be deferred to June.

ACTION: Jane Wilson

FIP/23/04 Matters arising and action log from the meeting held on the 20 March 2023 (item 4)

AS provided the update, stating that the majority of the actions are to be updated in June and they are all live pieces of work.

- **AC144**
  AS confirmed that in relation to the Mental Health Investment Standards (MHIS), a paper was being presented at today's meeting.
- **AC147**
  AS confirmed that as per the comment DW made earlier the risk action has been reset for discussion in June.
- **AC151**
  AS stated he will revisit this when we get to the Horizon scanning agenda item when he will provide an update on how plans are looking across the system and where the Trust fits in with those plans. He confirmed that OMG will be the primary vehicle for CIP management and that Carol Harris (CH), Rob Adamson (RA) and himself will look at how we can do further deep dives into this when it is not on track, also the fact that OMG already has a packed agenda and adding something fairly substantive to this might require us to have a spin off on occasions. AS confirmed they are currently working through the practical implications of this.

- **AC152**
  AS confirmed that there will be a brief update on performance and benchmarking at the meeting today with something more substantiative being brought back to the meeting in June.

ACTION: Adrian Snarr

- **AC153**
  AS stated that Capital is being picked up as part of planning, there was also an ask to arrange a training session, which has now been communicated to the wider NED community through Board, and there has been interest shown. AS confirmed that when setting this session up in June he will ensure all who would like to attend can do so.

ACTION: Adrian Snarr

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

FIP/23/05 Actions delegated to Finance, Investment & Performance Committee from Trust Board (item 5)

DW confirmed there were no actions delegated from the Trust Board to report.

FIP/23/06 Consideration of items from the Organisational Risk Register allocated to the FIP Committee (agenda item 6)

AS presented the review of committee related risks stating there were no real changes since the last update and that the two significant risks remain.

Risk 1114

AS confirmed that the Capital position remains as is and that we will be able to align our capital ambitions to the Estates Strategy which Nick Phillips (NP), Head of Estates and Facilities is finalising the work on. He explained we will have a clear strategic point we are aiming for and then be able to map available capital resources to this. AS felt it was a little too early to say whether it will impact the risk or not, he remarked as we saw with the Bretton Centre inflationary pressures, those major schemes are having an impact so we will have to continue to manage those strategic ambitions against the funding reality. He confirmed the capital risk would need to be reviewed following Board sign off of the Estates Strategy.

DW asked in relation to the potential Bretton scheme, is this one we will be able to cover off.
AS replied we will be providing an update on Bretton, and the market has not moved significantly so we will not be coming back and saying that all the prices have fallen back into line with what we are expecting. He remarked another challenge is the work that NP is undertaking on the Estates Strategy, and the fact that there are 3 strong emerging themes from this as priorities, and we have to figure out where Bretton fits in with this. These are, the continued development of hubs across the Trust, the investment/development required on inpatient units that we do not own and how that aligns to clinical strategies, and forensics in its broadest sense rather than the Bretton itself.
AS stated we need to ensure we have these 3 ambitions nailed down before we present to the Board, and then figure out how we are going to finance them and therefore set our ambitions in line with the 10 year estates plan. He remarked that Bretton is still looking really difficult.

DW commented that although AS has confirmed it will not be resolved it will be addressed as part of the overall plan, which now allows us to close off that part of the action.

It was RESOLVED to NOTE the risks, relevant to this Committee, and NOTE comments made in relation to the risk content, risk levels and risk appetite.

FIP/23/07 Month 12 Financial Performance (agenda item 7)

RA presented the update stating the Month 12 report presents the current live unaudited financial position for the financial year 2022/23.

Key headlines:-

- The report highlights delivery of the planned surplus value £3.2m, additional (unplanned) costs covered by additional income from commissioners.
- Year-end position includes one off adjustments covering both income and expenditure as per accounting standards and guidance; notional pension contributions, potential pay awards impacts, stock adjustments.
- Additional income has been received in March 2023. Some of this was not forecast but has been agreed with commissioners and/or NHS England. For example, this includes £9.1m income relating to the potential impact of proposed 2022/23 pay awards in March 2023.
- Other increased income relates to contract variations now agreed and finalised with commissioners. This, and full year effects, have been reflected in the Trust 2023/24 financial plan.
- Pay expenditure has been included as per Trust calculations which highlights a shortfall against income of c. £0.9m. As in previous months the pay expenditure run rate has been impacted by one off / non recurrent adjustments such as the pension and pay award adjustments.
- The trend of increasing WTE run rate has continued in March with a stepped change in substantive worked WTE. This includes periodic recruitment into services such as IAPT; is aligned with training places and timescales.
- Agency costs have a continued focus for the NHS nationally and for the Trust. Agency spend is £1,073k in March. Spend in 2022/23 is £10.0m. As experienced in previous years there is an increased level of agency expenditure reported in March.
- Recruitment and retention workstreams continue and have been modelled as part of the Trust 2023 / 24 annual plan submission. This will continue to be monitored and reported.
- Non-Pay spend continues to be predominately Adult Secure Collaborative spend. Inflationary pressures, on areas such as utilities and catering / food costs, continue to be mitigated as far as possible within the overall financial position.
- Financial KPI's remain green except agency. Updated scrutiny and review structure for 2023/24 led by Chief People Officer with monthly care group meetings. Reduction of run rate required to achieve 2023/24 plan.
- Out of area beds remain a pressure. Expenditure remains the most explicit financial risk at year end with continued high levels of usage required in March. This remains a Trust priority area to reduce.
- Capital - although the Bretton Centre scheme was paused, considerable capital activity and expenditure has occurred in March resulting in total spend of £7.0m.
- Cash position remains positive overall at £74.6m but has reduced considerably in March due to PDC payment and large volume of other invoices paid. Better Payment Practice code performance has been maintained throughout the year in excess of 95%.

RA confirmed Susan Baines, Head of Financial Accounting, is pulling together the accounts and they are looking to share a draft version with people later this week.

DW asked RA if the spike in March in agency spend was as a result of it being year-end and people using their holidays. RA replied that there is increased usage of substantive staff that we

have required coverage for, also assumptions have been made around how to cover off every eventuality in terms of outstanding invoices etc.

KQ asked AS if the sudden influx of money gets smoothed out through the ICBs.
AS replied it depends, as the biggest amount this year was for the pay award which was just over £9m, from an accounting point of view that was fine as we had a reasonable assumption that we would have to pay that money out and therefore we could match it to the income received. He confirmed that some things would go via the ICB.

KQ remarked in relation to the non-recurrent assets it states there has been a stepped change in the value of the Trust's assets because we have added in the Trust leases. She asked if there has been a professional valuation of the estate this year and has the value gone up.
RA replied yes there has been a professional valuation which an independent district valuer carries out and which values the physical assets. He explained this physical review of all Trust assets takes place every 5 years and everything else is a desk top. He confirmed the stepped changes described in the balance sheet page relates to the IFRS16 leases again, and previously they were not counted on our balance sheet and now they are, and this added £56m.

AS commented that the IFRS16 is an international accounting standard that the government has been delaying for quite a few years now, its implementation was also delayed within the NHS a further year because of Covid, so it basically brings us into line with standard accounting practices across the UK.

RA confirmed that an update on accounting principles and the Trusts approach to valuation is presented to the Audit Committee annually.

KQ thanked RA for the helpful update.

Collaborative financial update
RA provided a verbal update. He confirmed that a paper would go to Trust Board next week.

FIP/23/08 Annual Plan (agenda item 8)

AS presented an update on the ICB and system plan and a discussion amongst committee members and attendees took place.. It was confirmed that the plan was yet to be finalised and updates would be provided to future committee meetings.
DW remarked that we are already in the year and whilst he realises the plan does not get finalised until the end of the year, it all seems very last minute.
AS replied that part of the challenge is we have all put our plans in on the 31st March prior to the start of the year, they have aggregated them nationally and the answer is unpalatable, which is about a £3bn gap, and an unacceptable position to be in. He confirmed this will certainly continue to be discussed at our Board.

It was RESOLVED to RECEIVE the update on the Annual Plan

FIP/23/09 Benchmarking Update (agenda item 9)

AS remarked that he would like to introduce this item and then handover to Mel Wood, Head of Performance and Information who would provide further detail. He said he was conscious of the fact that the Committee has not received any benchmarking reports for quite some time, so we wanted to look at how we deal with benchmarking information. AS confirmed that at executive level it had been agreed that it would transfer from CH to himself, and he wanted to give it a little bit of time to understand what it is we get, when we get it, and what we do with it, and he felt from an organisation point of view the challenge has been around what we do with it.
AS stated at this point in time the benchmarking network is really powerful as the vast majority of organisations participate, he said he is starting to pick up a little bit of mood music that one or two

organisations might be moving away from it, and he felt that might be because they receive the reports and they do not see the value in doing anything with them.
AS remarked that one of the challenges is the way the reports come in, as there is a time lag between collecting the information, processing it, and feeding it back, so there is always a risk that things have moved on by the time you get the feedback reports. He explained for our area in particular for Mental Health they all come in at the same time, so we have a mad rush to try and understand them, turn them around, and think what we are going to do. He confirmed he has asked Julie Williams, Mel Wood, and her team to think about how we can come up with an annual plan, which is a bit of a balancing act because to do that it might mean we have to deep dive on the adults and then the children later, and if we do children later, the report is old and is it still valid. He explained year on year these benchmark reports come through so we will start to see the trend lines, and we will start to see where there are movements.

AS stated what he has also asked the team to think about is alternate sources of benchmarking information rather than just the benchmark network, he said the most obvious one being as we develop our patient level reporting systems, we should do comparisons. He remarked that when he has dealt with benchmarking in the past, one of the challenges has always been that when the reports come into the organisation you can spend an awful lot of time trying to justify why you are different, and convince yourself there is a reason why you are different, and this is a real challenge for us internally to ensure we do not spend a disproportionate amount of time validating the variation.

MW commented that there is also some additional resource in the health intelligence function which will help with this agenda going forward and help us to be able to do some of the historic and trend analysis work, also we are now building up a bank of that information and some of this can be seen in the second appendix which has the details of the CAMHS report in there.

MW stated that one of the issues is that the report they receive back from the Network is at Trust level and quite often this can disguise any issues at local level, so we are also trying to build in the ability to break that data down into local level reporting so that it is more meaningful, and we can tease out some of those issues that the data is telling us.

AS commented that is a really good point, and it is always a challenge when you look at an organisational aggregate, it can disguise things that might be happening at team level. He gave an example of CAMHS and the fact that a lot of the Trusts did not submit, and it will start to make it more challenging as to what we do with them if more organisations opt out.
AS commented that the committee will be able to see the quite granular content that comes through in the reports, he said part of the challenge is choosing what we deep dive into because you cannot deep dive into every line. He explained that there is a local process in place whereby local Trusts share each other's reference numbers and therefore you can start to compare to nearby neighbours, so we can then start to see if we are an outlier nationally, regionally or in the ICB. He said as MW stated earlier the data analyst resource is what we have been lacking in the past to help us navigate what is important and what we need to be looking at.

AS stated our proposal is to bring an annual plan back here once we have had time to shape it up, make sure it aligns to FIP meetings and most importantly ensuring we can bring meaningful updates each time it is on the workplan.

DW commented that there is a lot of detail in here and the focus for him is seeing what is significantly better or significant worse, as we need to know what we are doing well and also not doing so well, and he felt this was the crucial part of what this committee needed to see.

KQ remarked that she had a couple of questions, her first one is around caseload, she said over the years we have had a lower number of contacts and lower caseloads than the national average and she is aware it varies in our different patches, and it would be interesting to know what that is

telling us.

KQ stated her second question is a general one about marrying up the benchmarking reports with other information that we need, so for example this level of data cannot tell us how the levels of our provision compare with the levels of need, or what happens to the children who are referred but do not receive treatment, or about the outcomes that our CAMHS services bring about or how our services are experienced and how it links into the wider system information. She felt there was a lot of things this report cannot tell us, and it would be helpful to put it alongside the other reporting that we do.
KQ commented that as always it is a very useful and detailed document and we have to be guided as NEDs as to where to look, and what it is telling us.

CH remarked that she wanted to ensure the narrative was right and it is really important to note that consistently we might have lower caseloads, but we have a higher level of contacts and that is what this report is telling us. The reassurance we can take from this is that we are seeing the right people and we are providing the right level of care when we have drilled down.
CH stated there are also many factors to take into account, for example we also work with third sector partners that are providing a certain level of care for us that in another Trust it would be provided by that Trust.
CH stated that the important one that she wanted to impress today on everybody is that in this we might have lower caseloads, but we are providing more contacts and therefore arguably more care.
KQ thanked CH for the update stating that is really interesting and important to note, and this needs highlighting in the report.
AS commented it is really important to look at the entire picture before just jumping on one of the indicators and he referenced the point KQ made earlier about other indicators outside of the benchmarking is quite important, as there is something about the quality of the service rather than just the quantification which the benchmarking reports focus on.
KQ remarked it also helps us triangulate information.
CH confirmed this benchmarking gives us an idea of where we need to be looking and certainly directs discussions.

CH stated she was conscious that in the IPR we are talking about the pressures on the children's eating disorder pathway, and she was really surprised to see that our referrals are much lower, and she wanted to look further info this.

ACTION: Carol Harris

DW commented that this was a very helpful update, and he was looking forward to seeing how the annual plan would fit together to ensure the committee receive the right level of detail at the right time.

It was RESOLVED to RECEIVE the update on the Annual Plan

FIP/23/10 Mental Health Investment progress (agenda item 10)

AS stated he was not intending to go through this report in full and he hoped the executive summary provided the right level of detail. He said the report provides a year end snapshot of where we are, bearing in mind the Board conversations around the challenges around recruitment
AS said it is quite pleasing in one respect that most of the indicators in this report are green i.e. we are successfully recruiting to many of the roles that are funded through the MHIS, the flip side to this is where people come from and quite often they come from other services within the Trust.
AS remarked that as a tracker for MHIS, broadly speaking we are doing really well in recruitment. There are a couple of hotspots in there i.e., a couple of red indicators that we have to focus on but by and large we have done what we said we would do.

AS stated that our commissioners took a slightly longer term view which is helpful in that they recognise the recruitment challenges and a lot of the investments that started in 2022/23 are all part year effect, and they come into play in the 2023/24 planning discussions that we have just been through, so rather than taking that short sighted one year view about everything Commissioners have worked with us knowing that there is a lead in time for an awful lot of this. He said it is fair to say given the challenges he has just described about planning our commissioners have remained committed to MHIS, but there has been a bit of a time lag certainly from a finance point of view on squaring everything up for 2023/24 which is in the next paper. AS felt that from a 2022/23 point of view we had a good lead in time and a pretty good understanding of what the trajectories were going to be and what was expected by when and we built up this plan. He felt for 2023/23 things are slightly trickier and it does feel like we are a little off the pace in firming some of this up.

KQ thanked AS for the helpful summary, stating the executive summary sheet was also very helpful.

It was RESOLVED to RECEIVE the update on the 2022/23 Mental Health Investment Standard.

FIP/23/11 Bids and Tender Update (agenda item 11)

AS presented the update stating there is a process in place within the Trust that tracks various tender portals and discussions with local Commissioners, so we have pretty good intelligence about what is going on out in South and West Yorkshire and potentially on occasions slightly further beyond. He explained we then put them all through a decision tree process, we do not necessarily rule things out early on, we look at them, evaluate them and we have a decision tree process to see whether we want to express an interest in any commercial opportunity, and there are various different tiers that this goes through. He stated as always we start with quite a high level of opportunities and drill down into a more manageable number of what is coming through, that we will definitely be interested in.

AS stated in terms of the market what we have seen over the past couple of years is that NHS tenders are diminishing significantly because we are now working in systems, and we have discussions as partnerships rather than formal tenders. He explained opportunities are still there, but they are not always formal tender opportunities, they might be more informal discussions or bids or a partnership approach.

AS stated that Local Authorities are still using formal tender opportunities for contract renewals and the biggest challenge with them is the prices that they quite often attach to these tenders are incredibly tight, and part of our review process is to test the financial viability, closet margins are tight on all of the Local Authority ones. He said they are proving particularly challenging, but we have continued to bid, and we have had to reshape services where we have had to take things and reduce the cost envelope to make it viable for the new bid. He stated by and large we still have a pretty good hit rate when we decide we are going to bid for something, either to retain or expand. We put good quality bids forward with a good success rate.

AS stated that in recent weeks most time has been spent negotiating with Commissioners on MHIS and service development funding. He said we have broadly got a strong indication from all our Commissioners in each Place now how they intend to invest the MHIS, so there will be some planning/time lag on getting some of those things off the ground. He stated the ICB Places just need to go through their process and get it signed off and even though there is significant pressure on the financial position they have ringfenced the money in their plan, they have just not told all the recipients how they intend to play it out in full yet.

AS commented that we just need to remind ourselves that the MHIS is still in place and the Commissioners are going to be compliant with the MHIS, but that does not mean they have to invest the money with SWYPFT. We can appropriately hold them to account to ensure they invest

money in the right places, but we cannot hold them to account if they decide not to invest it with us.

AS stated that the commissioners do feel they are probably around a month behind working all of this through, but the basics are all there, it has been communicated well and discussions are ongoing, it is just that final getting it over the line and setting clear the expectations of what will be delivered by when and what will be the key measures going forward.

DW commented that there was a lot of detail in the paper, but lots of opportunities, hopefully we will still get our fair share to benefit services users.

AS stated that in the overall plan we have assumed 3% headcount growth in the organisation and at that point when we submitted that plan it explicitly excluded the MHIS, so translating these pounds into headcount will require a conversation with Greg Moores and his team and Carol Harris and her team.

KQ asked when things come to decision tree making decisions at EMT do we look at loss making services and is that part of our thinking and discussion.

AS stated that part of the challenge is when it is run as a formal procurement, no bidding entity should submit a bid that they know is loss making, i.e., they submit it at a loss to win the business on the hope that it will give them more business in the future, or they will earn top ups from the contracts, which is definitely a procurement no no. He stated we have looked at quite a lot of loss-making ones recently but what we have had to do is look at what are we going to change in the service model to get it to a financial sustainable position.

AS remarked that at this point we have never submitted a loss-making bid.

KQ thanked AS for the helpful update.

I**t was RESOLVED to RECEIVE the Bids and Tender update.**

FIP/23/12 Capital update (agenda item 12)

Nick Phillips (NP) presented the update, he apologised for a typographical error on the front sheet of the report where should have stated April and not January.

Key headlines

- Major Capital as previously reported was reduced substantially in year with the Priestley works being the scheme taken to completion on site. This project is ongoing with some minor delays due to operational and supply chain issues but will complete in April 23 meaning dome expenditure will move into the new financial year. Overall, the scheme will outturn at £700k with £40k expenditure pre committed to 2023/24
- The Minor capital programme for 2022/23 is now complete and is slightly underspent at the end of the year, this is across a number of schemes and is in part due to materials not being delivered on some schemes and a two-week delay on another scheme due to operational pressures and some covid related delays.
- Up until March this year the capital plan was on target to come in at £7.5m, during the early part of the year a couple of schemes have slipped off the plan and we are now looking to come in at £7.045. NP confirmed that he had held a lessons learned session with the team.
- There have been challenges around the Seclusion Room upgrade programme – this is the largest single underspend project which has had to be redesigned due to structural issues. In the interim some revenue works have been completed to the keep the buildings, service users and staff safe.

- The Bretton scheme remains in review with a workshop scheduled in April to bring the review period to a close and which will enable a renewed position to be brought before Trust Board.
- The digital capital schemes for 22/23 were fully expended in line with the previously revised and agreed forecast position to within £11k of the full allocation.

Overall, the programme has out turned £400k below plan which is being reported into the ICB to contribute to the overall capital figure. The underspend was in the main unavoidable but was contributed to by the estate element being spent toward the year end with delays not being manageable in year. This learning will be taken into 23/24 and already works are in progress on some schemes to bring expenditure early into the financial year.

NP confirmed he is in the process of pulling together the year in detail and working on a detailed cash flow process which will be shared with the Committee as part of the next Capital update.

DW remarked that with the largest scheme being pulled out of the plan he appreciated that NP and his team have had to deal with a lot of change in order to still deliver a figure, and they have still managed to get lots delivered in a short period of time, he said that was testament to the team.

NP replied that he had fed back to the team that he was very happy with the work that had been carried out but that he also wanted them to take on board the lessons learned and the need to work smarter.

I**t was RESOLVED to RECEIVE the Capital update.**

FIP/23/13 Artificial Intelligence ADHD (agenda item 13)

DW asked AS if he could give the Committee a brief overview and then take comments on each of the recommendations.

AS stated that this is a really good positive research programme which we feel has some opportunity for commercialisation. He confirmed the Trust does have a policy for such things, but we have not used it before, and this is the first research programme that the Trust has led on that has come to fruition.

KQ commented that she did not feel ready to approve the recommendation as the committee have not seen this since February 2022 and as she understands it no other non-executive directors have been involved at all. She felt it would be helpful to involve other NED colleagues in the discussion as there has been no scrutiny and challenge around this.

AS stated he was very happy to take the broader point that there are other NEDs who would be interested to see this. He explained there is a significant time pressure because we could lose the investors if we do not make a decision within the Trust very quickly. He stated there is an opportunity if he can get Mark Brooks, CEO and Marie Burnham, Chair, to agree to sharing the paper once again in the private Board Session.

KQ remarked this would be very helpful as we have never undertaken this before it would be helpful to have some oversight of this and have some appropriate challenge from the NEDS.

KQ remarked that this has been a very helpful conversation, but she still felt it would be very helpful to involve other NEDs.

DW remarked in relation to the founders, the people who developed this and whether they should be getting a very small percentage. AS replied, our IP policy covers it, and we have compared our Intellectual Property (IP) policy to the Universities and theirs is much more comprehensive, but the broad principals are the same. The inventor will receive some income if we receive some, and it is capped at £10k.

DW stated his other comment was in relation to the royalty which makes complete sense, although he could not see it specifically, he presumed that it is a revenue rather than a profit and he asked that this in the final agreement this is absolutely explicit. Also, what happens at the point of these investors exit, does that royalty then pass on in perpetuity to the future licence holder. AS replied that he would explicitly check this out.

ACTION: Adrian Snarr

DW referred to the zombie clause where it states that an adequate level of investment and the term is £50k over the lifetime, he felt this needs to be defined more.

ACTION: Adrian Snarr

DW commented on the peer review paper and whether we are allowed to share it will determine on what we have done with the journal, so if we have paid for open access it is within our right to share it, if we have not then the journal will own the papers, so we just need to ensure we have paid for that open access.

ACTION: Adrian Snarr

DW asked if we had considered building in anti-poaching from a staff perspective as there have been some brilliant minds that have worked on this and the last thing we want is for this new company to be set up and for them to steal half of our team that have been working on this.

AS stated there is some discussion around whether they could make contact directly with the researcher to keep the product live and uptodate as a direct relationship rather than via the Trust. AS stated he would clarify where this conversation has got to.

ACTION: Adrian Snarr

KQ commented that one of the recommendations was in relation to the patent application outside the UK not being pursued and is there an issue about pharmaceutical company's using it outside the UK.

KQ commented that twice in the document it referred to this as being a new adventure, and this did not sound right and should it be new venture.

ACTION: Adrian Snarr

KQ made reference to the two recommendations clashing. AS stated that he would look into this.

ACTION: Adrian Snarr

AS stated he would take an action to speak with MB with a view to arranging a further discussion around this at Board in the private session. He also said he would speak with Subha Thiyagesh because he felt the questions that KQ has posed, and that others may pose are not about the commercial aspects.

ACTION: Adrian Snarr

DW stated we need to be clear in what we are discussing at Board, as we are broadly happy with the commercial aspect, it is more around the ethics and safety that we need to pick up.

I**t was RESOLVED to NOT APPROVE the RECOMMENDATION for the Commercial Exploitation of diagnostic tool for ADHD in Adults SUBJECT to additional Board Approval.**

FIP/23/14 Horizon Scanning update (agenda item 14)

AS presented the update, he said planning is going to take over for the next couple of weeks, also a bids and tenders update has been completed which sets out the pipeline for the immediate future. In relation to the work around the development of the IPR, the team are due to present the same demo to executives as was presented here. He remarked that what he has asked JW and MW to consider is when we are ready with the National indicators in the new format, is there any realistic prospect of introducing this and leaving the rest of the IPR as it is as we develop this, which is in effect separating the IPR into two documents to bring together, he said we need to see if this is practically possible. Also, given how long it will take to do the full build there will be a desire from the executive team and Board to see some notable change in this financial year, and this is being tested out at the minute.

It was RESOLVED to NOTE the Horizon Scanning Update

FIP/23/15 Workplan (agenda item 15)

DW commented that we have covered everything this month and we are now just getting into the cycle.

FIP/23/16 Any other business (agenda item 16)

There was no further business to discuss.

Significant issues to report to the Board of Directors

Advise

- Risk on financial sustainability, no immediate increase but a general tightening across the wider market
- In line with plan, main items are a commercial provision, providing for a greater cost than income for pay award.
- MH investment standard, new roles are not assumed in plan, any growth is potentially additional.
- Capital plan £7.1k versus a revised plan of £7.5k, biggest issues - heavily backloaded, materials availability.
- AI tool and commercialization of this.

Alert

- Challenging financial position in West Yorkshire, receiving higher national scrutiny, and therefore will be discussed at Private Board

Assure

- Benchmarking annual plan being produced which will enable us to address and act on key information.
- MHIS – commissioners are keen to ensure this funding is still available.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of the Mental Health Act Committee Meeting held Virtually via Microsoft Teams on 7 March 2023

Present:	Kate Quail	Non-Executive Director (Chair)
	Erfana Mahmood	Non-Executive Director
	Mandy Rayner	Non-Executive Director
	Dr Subha Thiyagesh	Chief Medical Officer (lead Director)
	Darryl Thompson	Chief Nurse / Director of Quality & Professions
Apologies:	None	
In attendance:	Julie Carr	Clinical Legislation Manager
	Dr Jhansi Rani Dussa	Consultant Psychiatrist, CAMHS (for item 2)
	Yvonne French	Assistant Director, Legal Services
	Chris Lennox	Director of Services (from item 5.2)
	Dr Manoj Mathen	Consultant Psychiatrist, Adult Inpatient (for item 2)
	Beverley Powell	Governor (observing)
	Carly Thimm	Mental Health Act / Mental Capacity Act Manager
	Gordon Walker	Independent Associate Hospital Manager, Chair of the Hospital Manager Forum
	Gemma Williamson	Mental Health Act Officer
	Sarah Millar	PA to Chief Medical Officer (author)

MHAC/23/01 Welcome, Introductions and Apologies (agenda item 1)
The Chair, Kate Quail (KQ) welcomed everyone to the meeting.

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/23/02 The Act in Practice (agenda item 2)
MHAC/23/02a CAMHS and Adult Services joint working for a young person detained to the acute trust – Dr Mathen and Dr Dussa (agenda item 2.1)
Presentation from Dr Jhansi Rani Dussa (JRD) and Dr Manoj Mathen (MM) on the interface between partner organisations and different legal acts in the complex case of a young person admitted to an acute trust.

JRD explained that the case related to a 15 year old (who turned 16 during admission) who presented in Accident and Emergency as distressed and with challenging behaviours which were identified as manic symptoms/first episode psychosis of rapid onset. The young person was admitted to a paediatric ward and made subject to a Section 5(2) which was

regraded to Section 2 Mental Health Act (MHA). They were initially treated with antipsychotic medication which led to a change in presentation and a new diagnosis of malignant catatonia. There was unfortunately a rapid deterioration in the young person's physical health, and they were transferred to intensive care and intubated. Prior to the Section 2 expiring, a Second Opinion Appointed Doctor (SOAD) referral was made and during this time there was a first Electroconvulsive therapy (ECT) treatment carried out under Section 62.

JRD reported that there had been a medical recommendation for a Section 3, however as the young person was being treated under an induced coma, the Approved Mental Health Professional (AMHP) determined that it was not possible to proceed with a MHA assessment at that time.

It was noted that a number of partner organisations had been involved in the case and the young person's parents were also involved in decision making. ECT and life saving treatment continued with slow progress and six weeks after admission, a MHA assessment concluded with Section 3 due to an increase in psychiatric symptoms as anaesthesia was in the process of being reversed.

The young person was discharged after a further two months in hospital during which time they were granted Section 17 leave. JRD advised that Section 117 after care was in place at the point of discharge.

JRD reflected on the positive example of teamwork in this case from multiple trusts and services with care wrapped round the young person. There had been appropriate use of the legal framework in a rapidly changing clinical situation which had been complicated by the fact that the patient was being treated in an acute care setting. JRD went on to say that difficult decisions had been made in challenging circumstances and differences of opinion had been well managed, with the young person at the centre of decision making.

KQ thanked JRD and MM for the presentation and invited questions from the Committee.

Erfana Mahmood (EM) queried if there was any learning for the Board or Mental Health Act Committee (MHAC) on how things could have been done differently. JRD raised that the difficulties were compounded by there being no Tier 4 beds available nationwide however noted that the case was exceptional and had been managed very well in the circumstances. MM added that there had been incredible support from the MHA team.

Subha Thiyagesh (ST) referred to the case being very challenging professionally and emotionally difficult in rare circumstances. ST acknowledged that not only had SWYPFT clinicians come together but also other organisations at different levels and commissioners. The learning that could be taken was that good relationships and communication was key to the positive outcome and if that had not been the case, we could have potentially lost a life. ST also acknowledged how dedicated colleagues had been.

JRD agreed that it had been challenging to manage and contain emotions while dealing with a difficult clinical presentation, a legal framework and managing the expectations of the family. JRD also referred to the legal team being there every step of the way and supporting safe decision making.

Darryl Thompson (DT) raised that this was a really positive example of exceptionally skilled people working together and caring for each other. DT added that MHAC should not underestimate the courage that is needed when making difficult decisions. Yvonne French

(YF) highlighted that despite some conflict between the parents' wishes and the medics' recommendations, the family were contacted every day and kept fully updated. YF indicated that that had gone a long way to ensuring that the family had faith in the medic team.

MHAC/23/03 Legal updates (agenda item 3)

MHAC/23/03a CQC Monitoring the MHA 2021/22 annual report (agenda item 3.1)

Julie Carr (JC) advised that this was a national report and not specific to the Trust. The report summarised the CQC's findings from visits across the country and set out the priorities for the next 12 months. It was noted that steps have been taken to identify any gaps in our service provision against the points identified by the CQC.

JC raised that the report recognised the continuing impact of Covid 19. It had also noted a 32% increase in the number of under 18s admitted to adult wards in 2021/22 compared to the previous year. JC indicated that there had also been an increase in admission to paediatric acute wards although that was not included in this report.

Mandy Rayner (MR) referred to the issues and challenges the Trust was experiencing as a result of young people being admitted to our adult wards. An example of this was Reducing Restrictive Physical Interventions (RRPI) training and difficulties with compliance which could impact on our ability to make improvements in that area. DT advised that the RRPI paper to Clinical Governance and Clinical Safety Committee (CGCSC) next week has more detail about the challenges for services to consider and agree actions.

A link to the full report had been shared with Committee members and attendees.

It was RESOLVED to RECEIVE the briefing.

MHAC/23/03b Fixed penalties of £8,000 for failures around consent (agenda item 3.2)

JC reported that University Hospitals Birmingham NHS Foundation Trust had received two fixed penalty notices of £4,000 each for failing to seek consent to care and treatment of someone in their care, which was a breach of Regulation 11 of the Health and Social Care Act. It was noted that this related to significant invasive treatments.

JC highlighted next steps:

- To share the briefing with the Trust Record Keeping Group
- To share the briefing at the Chief Medical Officer medical webinar
- To share with the Clinical Governance Group
- To share with the MHA/MCA Code of Practice Group.

It was RESOLVED to RECEIVE the briefing and to SUPPORT the next steps identified.

MHAC/23/03c Gap analysis MCA/LPS (agenda item 3.3)

JC advised that the final code of practice, regulations and training plan are still awaited. The government have advised that they will be published before the end of winter 2022/23 and an implementation date will then follow. JC reported that work continues with the 9 key workstreams to improve quality which would benefit our service users even if there is a further delay with implementation of the Liberty Protection Safeguards (LPS). KQ acknowledged the hard work of the current working groups to be as prepared as possible.

MR thanked JC for a good summary and referred to the clinical record keeping workstream. MR raised that we need to be mindful of potential changes to SystmOne and our reliance on

TPP (the company who provide SystmOne), particularly in the case of national change. MR also queried whether information sharing agreements were already in place and JC advised that they are but would need to be reviewed and updated. This would allow for access to records by other organisations, for example Independent Mental Capacity Advocates (IMCAs) and to allow for documents to go with the person, which is being proposed. JC added that once we have final details, the Information Governance team are ready to act. MR recognised the great work in moving things on and not waiting until the LPS are published.

It was RESOLVED to RECEIVE the briefing.

MHAC/23/03d The Select Committee Report; Draft Mental Health Bill (agenda item 3.4)
JC reported that the Draft Bill had been in front of the Select Committee who had published their report containing over 50 recommendations.

JC highlighted some of the key areas of recommendation:

- Introduction of an independent body 'Statutory Mental Health Commissioner' with the support of an office to have oversight of the reforms and monitor the outcomes and cultural changes.
- Community Treatment Orders (CTOs) should be abolished for Part 2 patients. There should be a period of 3 years to collect further data on their use for unrestricted Part 3 patients. If the evidence is not compelling, then these too should be abolished.
- Learning Disability and Autism should be supported by shortening the time between Care (Education) and Treatment Reviews C(E)TR from 12 to 6 months. That the proposed risk register should be more positively named 'dynamic support register' with a firm duty on commissioners to ensure an adequate supply of community services. It was recommended that a staged approach to these reforms be adopted to ensure that investment and the building of community resources can be achieved. It was recommended that DoLS/LPS should be amended to prevent this from being an alternative route to the MHA.

The next steps were noted as:

- The publication of the Mental Health Bill is awaited
- Updates regarding the progression of the Bill and potential impacts on services will be reported to MHAC
- Anticipatory work for advance care planning has been incorporated into the Trust Record Keeping Group.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/23/04 Feedback from partners (agenda item 4)
MHAC/23/04a Independent Hospital Managers feedback and Forum notes 16 December 2022 (agenda item 4.1)
The Committee received the notes of the Mental Health Act Managers' Forum meeting from 16 December 2022 which were taken as read.

Gordon Walker (GW) reported that the final part of the process to recruit a further 4 Hospital Managers was underway. This would take the total from 15 to 19. GW indicated that this would not only bolster the numbers but also bring a new perspective. KQ raised that the intention is to recruit a few more Hospital Managers and to improve the diversity of the group to better reflect the service users and communities we support. ST added that this is such a key role and we need a full complement to support discharge and our Trust responsibilities.

GW referred to the earlier presentation and raised that the Hospital Managers would find it very interesting. GW was very grateful that the health professionals had worked hard to keep the family on side as there would have been the potential for a best interest request for Hospital Managers to decide if the young person should be on a section or not, which would have been a difficult decision. ST suggested that JC liaise with JRD and MM to present the case at a future Hospital Managers' meeting.

MHAC/23/05 Minutes/Actions (agenda item 5)

MHAC/23/05a Minutes of previous meeting held on the 1 November 2022 (agenda item 5.1)

It was RESOLVED to APPROVE the notes of the meeting held on 1 November 2022 as a true and accurate record of the meeting.

MHAC/23/05b Action points (agenda item 5.2)

The action points were noted and all had been completed.

- In relation to Section 17 leave in Forensics, the service will work towards reducing cancellation levels by at least 2% a quarter to achieve and sustain 90% by Quarter 2 23/24.
- YF confirmed that comments from KQ in relation to the Terms of Reference for the MHA/MCA Code of Practice oversight group had been incorporated and no other comments had been received. YF had added that the group also have oversight of 136 policy, Section 17 leave, seclusion and segregation, RRPI and patients' rights. The Committee supported implementation of the Terms of Reference.

MHAC/23/06 MHAC Annual Review (agenda item 6)

MHAC/23/06a Annual report (agenda item 6.1)

Committee received the draft annual report. KQ advised that attendance would be updated following today's meeting.

EM raised that the report does not really capture the excellent progress made by MHAC and feels very compliant. DT agreed that the report was robust given the audience but queried how we could better capture the improvement element. ST raised that the purpose of the report is to demonstrate to Board that the Committee is discharging its responsibilities and duties. ST noted that more had been added to the progress section to highlight what was being done but that the format could be reviewed for next year. MR suggested including an executive summary and KQ agreed that there was potential for the report to be improved.

MHAC/23/06b Terms of Reference (agenda item 6.2)

Committee received the draft Terms of Reference.

MHAC/23/06c Work programme (agenda item 6.3)

Committee received the draft work programme. EM referred to the CTO review being due in November 2023 and queried if, given the potential changes and a possible CQC visit, this should come to Committee sooner. YF advised that the position had improved since the last review and is reported in the performance report. EM suggested keeping the full review for November but for YF to review the last report to ensure all actions have been completed.

MHAC/23/06d Self-assessment (agenda item 6.4)
Committee received the self-assessment report. MR queried if having more Non-Executive Director members than Executive Director members was an issue and KQ advised that it should be that way to ensure an impartial and independent view.

It was noted that the annual report, Terms of Reference, work programme and self-assessment report would go to Audit Committee in April and then be presented to Trust Board to demonstrate MHAC's effectiveness and added value to the organisation.

MHAC/23/07 Risk Registers (agenda item 7)
MHAC/23/07a Consideration of items from the organisational risk register relevant to MHA Committee (agenda item 7.1)
JC reported that there was a new risk on the Organisation Risk Register (ORR) which was relevant to MHAC. This related to a risk that the Trust has insufficient capacity to implement the changes to practice arising from LPS and the Mental Health Bill. Whilst the risk was acknowledged, this is currently being mitigated within the care groups.

JC asked Committee to consider if it can be assured by the risk being on the ORR or if it needs to be on a separate MHAC risk register. MR raised that there was potential impact on capacity across the Trust in many different areas with lots of mitigation and prioritisation going on as had been discussed in People and Remuneration Committee (PRC). KQ suggested that as the ORR and PRC have oversight of capacity and mitigating actions, there was enough assurance and it did not need to be on a separate MHAC risk register. DT agreed and noted that the MHAC did not have specific ability to affect change to capacity. KQ referred to a business case being submitted to increase the capacity to implement the LPS changes.

MR raised that recruitment and retention is a focus in all aspects of the Trust and this sits with PRC. The Alert, Advise, Assure (AAA) report to Board includes mitigation of the risk which impacts on all of us at different times and to different degrees.

Committee acknowledged the risk and agreed that it should not be on a separate risk register. YF will raise any specific issues with Committee as appropriate and will update on progress with the business case. KQ will also raise this on the AAA to Board so they are aware of the huge amount of work required with changes to legislation.

It was RESOLVED to RECEIVE the update and to NOTE the current Trustwide corporate/organisational level risks relevant to this Committee.

MHAC/23/07b Mental Health Act Committee risk register (agenda item 7.2)
Committee noted that there were currently no MHAC risks.

It was RESOLVED to RECEIVE and NOTE the update.

MHAC/23/08 Statistical information use of the Mental Health Act (MHA) 1983 and Mental Capacity Act (MCA) 2005 (agenda item 8)
MHAC/23/08a Performance report - Monitoring Information Trust Wide October – December 2022 (agenda item 8.1)
The report was noted and Chris Lennox (CL) highlighted the following:

- The Trust is broadly in line with the national picture in relation to admissions and detentions.
- There is some variation in admissions between localities.
- Two patients under the age of 18 had been admitted to the Trust in Quarter 3. This was a decrease from the last Quarter. One young person is 17 and there is little indication that they will move on before reaching 18.
- 39% of all new admissions in Quarter 3 were under the MHA.
- 63% of Section 5(2) use resulted in detention under Section 2 or Section 3.
- Calderdale had the highest number of internal transfers with 25 out of a total of 62.
- There had been a decrease in Hospital Manager appeals.
- Section 49 activity has reduced with 5 new orders being pursued, 4 of which were received and 1 was repudiated. It was noted that this reduction could possibly be due to the new guidance. Due to the pressures in clinical services, the Trust has advised the courts that reports are taking longer to complete.
- A total of 134 assessments took place in the 136 suites which is a decrease of 18 (from 152) in Quarter 2.
- In relation to ethnicity, the 2021 census indicates that ethnic groups accessing our services are still under-represented but over-represented in terms of admissions and detentions. This reinforces the work to encourage people to access services sooner.
- In Quarter 3, 55 patients were subject to conditional discharge.
- There were 55 open CTOs at the close of Quarter 3 which is a decrease of 4 active CTOs from the previous Quarter. Two of the open CTOs are being supported by Section 37 and we are not seeing a static position.
- There were no trends in relation to Tribunals and face to face Tribunals were increasing, as determined by service user choice.
- In relation to consent to treatment, there were some challenges with SOAD attendance, and we are working with the CQC requirements. All affected patients have Section 62 certificates in place to authorise ongoing treatment.
- There were 12 applications for Deprivation of Liberty (DoLS) made in Quarter 3.
- There had been one notifiable death in Quarter 3 of a 73 year old female who was subject to conditional discharge.
- 5 civil section exception reports were made in Quarter 3, one of which related to a Section 5(2) not being reviewed within 72 hours.
- There were 22 consent to treatment exception reports.
- 9 Section 136 exception reports were made. 3 of those related to the Barnsley suite being unavailable due to staffing, 3 related to no bed being available for a detained patient, 1 was due to a suite being closed for repairs and 2 were for unsafe detentions. A protocol is being developed on how to balance the potential need to over-admit to a ward to free up a 136 suite and also to ensure that there is appropriate multi-disciplinary team (MDT) support to anyone who remains in a suite.
- In relation to Section 17 leave compliance monitoring, the improvement trajectory for Forensic services had been noted by Committee. It was noted that due to the way leave is reported in other services, it is not easy to compare the data. YF is considering ways to improve the reporting to MHAC.
- A paper on consent to treatment compliance is being taken at Committee today.
- In relation to Hospital Managers compliments and concerns, there was one compliment and 5 concerns raised in Quarter 3. One concern related to discharge planning, one was about a lack of empathy towards a patient during a hearing and one was regarding the conduct of an interpreter during an appeal.
- There were 3 formal MHA complaints. Two of these had been closed due to no consent.
- All advocacy services had been active during Quarter 3.

- In relation to patient rights monitoring, compliance rates were 99% for detained patients, 92% for informal patients and 87% for those on a CTO.
- Good rates of compliance were noted for both Mental Capacity Act (MCA) and MHA mandatory training.

MR thanked CL for the summary and queried why the rise in length of stay had not been included on the front sheet as a key point when there had been a significant increase. CL noted the omission. EM queried what was driving the increase and CL advised that there were a combination of factors including some delayed discharges but also some lengthy stays for a few individuals. It was noted that increased figures could relate to one person with several placements, including in rehabilitation services. CL referred to a significant piece of work to move people through the system quicker, however availability and suitability of placements are often poor despite investment over the last few years, and this represents a challenge.

EM referred to a graph showing the outcome of Section 136 referrals and 19 'other' attributed to Barnsley. EM queried if that was correct and possibly related to one person. CL will check what 'other' refers to in this case and EM and CL agreed to pick this up outside of the meeting.

DT raised that we hear a lot about acuity and the potential for CTO use more often to accelerate discharge. DT went on to say that it takes a strong MDT to not apply and rescind a CTO due to the level of acuity. CL agreed that it is often seen as a restriction however it can also be an opportunity for a positive experience and it is good to see people move on.

KQ referred to black men nationally being over-represented in relation to CTOs, however that is not reflected in SWYPFT's figures and it is not clear what we do differently. KQ has asked Mike Garnham to review all our ethnicity figures based on the latest census and raised that it would be helpful for Committee to have an update on the actions planned from Equality, Inclusion and Involvement Committee (EIIC). YF advised that Mike had taken a presentation to EIIC and this could be followed up with the Chair. KQ asked for a specific update on the work MHAC had commissioned and handed over to EIIC.

Action: Yvonne French

ST advised that there had been national discussions and a mixed reaction to the potential abolition of CTOs. ST referred to the steady numbers of CTOs in SWYPFT over the last 3 years and highlighted that they are being used for the right reasons, to keep people well, safe and in their own homes so it would be worrying if they were no longer an option.

KQ thanked YF and her team for the positive mandatory training figures, particularly given the significant current pressures on staff. It was noted that any hotspots had been identified and were being managed.

It was RESOLVED to RECEIVE and NOTE the monitoring report.

MHAC/23/09 CQC compliance actions (agenda item 9)

MHAC/23/09a MHA/MCA Code of Practice oversight group feedback (agenda item 9.1)

YF reported that several policies relating to MHAC were due for review and had been approved by Executive Management Team (EMT) in January and February. The next review is in 3 years unless there are changes in the meantime.

YF advised that a review of current blanket restrictions had been undertaken by the nursing directorate and no issues were noted.

At the meeting on 7 November, the group discussed the current MHA, Terms of Reference, draft Mental Health Bill, LPS and the CQC visits to Crofton and Horizon. On 12 December JC did a presentation for clinicians to take them through the roles in relation to LPS.

YF reported that there is a lot of activity at the moment making good practice changes to current practice and linking in with the work already being done in some governance groups.

KQ thanked YF for the clear report and assurance to Committee.

It was RESOLVED to AGREE the Terms of Reference for the Code of Practice group and to NOTE the update.

MHAC/23/10 Audit and Compliance Reports (agenda item 10)

MHAC/23/10a Consent to Treatment – record of assessment of capacity and of Responsible Clinician informing service user of SOAD outcomes (agenda item 10.1)

Carly Thimm (CT) presented the latest compliance report and noted two errors on the front sheet. '4 of the 137 records had the SOAD outcome recorded' should read '4 out of 60' as 137 was the combined number of T2 and T3 certificates. The records of capacity should read as a combined 83%, so from 137 patient records, the checks were over 80%.

CT reported that there had been an improvement in the recording of compliance and in the data over the past year following a Quality Improvement (QI) process.

MR referred to the request for MHAC to agree a compliance rate for assessment of capacity for those patients treated under a T2 or T3 and suggested that we should aim for 100% with a clear plan on how we will get there. CT agreed that taking a QI approach to a target of 100% would be an achievable and longer term solution.

EM added that timescales for an improved trajectory would be helpful and that QI would be fundamental to embedding long term changes. EM acknowledged the improved figures and thanked CT for the update.

ST agreed that the report was helpful and detailed and supported the QI approach. ST raised that a full assessment of the four key elements of capacity will have been done by clinicians, but the documentation is where improvements need to be made. YF added that all consent to treatment forms are reviewed on at least an annual basis.

Committee agreed to the recommendations but with a trajectory rather than compliance rate for capacity assessments.

It was RESOLVED to RECEIVE the report and to APPROVE the recommendations.

MHAC/23/10b Section 17 leave review (agenda item 10.2)

CT took the report as read and highlighted the really positive increase in compliance in Forensic services by 49% in the last year to 87%. There is a recommendation for this to reach a 90% target.

MR raised that this was a fantastic achievement and queried when the 90% was likely to be achieved. CT advised that the aim would be for Quarter 2 23/24.

KQ also acknowledged the significant increase and commented that it should be celebrated.

It was RESOLVED to RECEIVE the report and to APPROVE the recommendations.

MHAC/23/11 Care Quality Commission visits (agenda item 11)

MHAC/23/11a Visits and summary reports Quarter 3 including Care Group actions from previous visits (agenda item 11.1)

JC reported that there had only been two CQC Mental Health Act visits in Quarter 3, to Beechdale and Melton wards, with one summary report received.

It was noted that there are 4 outstanding issues which had previously been resolved but had been reported again since the last visit.

There were 7 actions not yet due and 9 actions closed during Quarter 3. There were 2 outstanding actions relating to Horizon Centre although it was noted that if there had been a slight delay due to the Christmas break, anything in January would not be captured in this report. JC confirmed that the matrons would address anything still outstanding.

KQ raised that we often focus on open and overdue actions although they are usually completed in the next Quarter. KQ acknowledged the significant progress over recent years.

It was RESOLVED to RECEIVE the update and NOTE the progress of the actions following CQC visits.

MHAC/23/12 Key Messages to Trust Board and other Committees (agenda item 12)

No issues identified for other Trust Board Committees. The key issues to report to Trust Board were agreed as:

Alert

- New risk
- Annual report
- Celebrating increase in compliance of Section 17 leave reporting
- Consent audit and QI process

Advise

- Act in Practice
- Legal briefings

Assure

- Code of Practice Terms of Reference approved
- Risk Registers – assurance
- CQC visits – actions and updates
- Progress on recruitment of Hospital Managers

EM suggested that the subject of today's Act in Practice would be a good service user story for Board. ST had asked for the positive work of SWYPFT, the acute trust and the commissioners to be shared at Integrated Care System (ICS) level. EM raised that the partnership working demonstrated under the Health and Social Care Act had been invaluable and DT added that it was also really important to capture the positive system working.

MHAC/23/13 Work programme (agenda item 13)
The work programme was noted.

MHAC/23/14 Date and time of next meeting
The next Committee meeting will be held on 16 May 2023, 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 24 February 2023

Hybrid meeting
Large Conference Room, Fieldhead Hospital, Wakefield
and Microsoft Teams

Present:	Marie Burnham (MBu)	Chair
	Bill Barkworth (BB)	Public – Barnsley (Deputy lead governor)
	Cllr Howard Blagbrough (HB)	Appointed – Calderdale Council
	Bob Clayden (BC)	Public - Wakefield
	Jackie Craven (JC)	Public - Wakefield
	Daz Dooler (DDo)	Public – Wakefield
	Warren Gillibrand (WG)	Appointed – University of Huddersfield
	Laura Habib (LH)	Staff – Nursing support
	Tony Jackson (TJ)	Staff – Non-clinical support
	Adam Jhugroo (AJh)	Public - Calderdale
	John Laville (JL)	Public – Kirklees (Lead Governor)
	Andrea McCourt (AMc)	Appointed – Calderdale and Huddersfield NHS Foundation Trust
	Elaine Shelton (ES)	Appointed – staff side organisations
	Phil Shire (PS)	Public – Calderdale
	Sue Spencer (SS)	Appointed – Barnsley Hospital NHS Foundation Trust
	Tony Wilkinson (TWi)	Public – Calderdale
In attendance:	Mark Brooks (MBr)	Chief Executive
	Mike Ford (MF)	Senior Independent Director
	Carol Harris (CH)	Chief operating officer
	Carmain Gibson-Holmes (CGH)	Deputy Director of Nursing, quality and professions *(deputising for Darryl Thompson, Chief Nurse and Director of quality and professions)*
	Lindsay Jensen	Deputy Chief People Officer *(deputising for Greg Moores, Chief People Officer)*
	Erfana Mahmood (EM)	Non-Executive Director
	Natalie McMillan (NMc)	Non-Executive Director
	Kate Quail	Non-Executive Director
	Mandy Rayner (MR) (previously Griffin)	Non-Executive Director/ Deputy Chair
	Dr Subha Thiyagesh (ST)	Chief medical officer
	Julie Williams (JW)	Deputy Director of Corporate Governance, performance and risk
	Asma Sacha (AS)	Corporate Governance Manager (Author)
	Gemma Lockwood (GL)	PA to Chair and Chief Executive (Presentation)

Apologies:	Members' Council:	
	Keith Stuart-Clarke (KSC)	Public - Barnsley
	Dylan Degman (DDe)	Public – Wakefield
	Cllr Brenda Eastwood (BE)	Appointed – Barnsley Council
	Gary Ellis (GE)	Appointed – Mid Yorkshire Hospitals NHS Trust
	Jackie Ferguson (JF)	Appointed – Wakefield Council
	Claire Den Burger-Green (CDBG)	Public - Kirklees
	Helen Morgan (HM)	Staff – Allied Health Professionals
	Cllr Mussarat Pervaiz (MP)	Appointed – Kirklees Council
	Beverley Powell (BP)	Public – Wakefield
	Nik Vlissides (NV)	Staff – Psychological therapies
	Attendees:	
	Greg Moores (GM)	Chief People Officer (sent deputy)
	Sean Rayner (SR)	Director of provider development
	Adrian Snarr (ASn)	Executive Director of finance, estates and resources
	Darryl Thompson (DT)	Chief Nurse and Director of quality and professions (sent deputy)
	David Webster (DW)	Non-Executive Director
	Salma Yasmeen (SY)	Deputy Chief Executive/ Director of strategy and change
	Andy Lister (AL)	Head of Corporate Governance/ Company Secretary
	Laura Arnold (LA)	Corporate Governance Officer

MC/23/01 Welcome, introductions and apologies (agenda item 1)

Marie Burnham (MBu) formally welcomed everyone to the meeting, apologies were noted as above. The meeting was quorate and could proceed.

MBu reported that the meeting is being recorded to support minute taking. The recording will be deleted 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).

Due to technical difficulties with Microsoft teams, governors who were joining the meeting virtually could hear the meeting, but they could not be heard by Members' Council in the Large Conference Room. They were asked to use the chat function and apologies were conveyed to those joining virtually for the problems encountered.

MBu informed Members' Council that this was the last meeting for some of our governors. She thanked the following governors for their service to the Members' Council and to the Trust and wished them well.

MBu informed that Bill Barkworth (BB) has served as a public governor for Barnsley for 6 years and as a Lead Deputy Governor. She thanked him for his time and effort in

supporting the Lead Governor and the Members' Council. He was thanked for his contribution to the Members' Council and to the Members' Council groups.

MBu informed that Jackie Craven (JC) has now completed 3 terms as public governor for Wakefield and is not eligible for re-election, she also served as Lead Governor in her first term. JC has also attended numerous Welcome Events in the Trust. JC was thanked for her contribution as Lead Governor and public governor.

MBu informed that Dylan Degman (DD) could not join us today and he has decided to stand down and is not seeking re-election. DD has served 6 years as public governor for Wakefield and she thanked him for his contribution to Members' Council and to the Members' Council groups.

MBu informed that Tony Wilkinson (TW) has completed 3 terms as public governor for Calderdale and is therefore not eligible for re-election. She thanked him for his contribution to Members' Council and to the Members' Council groups.

MBu informed that Tony Jackson (TJ) will complete his first term on the 30 April 2023 and is seeking re-election to the Members' Council to represent non clinical support staff. MBu thanked Tony for his contribution to the Members' Council.

MBu and MBr thanked all governors for putting the voice of their constituents forward.

It was RESOLVED to RECEIVE the welcome, introductions and apologies as described above.

MC23/02 Declarations of Interests (agenda item 2)

No new declaration of interest.

Mike Ford (MF) asked whether he and Non-Executive Director, Kate Quail (KQ) need to log off for items 6.8 and 6.9. It was agreed that they would log off and be asked to return for these items.

It was RESOLVED to NOTE the individual declarations from governors.

MC/23/03 Minutes of the previous Members' Council meeting and the Joint Trust Board and Members' Council meeting held on 9 December 2022 (agenda item 3)

Members' Council meeting
Mandy Rayner (MR) asked to amend page 15 of the Members' Council minutes under heading; MC/22/64i Integrated Performance Report (item 7.9) paragraph 2;
"since there are challenges with staffing" to be changed to "despite staffing challenges."

Joint Members' Council and Trust Board meeting
MR asked to amend the typo under Group E feedback, social responsibility and sustainability, which should read "strategy is now in place" and not "now and place".

Action: Corporate Governance Team to amend the minutes of the 9 December 2022

It was RESOLVED to AGREE the minutes of the Members' Council meeting and the Joint Members' Council and Trust Board meeting held on 9 December 2022 as a true and accurate record with the noted amendments.

MC/23/04 Matters arising from the previous meeting held on 9 December 2022 and action log (agenda item 4)

MC/22/63 Freedom to speak up development session
Bob Clayden (BC) enquired whether this development session has been arranged as he has not received the date and time. Julie Williams (JW) confirmed that the date is due to be released to all governors and it has been arranged for Wednesday 22 March 2023, 9.30 – 11am. The corporate governance team will confirm whether the meeting is hybrid or just on Microsoft Teams.

MC/22/52a Consultation around the sustainability and social responsibility work
BC asked whether governors have been consulted to take part. MBr informed the Members' Council that work is ongoing and we have planted around 400 trees around the Fieldhead site and 100 trees will be planted next week at Kendray Hospital. MBr confirmed this work is not one single event but a series of events and work which will take place over the next few years. BC asked whether governors have been specifically asked to be sustainability champions. JW said she will look into this action point.

Action: Corporate Governance Team to liaise with the Sustainability Change Manager.

It was RESOLVED to NOTE the Action log of the Members' Council.

MC/23/05 Chair's report and feedback from Trust Board (agenda item 5)
MBu asked for the paper to be taken as read to allow more time for discussion items and asked for any questions.

MBu said although it is detailed in the report, she would like to give a special mention to the engagement event with the University of Huddersfield on the 2 February 2023. She said it was attended by herself, John Laville (JL), Warren Gillibrand (WG), Tony Jackson (TJ) and Asma Sacha (AS). She said it was a fantastic event and they had a really good turnout. The students engaged well and 40 new members signed up to become a Member. She explained the intention is to arrange further engagement events in the future.

JL thanked WG for facilitating the event and to AS for their support in arranging the day. JL said there was a great interest from other places as well and it would be a good idea to arrange more events.

MBu thanked the Non-Executive Directors for their hard work since the last Members' Council meeting.

MBu informed Members' Council that at 11am we will be observing a minutes silence for Ukraine.

It was resolved to NOTE the Chairs' report.

MC/23/06 Members' Council Business items (agenda item 6)

MC/23/06a Governor Feedback (item 6.1)
JL provided a verbal update.

JL highlighted that the main feedback from staff is appointment wait times and staffing challenges and retention. He said there was good stories from nursing support in relation to development days and joint working between service users, carers and the Trust. JL said it was highlighted that induction was good in some areas but not as good in other areas.

JL said when we look at the recruitment figures, we have increased but some of them were new roles and movement within the workforce. He stated there were common themes such as people being barred from the crisis team. He said he has heard how some people being referred to IAPT for talking therapies but then referred to a third party charity.

JL said some individuals were moved from the enhanced to the core pathway without any communication with the carers although it was noted on clinical notes that carers were to be consulted.

JL said at the carers forum meeting last week they heard from one lady and her daughter's journey, and she said she felt abandoned. JL said there was a carers worker present at the meeting who will look into her individual case.

JL highlighted governors had observed two board committees. JL said he observed the clinical governance and clinical safety committee, and Tony Wilkinson (TW) observed the People and Remuneration Committee. JL said next week Beverley Powell (BP) will observe the Mental Health Act Committee. JL said it has been fantastic to observe the committees between the Non-Executive Directors and the Executive Directors and it was reassuring. JL said the corporate governance team circulate a schedule of Committee dates for the rest of the year and he encouraged governors to attend a Committee meeting. JL thanked MBu, MBr and all the Executive and Non-Executive Directors for giving this opportunity to governors.

MBu said it was important to receive this feedback. JL said they appreciate that they, as governors, will only hear one side of the story and it was important to feed this into the Trust.

Carol Harris (CH) informed JL that if there is no progress in the individual cases, he has mentioned then he can contact CH. JL confirmed he will contact her if needed.

Daz Dooler (DD) said he has lived experience and some of the feedback is poor, he said that we need to see a culture change. MBu said we will look into this and we are continually seeking improvement and she welcomes this feedback. JW said she will take the points raised by JL and DD and liaise with CH if needed.

Action: JL and JW to discuss the issues in their monthly catch up and liaise with CH if needed.

It was resolved to RECEIVE the governor feedback.

MC/23/06b Assurance from Members' Council groups and Nominations Committee (To be taken as read and submit questions in advance) (item 6.2)

The governors were presented with a paper to provide assurance to the Members' Council that the Members' Council Co-ordination Group, Quality Group, and the Nominations Committee were fulfilling their duties in accordance with their terms of reference. MBu noted that no questions had been submitted about the papers and they can be taken as read.

It was RESOLVED to RECEIVE the Assurance from Members' Council groups and Nominations committee.

MC/23/06c Governor appointment to groups and Committees (To be taken as read and submit questions in advance) (item 6.3)

Asma Sacha (AS) informed the Members' Council that this paper is to support the appointment of governors to the Members' Council groups.

On the 1 November 2022, nominations were received from Phil Shire (PS), public governor for Calderdale and Daz Dooler (DD) public governor for Wakefield expressing an interest to extend their membership to the Members' Council Quality Group. As their nominations were uncontested, they will automatically fill the two vacancies.

AS relayed there were 3 vacancies on the Members' Council Co-ordination Group and there was 1 vacancy on the Members' Council Quality Group although this seat could not be filled at present as we do not have a public governor for Rest of Yorkshire and Humber representatives.

JL said we have a lot of vacancies due a period of transition. There are also a few governors coming to their end of term and he is confident that from the 1 May 2023 we will fill the places when new governors are appointed.

JW said she will also go through the different Members' Council groups as part of the governors induction process.

It was RESOLVED to RECEIVE the update on appointment to Members' Council groups and committees.

MC/23/06d Constitution, Standing Financial Instructions and Scheme of Delegation update (item 6.4)

JW presented the Constitution; she said the primary purpose of the change was due to the change in the Health and Social Care Act 2022. She said it reflects the statutory changes to the NHS England Code of Governance for NHS provider Trusts, it will be effective from the 1 April 2023 and it reflects the organisational need. JW thanked BC for providing a comprehensive feedback and she will be working through them. She said none of the comments will effect the legality of the document. JW said the statutory changes are highlighted and changes to the Social Care Act have been added. She said the Integrated Care System (ICS) structures are referenced in the document as well as ICB and ICP. She said Monitor references have been removed and replaced with NHS England and BC has highlighted that there are some Monitor references in the document.

JW confirmed they have to remain as they are historic in terms of the structure of the Foundation Trust.

JW said the Standing Financial Instructions is to provide a framework for the proceedings and business of the Trust, this update follows previous updates agreed through the Audit Committee in October 2021 and January 2022.

BC informed JW that he has made a series of recommendations, JW confirmed that she has received his feedback and worked through them. BC said he could not feedback earlier because he did not receive his papers in the post and the papers were difficult to reference as they did not have page numbers. JW apologised and said she was aware of the issue with the post and provided assurance that this won't happen again.

BC asked about governor expenses and whether this could be extended to reimbursement of digital expenses as well as for physically travelling to a venue for Trust business. He asked whether they could be reimbursed for things such as printing and use of computers. JW said we are relying on the way to do business digitally more and more and she can look into this and find out what we can reimburse.

Action: JW to confirm whether governors can be reimbursed for digital expenses

BC said it was also written that Non-Executives Directors were able to apply for loss of earnings.

BC asked about the disqualification of membership. He said it seems to be unfair because if a member of staff attacks someone else then they wouldn't be barred from being a member but if a member of the public did the same then they would be disqualified from membership. BC said if a member of staff was consequently terminated from employment, then they could apply to become a member but if a member of the public did this then they could not become a member again. JW said this was standard constitution language and we can discuss this outside of the meeting. JW confirmed they were statutory requirements. It was agreed that subject to changes made following further feedback from BC then the Constitution was approved.

Action: Corporate governance team to contact BC to note any further feedback

PS said there was a new role added under the Foundation Trust Code of Governance and we are unable to amend anything as it has been added nationally.

JW said we have organisational policies and procedures in relation to staff and the constitution will be implemented as an overlay to them.

JW said the scheme of delegation has been reviewed and amended to include the following updates:

- Monitor references removed and replaced with NHS England
- Executive job titles updated
- Committee titles updated and Collaborative Committee added
- Trust Board strategy, plans and budgets updated to include the financial approval hierarchy table that has been updated to reflect the new limits

JW said the differential between a Non-Executive Director and the Associate Non-Executive Director roles have been added but they don't have a statutory role in the organisation.

JW said the Members' Council can stand up and stand down forums. She highlighted that it was discussed in the Members' Council Quality Group about pulling different teams together to make an improvement to services. JW said we have talked about governors supporting forums such as a young person's forum or a carers forum. This has been left vague on purpose in the report, so the Trust has the flexibility to choose.

The Trust seal has been updated to be signed by the Chief Executive (or his/her nominated deputy) and witnessed by the Company Secretary. This is to improve efficiency.

Scheme of Delegation

JW presented the changes to the scheme of delegation, there has been an update to appendix 4. This includes statutory changes and making sure documents support that.

BC said he wanted to give feedback regarding the scheme of delegation document, on page 13. He said under Members' Council it states; "Appoint and removal of the Chair and Non-Executive Directors." He asked whether this should include the Associate Non-Executive Directors. JW confirmed it doesn't include the Associate Non-Executive Directors because they are not statutory.

JW said the Constitution will be replaced by midnight from 31 March 2023 and she will feedback if there are any issues that need to come back to the Members' Council.

It was RESOLVED to APPROVE the updates to the Constitution, Standing Financial Instructions and Scheme of Delegation as set out in the paper.

MC/23/06e Local Indicator for Quality Accounts (item 6.5)

Carmain Gibson-Holmes (CGH) presented this paper and explained that this is an annual report that focuses on how the Trust performs against a set of quality priorities that have been set alongside a range of mandated items as identified by NHS Improvement (NHSI) and Department of Health and Social Care (DHSC). The Quality Account requirements/ guidance is expected to be received by the end of February 2023. The preparation is underway to prepare the report as the Trust have done in the previous years. She explained that pre Covid-19 the Trust members were asked to identify quality indicators to review as part of the Trust's internal and external data quality checks. This requirement was stepped down and it is expected to remain this way but if this was to change then the Members' Council will be informed.

It was RESOLVED to RECEIVE the update to the Local Indicator for Quality Accounts

MC/23/06f Members' Council elections (update) (item 6.6)

JW updated the Members' Council in relation to the Members' Council elections. She informed that the Trust has had a very successful election campaign and nominations were concluded on 16 February 2023. JW thanked the Chair and governors for their support with the election campaign and a thank you to AS and TJ for their support with the engagement day.

JW informed the Trust has received 24 verified nominations for 14 vacancies.

She explained one place will be uncontested, and all other vacancies will be subject to an election process. One vacancy will remain which is for the social care staff (working in integrated teams).

JW provided a breakdown of vacancies and nominations as displayed in the following table;

Vacancy type	**Constituency**	**Number of vacancies**	**Number of nominations**
Public	Barnsley	2	4
Public	Calderdale	1	2
Public	Kirklees	4	5
Public	Wakefield	2	4
Public	Rest of Yorkshire etc	1	3
Staff	Non Clinical Support	1	2
Staff	Medicine and Pharmacy	1	1 (unopposed)
Staff	Nursing	1	3
Staff	Social care staff (working on integrated teams)	1	0

JW informed Members' Council that the voting packs will be circulated on 4 March 2023 and voting will close on 4 April 2023.

JW informed that there were a few young people who have applied as public governors and she would like to thank DD for his help and assistance with this. MBu also thanked DD and all the governors for all their help.

JW said the corporate governance team will also be working with the lead governor on the governor induction programme.

BC said he is unclear about the voting process. JW said she will liaise with BC outside of the meeting.

Action: JW to meet with BC to explain the voting process.

It was RESOLVED to RECEIVE the update on Members' Council elections.

MC/23/06g Members' Council Objectives (item 6.7)

JL said he has worked with governors on the Members' Council Objectives (1 April 2023 – 31 March 2025). JL thanked Claire Den Burger Green (CDBG), Tony Wilkinson (TW) Daz Dooler (DD) and Laura Habib (LH) for their help in drafting the objectives. JL explained he has discussed the headings with governors, and they have continued to use the same headings which are; Involvement, Quality and Effectiveness which has worked well previously.

JL explained the front sheet explains the statutory requirements of governors.

JL said there are 8 bullet points under Involvement and five of them are new.

JL went through some of the new objectives such as establishing a young people's forum and the Trust is seeking accreditation for triangle of care which is really positive.

JL said under quality we will continue the work of the Members' Council Quality Group and the interface with the Integrated Care System (ICS). He said governors will also support the Quality Monitoring Visits (QMV). JL explained they have specified that staff governors can also discuss the locality or team they work in rather than just the specific staff group they represent. JL asked for governors support and opened it up for discussion. BC asked why one of the bullet points has changed from "to work with" to "support". A discussion took place to clarify the work of the governors.

MBu agreed with the Members' Council that there were really good objectives. TW explained that the objectives do make it clear that governors are working in a much wider system now. Erfana Mahmood (EM) explained the Trust should also ensure that there is an improvement in diversity within our Membership and on our Members' Council. JD asked about younger governors and how we will engage them. DD said in Wakefield they have linked with the Young Lives Consortium. DD said he has also liaised with someone from the Wakefield Council who would be interested and helping governors get in touch with interested young members.

Andrea McCourt (AM) asked how they will measure progress. JL said they will implement different forums to assist with this.

Governors agreed to approve the Members' Council objectives subject to the following changes;

1. Involvement

1.8. "to support the Trust" will be changed to "to engage with the Trust"

2. Quality

2.5. "place visits" should read Patient Led Assessments of the Care Environment (PLACE)

Corporate Governance Team to amend the Members' Council Objectives and to re-circulate this out to the Members' Council

It was RESOLVED to APPROVE the Members' Council Objectives from 1 April 2023 until the 31 March 2025.

MC/23/06h Review of Chair and Non-Executive Directors' remuneration (item 6.8)
Lindsay Jensen (LJ) presented the paper on the review of the Chair and Non-Executive Directors remuneration. LJ explained the Members' Council undertake regular reviews of the remuneration. LJ explained that the Nominations Committee met on the 18 January 2023 to review the remuneration arrangements and agreed the current remuneration of the Trust Chair and Non-Executive Directors remains aligned to NHSE recommendations.

LJ highlighted that the Chair will be subject to a full annual appraisal in 2023 following which the Nominations Committee will review the Chairs remuneration and make a recommendation to the Members' Council. She explained should NHSE recommend any changes to the remuneration levels, a review will take place and Nominations Committee will be updated.

It was RESOLVED to APPROVE the review of the Chair and Non-Executive remuneration.

MC/23/06i Re-appointment of Non-Executive Directors (item 6.9)
(Mike Ford (MF) and Kate Quail (KQ) left the meeting)

MBu explained MF is a very good SID and brings a lot of value to the Trust. MBu asked the Members' Council whether they agree to re-appoint MF for a further 3 years. It was agreed to re-appoint MF for a second term of office for three years from 1 September 2023 to 31 August 2026.

MBu explained again, KQ is a very good Non-Executive Director and she successfully chairs the Mental Health Act Committee and is involved in others areas of the Trust such as the board development work. MBu asked the Members' Council whether they agree to re-appoint KQ. It was agreed to re-appoint KQ for a third term of office subject to annual review from the 1 August 2023 to 31 July 2023.

BC asked whether the relevant checks will be done again when they are re-appointed. JW confirmed the Trust carries out a fit and proper person test annually.

It was RESOLVED to APPROVE the re-appointment of Mike Ford and Kate Quail.

KQ and MF re-entered the Members' Council meeting.

MC/23/06j Re-appointment of Lead Governor (item 6.10)
(JL left the meeting)

MBu explained the corporate governance team wrote to all governors to express an interest for the lead governor role and JL self-nominated to be re-appointed as a lead governor. MBu said JL addressed the Nominations Committee on 18 January 2023 explaining why he would like to continue in his role as lead governor and how he would fulfil the role and what support he would need. She explained that the Nominations Committee considered JL's nomination and have made a recommendation the Members' Council to re-appoint JL as lead governor.

All governors expressed a view that JL was extremely likeable, worked really hard and engaged really well with the governors and constituents.

MBu said we haven't appointed to the Deputy Lead Governor and this discussion will continue outside of the meeting. MBu encouraged current governors to discuss this position with JL if they were interested. DD suggested a joint role or rotation until a permanent Deputy Lead was appointed. JW confirmed that they could do this in rotation as a temporary measure.

Governors to discuss with JL whether they would like to self-nominate for a lead governor position (rotation will be considered).

It was RESOLVED to APPROVE the re-appointment of John Laville as Lead Governor.

MC/23/06k Integrated Performance Report (To be taken as read and submit questions in advance) (item 6.11)

KQ joined the meeting virtually and due to the IT issues, could not present this paper.

It was agreed for MBr to present a brief summary.

MBr highlighted there were winter demands in the Trust as well as the Acute Hospitals and there was a huge increase in respiratory illnesses. MBr said various sectors have also had an impact in relation to industrial action. MBr explained that it has been challenging. The demands have been high in relation to complexity and acuity. The Trust has had out of area bed usage and this comes at a cost. MBr said the Trust have a 100 more staff and this might not always be in the areas of most need such as inpatient roles and this has been challenging for our teams. The performance metrics are holding up well and this is credit to all staff. He explained the Trust is getting more referrals from our primary care and delayed discharge. The sickness was high during the winter period and is coming down again.

MBr said financially the Trust has been fine for the last 3 years but next year it will be challenging for the NHS as a sector and for our Trust. MBr said although we are in difficult circumstances, and it was a great credit to our staff who are working hard across services.

The Members' Council observed a minute's silence for Ukraine at 11.00.

MBu explained we are doing well in relation to challenges that the Trust is facing. LJ said the Trust is seeing more starters and leavers and there are now 33 international nurses on our inpatient wards. LJ said the Trust is also looking at leavers survey and doing this much earlier rather than doing this when people have left.

DD said young people being admitted to an adult ward has doubled even though the numbers are small. CH commented that the Trust works closely with our partners and the demand has increased. DD asked about Red Kite View. CH explained the demand is significant and the level of observations of young people also has impact on this. MBr explained this also links in with acuity and staffing. MBr said between April – June 2019 compared to 2021, the number of referrals over the 4 places increased by 56%. DD said he understands there is a bigger picture and social issues needs to be resolved which then leads to mental health especially within the ICS. MBr said two members of staff were also hospitalised on our inpatient wards because they had been attacked by patients and this also has an impact on recruitment.

AJ said there was a serious incident in Manchester, and the Trust in Manchester were using nursing associates as nurses in charge, he asked whether this was happening within the Trust. CH said this does not happen routinely and they would not be put on a roster. CH commented that if this was to occur on an exception basis then it would be reviewed and go to the Nursing Directorate. CGH explained the Trust has a Safe care programme which is being rolled out and gives opportunity for clearer reporting on the quality of our staffing. CGH said the Nursing Directorate will be able to provide clearer reporting on this as the safe care programme progresses. AJ explained it isn't appropriate for a junior member of staff to lead a ward when there may be clinicians who were more qualified working in the crisis team. CH said they do have senior clinicians working on the wards and they look at staffing and the rosters. CH said our main decisions are based on patient safety. It was agreed for AJ to discuss this issue with CH outside of the meeting.

JW explained we haven't looked at safe care system in detail with governors, to look at this as a future session with governors. JL agreed with this.

Action: AJ to contact CH to discuss his concerns about staffing, in particular the use of nursing associates

Action: Corporate Governance Team to add safe care system as a future focus item

It was RESOLVED to RECEIVE the Integrated Performance Report.

MC/23/07 Focus on item - Trust Teaching Hospital proposal (item 7)

Dr Subha Thiyagesh (ST) presented this item.

She explained the Trust are going for the Teaching Hospital status and there is already a strong commitment to teaching, research and innovation.

ST highlighted that the Trust has established strong relationships with the University of Huddersfield, University of Sheffield and the University of Leeds.

She explained we already hold an Associated Teaching Trust status with the Leeds Medical School. She said the Trust trains medical students and nurses and allied health professionals and there maybe an opportunity to train pharmacy students.

ST said staff have managed to support these students throughout the pandemic.

ST explained that to allow the Trust to be recognised as a Teaching Trust, the Trust will have the name "Teaching" to reflect the significant teaching, training and research work of the Trust with our wide range of stakeholders including our Universities.

ST highlighted some key reasons why the Trust should apply to be a teaching hospital;

- Reflect the Trust's commitment to teaching and learning
- It was keeping with the Trust vision to provide outstanding physical, mental and social care in a modern health and care system
- In line with values of aiming to improve and be outstanding, relevant for today and ready for tomorrow.
- Supports our strategic objectives e.g. the Trust being a great place to work, and further, a great place to train our future workforce.
- Improves the visibility of the Trust as a learning organisation
- Will support attracting a high calibre workforce, whilst delivering high quality care to our service users and carers.
- Strengthens applications for research and development funding

ST explained that in relation to capacity, resources will need to be identified to support the project over a 6 month period and this has formed part of the planning and prioritisation discussions for 2023/24. She explained resource and capacity will be the main risk. ST said that costs associated with the name change, for example signage and templates will be updated as required rather than incurring a significant cost up front.

ST explained that there is limited guidance available to Foundation Trusts on how to gain Teaching Trust status and this has been established through engagement with other Trusts with experience of this process for example, through consultation with Humber Teaching NHS Foundation Trust and via engagement with the Executive Management Team (EMT), Committees and Board.

ST said this proposal was initially presented to EMT to gain Teaching Trust status in June 2022 and it was supported. The paper was then presented to the Clinical Governance and Clinical Safety Committee in November 2022 and there was agreement to progress. The paper was presented to Trust Board in November 2022 and an agreement was reached to commence consultation for obtaining Teaching Trust status with Members' Council for their consideration and approval.

ST said a steering group is being established which she will chair, and she will be responsible for oversight of all the workstreams including communications, engagement, corporate governance, legal, research and development and estates and facilities.

ST asked the Members' Council for their approval and to move to the next step of consultation. ST said the next step would be for MBu and MBr as Chair and Chief Executive to write to external stakeholders and NHSE.

ST made a recommendation to the Chair to write to the Trust membership with supported proposal asking for responses by exception.

MBu thanked ST for the presentation and explained that this would enhance the quality of people we attract and employ, and staff are regularly up to date with training and development.

TW asked whether patients will benefit directly. ST said patients will benefit from this and having the Teaching Trust status will attract the right calibre of staff and it also has a direct impact on the Trust clinical practice. The Trust would use research methodologies.

TW asked whether this would lead to greater staff turnover. ST said the workforce will be attracted by our culture and drawn by the ambition and learning. This will be linked to workforce recruitment and retention.

LH commented that this was a really good initiative and there will be a lot of support and we are heading in the right direction. MBu said there is fantastic learning and development drive. DD asked whether we would strip resources from our core services and we may lose staff from the core services to other projects. ST said this will attract people back into our services and she understands what he was saying, but this will enhance the Trust reputation and training. ST said we are validating what other staff are doing already, such as preceptorship and developing our staff further. DD said we need to reinforce that all staff are welcome and not everyone has to be ambitious as there are people who want to just do a good job. MBu and ST said this was a good point and as a Trust we will ensure we have an open message.

AJ asked whether people will be taking on extra roles on this project. ST said the Teaching Trust status will not change what people are already doing. ST said they have done a survey about looking at non-medical staff who want to engage in research and looking at the barriers. AJ said this was a good idea but what will happen in services if someone takes on an honorary lecturer role and they won't be on the ward. MBu said we are giving people acknowledgement for what staff are already doing and it is not giving them extra

roles. ST provided an example with her role and the application of her research. She said she was awarded the professor status at the University of Huddersfield.

WG explained many of his staff already work with NHS organisations and with SWYPFT as part of the nursing division and we can't disassociate from the teaching/ training and education. We need to bring the innovations together. WG said he has worked for different Trusts and as we move forward with digitalisation of care then we need to be at the forefront about bringing the education and research together. WG said the National Institute of Health Research have a programme which this Trust has got the success in achieving called research for patient benefit. It is solution focused and there are many benefits. This will also bring benefits and funding. DD relayed his concerns and WG said the patient interface will increase.

AJ said he can also see the benefits and he asked whether staff will be working in their own time and doing more than there allocated working hours. He asked how the organisation will help staff by making time out and back filling tasks. CH said if we create an improved learning environment, and this will help staffing and she is hopeful that it will help.

AM said she was very supportive of this. She asked whether the Trust has contacted other Trusts to consult on the process and who will be the ultimate decision maker as to whether the Trust receives the Teaching Status. ST said the Trust have worked with the Humber Teaching NHS Foundation Trust in relation to the governance process and also engaged with NHSE. MBu explained a few universities will also take this to Board to say they support our status and also the Members' Council would also have to support the status. MBu said the Trust will write to NHSE to request to add Teaching Status to our name.

JL said he fully supports this and asks whether it was too good to be true. He said it is positive that it was a 6 month timeline but there may be obstacles along the way. MBu explained that there are few mental health trusts with teaching hospital status, and our Trust is already doing a lot of work on Research and Development (R&D) and learning. ST said sometimes we need the right team to come together and have an ambition to go through this. MBu said the Trust already have an Associate Teaching Hospital status and we need to bring it together and receive this recognition. LH highlighted some research she is aware of on the wards which is really positive.

Cllr. Blagbrough asked when this will be communicated to the wider public. ST said we will do this once the steering group is established and once the Trust receives the status.

TW asked whether the community will care about this change as long as they receive the care they require. JL said he is happier to be treated at a Teaching Hospital than a non-teaching hospital. JL commented that there is perception that they may be better qualified staff at a Trust which is labelled "Teaching Hospital".

AJ asked whether the steering group will engage with service users. ST said there is a service user engagement and this is also applicable with research and development.

DD asked about evidence based and he asked whether as a Teaching Hospital they will have more influence. ST said they are already doing this. ST said we are already a specialist organisation and the Trust influences our discussions with our commissioners and look at our data in terms of waiting lists etc. MF commented that this was a good and effective debate.

It was RESOLVED to RECEIVE and APPROVE the Trust Teaching Hospital proposal.

MC/23/08 Focus on item - Single Point of Access (SPA) (item 8)

The team were presenting virtually so the item will be re-scheduled a later date.

JL highlighted he has discussed the crisis line at the Kirklees Mental Health Alliance, there has been various discussions about crisis lines being re-routed to NHS 111. JL said there were concerns in the MH Alliance as to the implications of this. JL asked whether this would include SPA and he also said there were great concerns as there are lengthy delays in them calling people back.

CH said she chairs the secondary care pathway meetings for the West Integrated Care System and 111 keeps us updated with their work. CH said she is relaying this from memory but the 111 will sit at the front but then they will re-route people to the most appropriate service and one of those services maybe the helpline. CH said she will raise his concerns and also receive an update and report back to JL. JL said they discussed at the meeting that if a member of the public was to call the 111 crisis line which was set up during the pandemic, this call would go to 111 and 111 may sign post people on but this may add delay. JL said the system leaders were equally concerned about this. CH said she will look to clarify the position and report back.

Action: Carol Harris to update John Laville

Cllr Blagborough asked how we deal with the homeless needing help. DD explained it may be the plan that everything is accessible via 111 which is easier to remember than individual service lines. DD said the change may be due to not many people getting the help they require from the existing SPA service.

AJ said that there will be difficulties with using 111, for example, with scarlet fever, people couldn't get through to 111, he explained he works in the GP practice and there were many people who needed antibiotics and when they called 111 they were informed that someone would call them back but then they received a second call saying they were too full and no one could call them back and their case was subsequently closed. AJ said this system would not work for people who were mentally distressed.

PS highlighted that SPA doesn't operate on weekends therefore there needs to be a discussion on how well the home based treatment teams worked at the weekends to handle the calls and whether the SPA team could include this in their presentation.

TW asked about engagement and consultation regarding this initiative. MBr said the Trust will get an opportunity to input within the consultation process. DD relayed that this was already happening in the South of England and it was creating a triage system.

Action: Corporate Governance Team to relay the above messages to SPA to add this to their presentation.

MC/23/09 Chair's appraisal (process) (item 9)

Mandy Rayner (MR) discussed the process for MBu's annual appraisal process. She explained that as the Members' Council were only discussing the process that MBu can remain in the room unless there were any objections. No objections were received.

MR confirmed that MBu's appraisal will be by MF as Senior Independent Director (SID). She explained that the process for 2022/23 will follow that of previous years which will enable all members of the Trust Board, governors and key stakeholders to contribute. She explained that NHS England publish an appraisal framework for NHS provider chairs which is a standard approach across the system.

She explained that MBu has been Trust Chair since December 2021 and her full appraisal will be from 1 April 2022 until the 31 March 2023. MR asked if a Chair is appointed mid-term whether they will have to wait 18 months until they have a full appraisal. JL said MBu joined us in December 2021 and MF confirmed that MBu has received an interim appraisal.

It was RESOLVED to RECEIVE an update on the Chair's appraisal process.

MC/23/10 Closing remarks and work programme 2023/24 (item 10)

The 2022/23 work programme was included in the Members' Council papers in error and the 2023/24 work programme was omitted. Apologies were relayed by AS and it was agreed to circulate the 2023/24 work programme to the Members' Council as soon as possible for comment and approval.

Action: Corporate Governance Team to circulate the Members' Council work programme 2023/24.

MC/23/11 Date of next Members' Council meeting (item 11)

BC highlighted that the Members' Council Coordination Group were asked to agree the dates of the Members' Council meetings for 2023/24 and noted that the date in August had changed from 16 August 2023 to 15 August 2023. Discussion took place in relation to governor and Board unavailability on Tuesdays and Thursdays, therefore it was agreed to schedule future Members' Council meetings on either Wednesdays or Friday mornings.

Future dates:

- May 2023 – TBC
- August 2023 – TBC
- Friday 29 September 2023 – Annual Members' Meeting
- Friday 17 November 2023 (including Joint Trust Board and Members' Council)
- Tuesday 20 February 2024

Action: Corporate Governance Team to reschedule the dates of future Members' Council meetings.

It was RESOLVED to APPROVE the Members' Council meeting dates for 2023/24 with the noted amendments.

MC/23/12 Any Other Business (item 12)

- BC said the 2021 cancer patient survey from NHSE showed that the two groups who are worse served as people with cancer were people with learning disabilities and those diagnosed with a mental illness. BC said he has been doing some work on this with them and is working with the cancer experience care lead from NHSE and they are doing work which will filter down to our Trust. He said they are working with local health teams and they are working with toolkits for professional use and reasonable adjustments mostly for acute health trusts and doctors. He said the group in Northumberland is working on patient passports and the local alliance is working on patient groups. BC said there are few mental health trusts getting involved with the process. CGH asked whether there was a system in place to determine that those people have a diagnosis of cancer and then the challenge of the treatment they receive. Natalie McMillan (NMc) explained as Chair of CG&CSC the Trust need to focus on this and she will take this as a discussion to the CG&CSC and to look at the the outcome of those with Learning Disabilities. She said we need to look at it as we have received the learning from deaths report, and it is about our learning of people from learning disabilities and to broaden it. NMc said it is about choices and how they can have this choice. AJ said it was an important piece of work and working in general practice there are people who are afraid of hospitals and an earlier input may have changed a persons prognosis. ST said this was part of our physical health strategy. ST said we are working with the executive trio to identify a strategy over the next 3 years and the use of more reasonable adjustments. EM said the Mental Health Act Committee also has data about rules about capacity and the MHAC also have other local authorities sitting on which providers assurance.

  Action: Natalie McMillan

- BC said the West Yorkshire and Harrogate Cancer Alliance have got monies of around £100,000 for innovative research. ST said she will make a note of this and discuss this with the R&D team.

  Action: ST to discuss this information with the R&D Team

- Asma Sacha (AS) informed Members' Council that although they are still considering different venues for hybrid Members' Council meetings for 2023/24, whether governors would be in agreement to hold the next meeting at Fieldhead Hospital to enable new governors to visit the site and for the corporate governance team to arrange a walk about. Members' Council agreed to this plan.

  Action: AS to arrange a walkabout of the Fieldhead site for all governors at the end of the next Members' Council meeting.

- JC, TW and BB thanked everyone for supporting them throughout their term as governors. MBu thanked them for their contribution to the Members' Council.

It was RESOLVED to NOTE any other business.

Close of Members' Council meeting

South West Yorkshire Partnership NHS Foundation Trust

Minutes of People and Remuneration Committee
21st March 2023
11:00 – 13:00
Microsoft Teams Meeting

Present	
Nat McMillan (NM)	Non-Executive Director (Chair)
Mark Brooks (MB)	Chief Executive
Marie Burnham (MBU)	Chair of the Trust

In attendance	
Richard Butterfield (RB)	Head of Recruitment and Resourcing
Carol Harris (CH)	Chief Operating Officer
Hazel Murgatroyd (HM)	Interim Head of People Experience
Richard Marriott (RM)	Consultant Psychiatrist
Zeruiah Nasir (ZN)	Clinical Skills Facilitator
Julie Williams (JW)	Deputy Director of Corporate Governance
Chloe Hoyland (CLH)	PA to Chief People Officer (Author)

Apologies	
Greg Moores (GM)	Chief People Officer
Lindsay Jensen (LJ)	Deputy Chief People Officer
Mandy Rayner (MR)	Non-Executive Director

PRC/23/141 Welcome, Introductions and Apologies (agenda item 1)

NM welcomed everyone to the meeting confirming she will be the Chair of the meeting in MR's absence. Apologies were received from Greg Moores, Lindsay Jensen, and Mandy Rayner. NM confirmed Marie Burnham will be dialling into the meeting and no approvals will be made until the meeting is quorate.

MBU joined the call for all approval items. It was noted that the meeting was quorate and could proceed.

PRC/23/142 Guardian of safe working report (agenda item 2)

RM introduced the Guardian of Safe Working Report confirming there hasn't been much change in terms of number of trainees. RM confirmed he has stated in the report there are still challenges with recruitment to higher training. There is a national issue around reducing numbers of higher trainees in Yorkshire and redistributing them to other parts of the country. Regarding exception reports there was an issue in the Q2 report from an area in Calderdale where there had been a vacancy on a ward resulting in the remaining Doctor working late. A locum has now been appointed in this area. In terms of gaps across the rotas, covid related issues have

remained low, most of the gaps are due to vacancies, people being part-time or staff having to come off the rota due to occupational health reasons. Existing trainees or others on the bank have been able to backfill any gaps. Regarding outstanding issues, there is still a concern around the business of the Wakefield rota. There is an extra pressure of having poplars off-site meaning when the trainee on-call is called to Poplars they are away from the Wakefield site and in that time jobs build up on the Fieldhead site with the main concern being patient safety if something urgent arises. Discussions have been held regarding Foundation Trainees joining the rota, so there is an additional person to cover jobs and discussions are still on-going on how we will move forward this.

MB highlighted the report states our bank rates are less competitive than our neighbouring organisations and would like to understand what that means i.e. what are the rates that we pay and what are the rates other organisations pay. MB highlighted as an integrated care system we should be paying comparable rates. RM commented that the British Medical Association (BMA) have released rates cards for all Doctors, the most recent being the Junior Doctor one. The BMA are recommending that people don't do additional work on top of their contracted hours for less than the rates they recommend. RM confirmed there has been discussions regarding rates of pay since the report was completed, Wakefield first on-call were being paid £45 per hour, Calderdale and the other non-resident rotas were getting £35 per hour as were higher trainees. The recent change has been to bring the Calderdale resident rota in line with Wakefield and the higher trainees would get the £35 per hour and the other non-resident would get the £35 per hour.

NM asked when will the Committee see some assurance regarding rates of pay, what discussion has happened and what decision has been made on the rates of pay. RB confirmed an update regarding rates of pay will come to the May Committee. RB highlighted that the stepping down policy has now been reviewed at JLNC in conjunction with Subha Thiyagesh and Diane Taylor.

NM commented is there some reticence about exception reporting. NM highlighted that at staff's induction there is a discussion item about speaking up and our culture of being open and honest. Is there something we should be doing more specifically around speaking up and our approach with our Junior Doctors. We need to continue to encourage the culture of speaking up.

NM thanked RM for his time and confirmed the Committee feel assured in terms of the paper and the exception reports.

GM and JW to explore what we can do to encourage doctors to speak up regarding exceptions.
Action: GM / JW

Update to be brought to the May Committee on the discussions and agreed rates of pay.
Action: GM / LJ

The Committee NOTED and COMMENTED on the Guardian of Safe Working Report.

PRC/23/143 Declarations of interest (agenda item 3)

There were no declarations over and above those made in the annual return to Trust Board in March 2023.

PRC/23/144 Minutes of the meeting held on 17th January 2023 (Agenda item 4)

- **17th January 2023**

The Committee confirmed that the above minutes were an accurate reflection.

The Committee RESOLVED to APPROVE the above minutes of the meeting held on 17th January 2023.

PRC/23/145 Matters arising from the meeting held on 17th January 2023 (Agenda item 5)

PRC/23/06 Covid – 19 update and Workforce Report
PRC/23/08 Mandatory Training Trust Compliance Targets

MB highlighted the leads on actions need to be better allocated, anything to do with the IPR needs to be Greg or Lindsay. NM agreed and stated it is the execs that are held to account.

Action: GM

PRC/23/18 Onboarding update Verbal

RB confirmed onboarding was set to go live in October 2022. He said a new application tracking system is being looked at. The recruitment system is broken down into three parts, NHS Jobs 3 which is a national system which covers the job adverts, the second part is the application tracking system which is where there are some difficulties. A new application tracking system has now been applied which is now starting to be implemented. The Onboarding system is now implemented and about to go live at the end of March and this system will work in harmony with the application tracking system.

NM would like an update on the Onboarding action to be included in the Chief People Officer's update at the next Committee.

Action: GM

The Committee NOTED and COMMENTED the actions from the previous meeting.

PRC/23/146 Chief People Officer updates (Agenda item 6)

Agenda item not covered due to apologies from GM.

NM did confirm from an audit and assurance point of view this agenda item needs to be a paper moving forward. MBU supported this.

Action: GM

PRC/23/147 Staff Stories International Nursing – Education and Training (Agenda item 7)

NM welcomed ZN and did formal introductions. RB introduced ZN to the Committee confirming she was here to talk about the work with the international nurse recruitment. ZN confirmed she joined the Trust in December as an OSCE facilitator and is very much enjoying the role. ZN stated her team provide maximum support to our international nurses and provide them with a very warm welcome and support into their new roles. When the international nurses come to the learning centre ZN provides them with a full overview of all their requirements. They are supported with all their registrations, opening bank accounts, tours of the sites etc so they are aware of their surroundings and environment. They also have pastoral support 24/7 as we know how daunting it must feel.

On the educational side ZN supports and prepares for their OSCE. ZN practices with them in a simulated environment to give them real situations to practice. She provides supports with transitioning into their roles. She also travels with the international nurses to their exams, so they don't feel overwhelmed with the travel and help build their confidence. ZN highlighted how all the international nurses feel very welcomed. ZN also takes the nurses to the wards ahead of them starting so they know where they are going. Overall, excellent support is given to all international nurses. ZN has received very good feedback from them, they are always very positive and love their environment. ZN thanked the Committee for their time.

NM thanked ZN on behalf of the Committee and highlighted that the wrap around support and care that ZN and the team are providing is invaluable.

MB commented now we are starting to build up a critical mass of nurses joining from overseas we are bound to have different capabilities and would like to ensure that when the international nurses are bedding in, they have every chance of success and promotion and playing a bigger role in the future. NM agreed and requested an action be noted that we don't lose track of this.

Action: GM

RB highlighted that it is not usual practice for Trusts to provide their own OSCE training, we have developed this which has been a fantastic boost for the Trust and we will be putting this in as an accreditation. ZN offered a 4-6 weeks OSCE course which leads the nurses up to their exams. We have a 70% pass rate at their first attempt. We have a 100% pass rate for second sitting. RB confirmed every interview leads to an open questions forum. He said every single person asks for a career development plan which proves how ambitious these nurses are. He said a celebration event was held yesterday for the international nurses and one nurse actually achieved a promotion to band 6 within 12 months.

NM asked ZN what we could do to make this process better. ZN asked for the possibility of another training room. RB confirmed that we are already looking into this.

The Committee NOTED the update from Zeruiah Nasir.

PRC/23/148 Workforce Performance Report (Agenda item 8)

RB confirmed this is the report for the end of January and said the IPR has had a significant update over the last month. Care Group level reporting has been added as requested by the Committee. The overall headline from this report is that our substantive staff in post has risen by a further 1%. February has seen the largest increase in staff, subsequently there has been a reduction in the vacancies which is down to 5.18 WTE. RB highlighted we have 30% increase in recruitment activity across all care groups. Vacancies have slightly reduced this month and the rolling turnover is about 14.3%, and he said we are projecting that to be around 13.7% by the end of March. RB did mention that the turnover rates are high and are fluctuating which he will be taking away and looking at this data in more detail as unsure that these are accurate. RB highlighted it would be better to have a rolling turnover per area. Mandatory training reports is at 89.4% which is above the Trust target. RB clarified in terms of appraisals the rate has increased to 69% this month and that we are seeing a lot of renewals of appraisals.

CH raised that we may have gone up in our establishment, however in relation to starters and leavers we have still had more staff leaving in Adult and Older People and Forensics than we have starters. She said we want to keep an eye on the figures in our Inpatient Services. Even with all the work that is taking place with international recruitment we are still losing more people than we are gaining. RB confirmed he is aware we do not have Inpatients as a direct line within the Care Groups and wondered if this should be included due to it being a main area of focus in terms of starters and leavers. NM confirmed this was discussed at the Clinical Governance and Clinical Safety Committee (CGCS) and it is great we are starting to see some of the Care Group metrics. She said we need some deep dives, so we are not working on assumption, so we are either working on assurance or highlighting the risks around it. RB highlighted it would be useful at each PRC to focus on certain areas so we can review in detail the work that is on-going. RB commented a piece of work has been completed on the internal staff movers reports which has been to OMG previously, there is a lot of movement within the Trust which has a big impact on the turnover rates.

JW said there is a timeout with Business and Intelligence and Directorate colleagues and said that Helen Smith had sent a detailed mapping report. She said to do a deep dive we need to ensure the people are mapping to the right place in their teams and localities. JW confirmed she will continue to work with RB for the deep dives and re-building the performance reports. JW confirmed we now have the fundamental data sets right which will help.

MB confirmed we need to separate the inpatient data, as well as looking at it at Care Group level and could look at splitting it by profession. MB challenged the request on the deep dive around Inpatients and said we need to look at how we can review this differently and address the issue in a different manner. NM confirmed the deep dive isn't about telling us what we know, it would be helpful for this Committee to see that data triangulated and gain some assurance around what we are trying differently. MBU agreed with NM's comment. MB highlighted there is another piece of work which is triangulation with the Staff Survey. MB summarised the turnover numbers cannot be right for areas such as Forensics and that we need a rolling number. MB confirmed as a Committee we need to recognise the actions that have been put in place around appraisals which is moving in the right direction. He said in June / July a lot of appraisals will be due for renewal, so we need to ensure the momentum of completing new appraisals doesn't slip. MB recognises the report is under development and suggested having a consolidated mandatory training number could mask some short falls. We may want something in the IPR around exceptions where we are not achieving the target. NM agreed with MB's comments around mandatory training. NM commented the report is developing in the right direction as a Committee and we need to continue to give RB specific improvements / changes to the report which will help. NM would like to see in the next 3-6 months the assurance coming through such as highlighting hot spots on the front sheet.

RB asked the Committee if they require the recruitment activity numbers in this report or as a separate report. MB confirmed this could be one verbal update per year as it is worth highlighting. NM stated it would be useful to have a meeting just on the IPR to discuss what information is needed in this. **Action: GM**

Inpatient services to be split out in the IPR. **Action: GM**

A deep dive around inpatients to be included in the IPR for review and discussion. **Action: GM**
Profession to be split out in the IPR.

The Committee NOTED and COMMENTED on the Integrated Workforce Report

PRC/23/150 Flu Vaccination Update (Agenda item 10)

RB confirmed the flu vaccination programme is now closed as of the end of last month and we achieved 64% uptake this year which is against Commissioning for Quality and Innovation (CQUIN) target of 90% so we are below that CQUIN target. However, we did get a better response than Bradford, Leeds and York. Last year we achieved 70% against a CQUIN target of 85%. He said the attempts to improve this has been on-going throughout the flu season, drop-in centres have been offered and having vaccinators on wards etc. RB confirmed Occupational Health are looking into implementing 2023 vaccines earlier.

MB commented the NHS nationally has suffered from vaccine fatigue. He said we can look at doing things differently for 2023. He said we have done better than majority of surrounding organisations. We will want to have a think about the profile of workforce has changed over the years. NM confirmed she felt assured by the update in terms of our rate and benchmarking with others.

The Committee NOTED the Update on the Flu Vaccination

PRC/23/151 Staff Survey 2022 Insights and Communications Plan (agenda item 11)

HM emphasised how we see the Staff Survey as one of our key engagement practices in the Trust. The assurance around how we have a plan in place to communicate and engage with our employees. Whilst we can celebrate lots of the improvements around response rates therefore the higher return in completed surveys, the real work happens on the back end when we go out and engage with staff regarding the fact we are listening to what has been raised in the survey and engage staff in the action planning following the survey. HM confirmed Ashley Hambling will be undertaking work and building information packs that will be supportive and a simple process

to support line managers on how to communicate with their teams and conclude what the actions are that we will be taking. We will be keeping momentum going around Comms and working with the Comms team.

NM said we understand at this stage it is high level and we support the approach with the ownership happening and the actions happening out and about in teams. Broadly aligned nationally it seems to have been a static picture across the staff survey. Overall, we must see it as a positive considering everything that is going on. NM confirmed her expectation is that the Staff Survey actions will continue to come to PRC at a high level. NM commented it is good to see in terms compassion and inclusivity given the profile the Trust has had around inclusivity and it is great to see it being recognised. The area she said she is most interested in is 'we are always learning'. It will be interesting to hear what the teams thoughts are on this and what they are planning to do improve that score. NM asked what has been communicated so far to staff. MB confirmed it has been fairly high level, we have a consistent process that people are used to. We do have the wider EEMT offsite where we will be launching how we plan to roll out to teams.

The Committee NOTED the Update on the Staff Survey 2022 Insights and Communications Plan

PRC/23/152 Gender Pay Gap audit and Action Plan (Agenda item 12)

HM confirmed this is a statuary report that we are required to report on the Government website. The data is what we are required to collect, and it has been checked for accuracy. It is different from the equal pay reporting which relates to the same work, this data is looking at that pay gap. She said we report on what the Government requires so there is standardised reporting. This is about giving the Committee visibility on what we are reporting on the Government website. HM confirmed from an assurance point of view it is accurate. We also include a development action plan which fits in with the wider work we are undertaking.

NM commented in terms of the action plan it reads more like recommendations rather than an action plan, and asked how as a Committee are we going to be assured that those actions are happening and when and is there any impact or evidence around them. NM would like further assurance at the next Committee.

Action: GM

The Committee NOTED the Update on the Gender Pay Gap audit and Action Plan

PRC/23/153 Annual Workforce Equality Report (Agenda item 13)

HM highlighted to the Committee that a paper isn't being presented at the meeting today due to a variety of reasons. She said an Inclusion and Belonging Lead has recently commenced in the People Directorate and their knowledge transfer has taken a while to come across and want that individual to feel confident to be able to report as this is a really significant report. She said the report has been worked on but is not in position to share with the Committee at present.

HM highlighted we would rather not share it than share something that is wrong. She said this is currently being worked on with our analytics and research team to ensure the data sets are correct and gain some supporting analytics so we can identify the true insights from this data and present it at high level. HM said the risk to the organisation is relatively low. The report is required to be published on an annual basis with the cut-off date being June 2023. She confirmed we are recommending that we deliver this report at May PRC with a view to it being published in June. This will enable us to us assure the Committee about the quality and accuracy of the data.

The Committee agreed the report be brought to the PRC meeting in May.

Action: GM

The Committee NOTED and COMMENTED on the Update on the Annual Workforce Equality Report

PRC/23/154 Workforce Plan 2023 – 24 (Agenda item 14)

RB confirmed there has been both an internal and external plan that is required to be submitted to NHS England annually and is part of the triangulation of the annual planning with the finance plan.

RB said that himself, Louise king and Rob Adamson have worked on the assumptions for the next 12 months within that plan. He said they are projecting a 2.6% increase in staff in post over the next 12 months. As an overview we are going to see more in terms of recruitment numbers and have a plan in place to address this. Part of this is our international recruitment offer which is a major workstream in terms of bringing nurses into the Trust. It is envisaged we will see 90 WTE nurses through that programme over the next 12 months.

RB said we also have a strengthening of our assessment centre delivery which is focusing primarily on nursing and HCSW roles across substantive and bank. The 2.6% increase would give us a closing of that vacancy factor, it is worth noting that this is based on a flat establishment structure across the next 12 months and we envisage that establishment will fluctuate as we get funding streams coming in across the place-based work. RB highlighted another major piece of work is the reduction of our agency spend, we need to meet the control target which we will be aiming to do by increasing our bank provision and increasing the recruitment activity. RB confirmed the final plan was submitted to Health Education England and NHS England on the 20th March 2023.

MB confirmed there are two points to think about, one of which there is a plan that we submit to NHS England and our ICB etc, a lot of work has gone into this and there are some good assumptions behind it. There is also the plan regarding the actions we are taking which are very robust, thorough and comprehensive. We have recognised that we have got an establishment that hasn't quite kept pace with the level of change over the last three years. In effect what we have done is add in the mental health investment standard to our establishment. We can't recruit that many staff, we know that. Secondly, we need to spend time looking at new roles, what our service offer is and to come up with a plan that is going to give us an establishment that we feel comfortable with.

NM thanked MB for the context. The challenge around our workforce does remain our biggest risk. Another key component is around the Agency Scrutiny Group. She said it is very clear the challenge through this Committee is, are we delivering on this plan and what are the risks. We need to continue to keep this Committee updated.

RB confirmed there is a plan to bring a quarterly workforce update to PRC as an update to plan versus actual.

The Committee NOTED and COMMENTED on the Workforce Plan 2023 – 24

PRC/23/155 Agency Scrutiny Group (Agenda item 15)

RB confirmed our cap is set at £7.8m so for this year by end of March and we are overspending on that.

RB said we are projected to spend £9.9m by the end of March, the focus for the Agency Scrutiny Group over the next 12 months is how we meet the plan for 2024. The two areas we are looking to focus on are the longer-term locum spend, we are going to do this on a line-by-line basis to identify some of those longer term positions and how we can put plans in place for individuals. The largest cost we see is in unregistered staff and this needs to be a longer term wider plan. The other area of focus will be within admin agency provision, which equates to around £500,000 of the total spend and we are looking toward potential for a return to zero tolerance policy for agency admin use.

NM commented regarding the zero-tolerance policy on the agency admin, this may want to go back to the exec group. NM highlighted it is unclear what the governance is around the Agency Scrutiny Group. She said the expectation is that it would report formally through this Committee, it is not clear how this is going to be done as it's not on the workplan. JW confirmed we need to set out how this will report through formally, if it is coming as part of the CPO report it needs to be written.

MB highlighted first and foremost this needs to go to EMT and then how does EMT report into the relevant Committees. He said there are two strands i.e. the financial controls which would sit with FIP and then the people aspect under this Committee.

GM to formally confirm how and where the agency scrutiny group will report to.

Action: GM

The Committee NOTED and COMMENTED on the Agency Scrutiny Group Update

PRC/23/156 Freedom to Speak Up (Agenda item 16)

JW confirmed we have recognised in previous years this report hasn't followed either a financial or calendar year for reporting, so it has never had a full reporting year in it. She said we would like to bring this back in line, so the Committee have sight of a full 12 months' worth of reporting from the 1st April to the 31st March.

The report is drafted and as has been through the Senior Independent NED and will be held to account for March data and will come to this Committee on the 23rd of May ahead of submission to the July Board.

JW confirmed the first meeting of the Freedom to Speak Up Steering Group is on 23rd March and a summary report of the minutes of this group will come to this Committee in May.

It was also agreed Freedom to speak up be changed to May on the annual work programme.

Action: GM

The Committee NOTED the update on Freedom to Speak Up

PRC/23/157 Workforce Risk Register (Agenda item 17)

RB confirmed he is happy to take away any questions regarding the Risk Register. NM highlighted the new risk score for risk 1758 which is jointly owned by CH and GM. This risk is around the risk of disruption to services and reduction of staff due to industrial action. There has been a recommendation made to increase the risk score or likelihood from 3 to 4. CH confirmed there is a timing issue with this risk whilst this was pertinent at the time, she wouldn't be recommending that we increase it. The Committee are asked to support the fact that we did increase it but we will now be moving it back down. MB wants the Committee to recognise that this will be dynamic as we are awaiting potential further action from Junior Doctors and will regularly be reviewing this with the Executive Management Team.

NM highlighted the new risk about accumulative impact of staff shortages and the culture of a ward which could lead to a potential risk on a ward. Just recognition that this risk has now formally been input on the register.

The Committee NOTED and COMMENTED on the Workforce Risk Register

PRC/23/158 Industrial Action (Agenda item 18)

RB confirmed we aware that out of all the unions the pay award that has been offered, at present only the RCN are yet to support the offer. In principle other unions have agreed to the proposal

the government has put forward, but there is no consensus of agreement that moves this forward presently.

The junior doctor strikes went ahead with no further agreements on pay awards. There is the potential for Consultants to strike and they are out to consultation now. No further strike dates have been confirmed at present.

CH confirmed a reflection meeting is in the diary to pick up any learning from the Junior Doctor strikes.

NM thanked everyone for all the work that went into managing industrial action.

The Committee NOTED the update on Industrial Action

PRC/23/159 Annual Report 2022/2023 (Agenda item 19a)

NM confirmed Mandy as Chair will attend the Audit Committee to present this. NM asked the Committee if they have any comments around the annual report. No comments were received.

The Committee APPROVED the annual report.

PRC/23/160 Draft PRC Terms of Reference (Agenda item 19b)

JW highlighted that Freedom to speak up is now a formal standing agenda item, JW needs to be shown as an attendee at the Committees. NM confirmed on behalf of the Committee the Terms of Reference is approved with the above change to be made.

Action: GM

The Committee APPROVED the Draft Terms of Reference, subject to the above amendment.

PRC/23/170 Draft Annual Work Programme 2023-2024 (Agenda item 19c)

Draft annual work programme approved following change of date for the Freedom to speak to up report to be reported in May not March.

The Committee APPROVED the Draft Annual Work Programme, subject to the above change.

PRC/23/171 Self-Assessment 2022 (Agenda item 19d)

NM highlighted on the self-assessment someone had added a comment that we don't have anyone from a finance background, NM highlighted MB is in attendance at all Committees. JW confirmed there will be a full review of the questionnaires based on the new code of governance meaning they will be more tailored to specific Committees.

The Committee APPROVED the Self-Assessment 2022

PRC/23/172 Actions from Trust Board (Agenda item 20)

There were no actions from Trust board to be discussed.

PRC/23/173 Matters to report to the Trust Board and other Committees (Agenda item 21)

People and Remuneration Committee	
Date	21 March 2023
Presented by	Nat McMillan (Non-Executive Director) on behalf of Mandy Griffin - Chair
Key items to raise at Trust Board	**Alert:** • The Committee agreed with the new risk that has been added as a result of ongoing pressures and challenges and the risk to a ward culture which could lead to patient harm. • The Committee agreed with the risk scoring around the Industrial Action and the dynamic management of the risk being increased but reduced by the time of this Committee. • The appraisal rate is improving at 69% however it is still below our target. • The Committee agreed to the Annual Workforce Equality Report being deferred to May's meeting and the work programme reflecting this timing going forward. There is no risk to this change and it is for information only to the board. • FTSU report for Q4 has changed on the work programme and will come to the May meeting and this timing going forward. As above there is no risk around this deferment and it is for information only. **Advise:** • The Committee heard from one of our team supporting International nurses and were delighted and assured to hear about the excellent Pastoral Care and the provision of internal OSCEs. • The Committee received an update on the flu vaccination which has closed at 64%. This is below the CQUIN target although we benchmark higher than our comparators across the region. • The workforce IPR continues to evolve and improve with further work to be undertaken to continue to triangulate and provide deep dive analysis for further assurance. **Assure:** • The Committee received the Safe Working Guardian report for Q3. The Committee is keen to continue to learn and listen from our junior doctors although no significant concerns raised through exception reports. • The Committee has requested a deep dive around Inpatients workforce data through the lens of what action is being taken. • The Committee received a high-level report on the Staff Survey results and the process around communication and actions across the teams and organisation. • The Committee received the Annual Gender Pay Gap and asked for the next level of assurance around the action plan i.e. milestones and ownership. • The Committee was assured around the ongoing quarterly report of the Workforce Plan (part of the Operating Plan) to monitor risks around delivery. • The Agency Scrutiny Group has been established and the board will be advised on the governance route into committees.

PRC/23/174 Date and Time of next meeting (agenda item 19)

The next meeting will take place on the 23rd May 2023 at 10:00 – 12:30 via MS Teams.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2023
Agenda item 11.1

Private/Public paper:	**Public**		
Title:	**South Yorkshire Integrated Care System (SY ICS) Update including Mental Health, Learning Disability and Autism Provider Collaborative (MHLDA)**		
Paper presented by:	Mark Brooks - Chief Executive Salma Yasmeen - Director of Strategy & Change/Deputy Chief Executive		
Paper prepared by:	Izzy Worswick – Associate Director, Provider Collaboratives & Planning		
Mission/values:	The development of joined-up care through Place and system working is central to the Trust's strategy, and is supportive of our mission- to help people reach their potential and live well in their community. The Trust values are central to our approach to partnership working.		
Purpose:	The purpose of this paper is: • To update the Trust Board on key developments in SY ICS and the SY MHLDA provider collaborative and linked programmes. • To update on partnership developments in Barnsley.		
Strategic objectives:	Improve Care	✓	
	Improve Health	✓	
	Improve Resources	✓	
	Make this a great place to work		
BAF Risk(s):	Risk 1.1 - Changes to integrated care system operating models and required cost reductions could result in less focus on mental health, learning disability and autism, community services and/or place Risk 1.2 - Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. Risk 3.1 - Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively. Risk 3.2 - Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.		
Contribution to the objectives of the Integrated Care System/Integrated	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through Place- based partnership arrangements and provider collaboratives, and also developments and discussions in progress where relevant.		

Care Board/Place based partnerships	
Any background papers / previously considered by:	The Trust Board receive regular updates on the progress and developments in the SY ICS, including the development of the provider collaborative.
Executive summary:	From 1 July 2022, NHS South Yorkshire Integrated Care Board (ICB) took on the commissioning responsibilities of clinical commissioning groups and leads the integration of health and care services across South Yorkshire. The South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative continues to develop. Work continues with our partners in Barnsley to evolve and develop place-based partnership governance arrangements. We have continued to develop the partnership with primary care as part of the Health and Care Alliance. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register and will need to be kept in view as the SY ICS and MHLDA Provider Collaborative develops. New risks may emerge.
Recommendation:	**Trust Board is asked to NOTE the SY ICS and Barnsley Place updates.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2023

Agenda item – 11.1 South Yorkshire update including South Yorkshire Integrated Care System (SY ICS)

1. Introduction

The purpose of this paper is to update the Trust Board on key developments in the South Yorkshire Integrated Care System (SY ICS) and the South Yorkshire Mental Health, Learning Disability & Autism Provider Collaborative (SY MHLDA) and linked programmes, and also on partnership developments in Barnsley.

The paper summarises key developments from recent Integrated Care Board (ICB) and place-based meetings.

2. South Yorkshire Integrated Care Partnership

South Yorkshire Integrated Care Board

Member	Chief Executive

Items discussed	Update from meeting of 3rd May 2023
	
	Key items discussed included:
	
	• Patient story: children and young people - this focused on an approach being taken to respond to youth violence in Sheffield.
	• Chief Executive report
	  ○ The South Yorkshire Integrated Care Strategy was launched on Tuesday 21 March 2023.
	  ○ Work is underway to develop a Five Year Forward Plan, which will be published in July 2023.
	  ○ The Hewitt Review was published on 4 April 2023 which set out to consider the oversight and governance of integrated care systems (ICSs).
	  ○ Achievements of NHS South Yorkshire's first year were reflected on.
	  ○ Challenges were reported with non-surgical oncologist staffing for breast cancer. Some mitigations are in place, including clinically triaging referrals.
	  ○ Impact of industrial action was discussed, which has been managed well across South Yorkshire.
	  ○ Toby Lewis has started as Chief Executive at Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) in March 2023.
	  ○ Salma Yasmeen has been appointed as Chief Executive at Sheffield Health and Social Care NHS Foundation Trust.

	• Place reports- these focused on approaches being taken to address health inequalities including.
	  o Barnsley – Barnsley's Place Based Partnership has aligned its approach to improving public health and reducing health inequalities under a three-tier framework. Voluntary, Community and Social Enterprise Sector (VCSE) engagement has been strengthened, and good progress has been made on increasing annual health checks for people with a learning disability.
	  o Doncaster- there has been a focus on three key areas: implementing a Core20plus5 programme for children and young people, increasing awareness across health, care and wider partners around poverty and impact on health inequalities, and focus on inclusion health.
	  o Rotherham – initiatives outlined included use of Rotherhive website, development of a dashboard, and joint work with Joseph Rowntree Foundation.
	  o Sheffield – there has been good progress on annual health checks for people with a learning disability, physical activity projects, wellbeing navigation, and work with the VCSE.
	• 2023/24 NHS South Yorkshire Operating Plan- an update was provided on the plan. There was recognition that work needs to start to prepare for 2024/25 planning now, and that there needs to be a more considered approach to transformational change to deliver savings.
	• Mental health deep dive- an update was presented on the plans for the six nationally identified mental health metrics. It was recognised that the Provider Collaborative will play a greater role, and that there are other key metrics the ICB may wish to focus on as well as those identified nationally. The need for good data and data quality was highlighted.
	• Developing the NHS South Yorkshire ICB 5-year Joint Forward Plan- the final plan will be shared with NHS England on 30th June, and will be received at the ICB Board meeting on July 5th. Engagement and involvement in the plan included the 'What Matters to You?' campaign, working with local Healthwatch and the VCSE.
	• Integrated Performance Report (IPR)- an update was provided on key performance risks and mitigation plans.
	• Primary Care Delegation – the decision to transfer commissioning of Pharmacy, Optometry and Dental Services to the ICB was ratified.
	• NHS South Yorkshire ICB Staff Survey- a verbal update was provided. The survey was carried out in November with a 69.4% response rate.
	• ICB Running Cost reductions: organisational change programme- the scale and scope of the change is better understood and the intended reduction amounts to

	approximately 35% of the running cost allowance which includes pay and non-pay costs. A programme approach is being taken. Organisational design is expected to be completed by the end of June. All functions are being reviewed. • Corporate Assurance Report- the update on the Board Assurance Framework and Risk Register were noted and Information Governance Policies approved. Update from development meeting of the ICB on 7th July 2023 The following items were covered: • The role of the ICB in digitisation and the scale of ambition for digitisation. • A review of governance arrangements in the first year of the ICB and how these can be developed.
Date of next meeting	Next meeting in public is scheduled for 5th July 2023.
Further information:	https://southyorkshire.icb.nhs.uk/our-information/meetings-and-papers

3. South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative

Member	Chief Executive
Items discussed	Update from meeting of 10th May 2023 • Lived experience story- experiences of neurodiversity were shared by Chilypep. • South Yorkshire ICB. o Integrated Care System development- South Yorkshire ICB Strategy has been published. 4 key areas were outlined: focus on early years and children, prevention and early intervention, inclusive economy, and workforce. o Integrated Care Board feedback- feedback from the South Yorkshire Integrated Care Board was provided. o Joint Forward Plan- NHS South Yorkshire together with partner NHS Foundation Trusts in South Yorkshire is required to develop a Five Year Joint Forward Plan by the end of June 2023. A Joint Forward Plan Coordination Group was established in January 2023. An update on progress was given. It was agreed to provide further input to the section on inequalities, and to ensure that mental health and wellbeing are a golden thread. o Annual planning submission- it was noted that NHS Talking Therapies targets are not being met

	consistently nationally. Out of area placements remain a key area of focus. • National MHLDA Inpatient Quality Transformation Programme. • Managing Director report. • Review of the South Yorkshire and Bassetlaw (SYB) Specialised Provider Collaborative Hub- an update was provided on the work of the SYB Specialised Provider Collaborative Commissioning Hub. • Collaborative funding and finance support to the programme- arrangements for the distribution of core costs and how financial support is provided to the programme were noted. • Finance Report. • Integrated Performance and Quality Report. • Changes to Lead Chief Executive role. • Risk register
Date of next meeting	Next meeting scheduled for 12th July 2023.

4. Barnsley Place

Barnsley Place Committee & Barnsley Place Partnership Board

Member	Chief Executive and Chair
Items discussed	Update from meeting on 25th May 2023 Key items discussed included: • Story from our communities- this focused on homelessness, housing and health. • Place Director update- The 'Proud to care' approach is being developed to improve recruitment and retention, career pathways and development for social care staff. A review of intermediate care services is underway, and the future model is being shaped. Co-location of out of hours services and teams is being progressed. • Barnsley Place achievements- over the last two months the Barnsley Place Partnership Delivery Group (PPDG) has been finalising the Barnsley Health and Care Plan 2023-25 and developing the programme delivery approach. The Place update to the Integrated Care Board earlier in May focussed on the progress in 2022/23 to tackle inequalities in Barnsley. • Feedback from South Yorkshire Integrated Care Partnership Board. • NHS 5 Year Joint Forward Plan for South Yorkshire Update- Key next steps include development sessions with the South Yorkshire System Leadership Executive to support further engagement and development of the plan. • Barnsley Health and Care Plan- the Barnsley Health and Care Plan 2023-25 and Tackling Health Inequalities in Barnsley report were approved.

	• Director of Public Health Annual Report 2022 – Tackling the cost-of-living crisis. The report was outlined which provides evidence of the impact of the cost-of-living crisis and how it is affecting households. Ways in which grants have been used creatively, and support provided from the community and voluntary sector was outlined. • VCSE Memorandum of Understanding (MOU)- it was noted that NHS South Yorkshire Integrated Care Board has adopted the Voluntary, Community and Social Enterprise Sector (VCSE) and Integrated Care System MOU. This describes the high-level relationship between the VCSE and ICS, building on existing Place arrangements and offering a framework to connect the VCSE across Places and with system-wide health and care work. • Quality and Safety Report- three areas were agreed to be escalated: complex nutritional failure patients including eating disorders, Dynamic Support Register and provider quality monitoring and levels of assurance. • Finance update – Month 12 – 2022/23. • Final Place Financial Plan 2023/24. • Committee minutes and assurance reports.
Date of next meeting	Next meeting scheduled for 29th June 2023.

Barnsley Place Partnership Delivery Group

Member	Director of Strategy and Change/Deputy Chief Executive
Items discussed	<u>Update from meeting on 13th June 2023</u> Key items discussed included: • Defining our priorities and delivery plans to support financial sustainability- this focused on finances and the Health and Care Plan. Directors of Finance each presented their organisation's financial position, followed by a discussion to identify key themes and possible areas of work to close the deficit gap. It was agreed that a further iteration of the proposal be brought back to the group. • Place Plan - Governance update- an update on current governance was shared. The role of the Community Health and Care Alliance in this work was discussed. • Partnership communications resource- views were invited as to whether this resource is required going forward.
Date of next meeting	Next meeting scheduled for 11th July 2023.

Barnsley Community Health and Care Alliance

Member	Chief Executive, Chair and Director of Strategy and Change/ Deputy Chief Executive
Items discussed	Update from meeting on 24th May 2023 Agenda items included: • Workshop Output: Barnsley Model- Feedback from the Alliance Workshop was shared. • Workshop Output: Health Inequalities. • Workshop Output: Look Back 2022/23. • Workshop Output: Summary Forward Plan. • Forward Plan: Current Workstreams. • Forward Plan: New Workstreams. • Forward Plan: Additional Priorities. • Key Messages for Place Based Delivery Group. A Medicines Management Task and Finish Group has been established.
Date of next meeting	Next meeting scheduled for 28th June 2023.

Barnsley Health and Wellbeing Board

Invited observer	Director of Strategy and Change/ Deputy Chief Executive
Items discussed	Update from meeting on 1st June 2023 Agenda items included: • Barnsley Culture Strategy engagement- a report was presented to outline the rationale for a Cultural Strategy to ensure work around participation and engagement with culture and heritage and that contribution to the visitor economy is strategically aligned to the Barnsley 2030 priorities of the borough. • Creativity and wellbeing. • Barnsley Premier Leisure presentation. • Health inequalities update.
Date of next meeting	The next meeting is scheduled for 9th November 2023.
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 June 2023
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:	Salma Yasmeen - Director of Strategy and Change/Deputy Chief Executive Sean Rayner - Director of Provider Development		
Paper prepared by:	Izzy Worswick – Associate Director, Provider Collaboratives & Planning		
Mission/values:	The development of joined-up care through Place and system working is central to the Trust's strategy and is supportive of our mission - to help people reach their potential and live well in their community. The Trust Values are central to our approach to partnership working.		
Purpose:	The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire Health and Care Partnership focusing on developments that are of importance or relevance to the Trust. The paper also includes an update on key developments in the three districts in West Yorkshire 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):	Risk 1.1 - Changes to integrated care system operating models and required cost reductions could result in less focus on mental health, learning disability and autism, community services and/or place. Risk 1.2 - Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. Risk 3.1 - Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively. Risk 3.2 - Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.		

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through Place-based partnership arrangements and provider collaboratives, and also developments and discussions in progress where relevant.
Any background papers / previously considered by:	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 and services. The Trust has continued to work with partners in each of its places to support the development of place-based arrangements.
Recommendation:	**Trust Board is asked to RECEIVE and NOTE the update on the development of Integrated Care Systems and collaborations:** o **West Yorkshire Health and Care Partnership;** o **Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees.** **and RECEIVE the minutes of relevant partnership boards/committees.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2023

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 2022 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.

The paper summarises key developments from recent ICB and place-based meetings.

2. West Yorkshire Health and Care Partnership

Updates from key recent meetings of the West Yorkshire Health and Care Partnership are summarised below.

West Yorkshire Integrated Care Board

Member	Mental Health, Learning Disability and Autism services are represented by Sara Munro, Chief Executive of Leeds and York Partnership NHS Foundation Trust, as partner member of the Integrated Care Board.
Items discussed	Update from meeting of 16th May 2023 Agenda items included: • Urgent decision- the urgent decision to approve the West Yorkshire ICS Financial Plan 2023/24 for submission to NHS England was recorded. • Focus on dentistry and oral health in West Yorkshire. • Chair and Chief Executive's reports. • Integrated Performance Dashboard including financial performance. • Emergency Preparedness, Resilience and Response Core Standards. • Committee Alert, Advise and Assure (AAA) Reports. • Joint Forward Plan. • ICB Constitution/Scheme of Delegation Review. • Committee Terms of Reference and Work Plans.
Date of next meeting	Next meeting scheduled for 18th July 2023.
Further information:	https://www.westyorkshire.icb.nhs.uk/meetings/integrated-care-board/integrated-care-board-meeting-16-may-2023

West Yorkshire Health & Care Partnership Board

Member	Chief Executive

Items discussed	Update from meeting of 6th June 2023
	
	Agenda items included:
	
	• Update from the Partnership Chief Executive Lead
	  ○ The Government announced on 25 May 2023 that it would rebuild five major hospitals by 2030, as part of the New Hospital Programme. This will include Airedale General Hospital.
	  ○ Calderdale Cares Partnership has appointed Jo Bibby to the role of Independent Chair.
	  ○ The requirement for all ICBs to reduce running costs by 30% is progressing, with a substantial amount of work being undertaken in the NHS West Yorkshire ICB.
	• Patient and Public Voice: Dentistry – What's happening for people in West Yorkshire.
	• Dentistry and Oral Health in West Yorkshire.
	• Tackling health inequalities for black, asian and minority ethnic communities and colleagues- an update was provided

	on the progress made on the delivery of the Tackling Health Inequalities for Black, Asian and Minority Ethnic Communities and Colleagues Review and subsequent action plan specifically focusing on population planning and reducing inequalities in mental health outcomes by ethnicity. • Developing a Partnership Agreement between the West Yorkshire Combined Authority and the NHS West Yorkshire Integrated Care Board- a draft Partnership Agreement that sets out shared commitment to working together on the factors that affect population health: fair economic growth, climate and tackling inequality was shared. • Social determinants of health and inclusion for West Yorkshire – a partnership approach. • Developing the WY Partnership Board.
Date of next meeting	Next meeting scheduled for 5th September 2023.
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-june-2023

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 June 2023 Agenda items included: • Chair's update. • Transforming Care Partnership. • Children and young people's mental health. • Premature mortality in adults with severe mental illness. • Maternal mental health. • 999 Push Model. • Escalation process: when outside of usual expected pathway (adult mental health inpatient bed finding). • MHLDA programme update. • Grief and loss. • Planning and performance. • Escalations.
Date of next meeting	Next meeting scheduled for 11th July 2023.

Wakefield

The Trust continues to be a pro-active partner in the Wakefield District Health and Care Partnership (DHCP) and associated work, leading in specific areas, for example, the Wakefield Mental Health Alliance.

Wakefield District Health and Care Partnership Committee

Member	Chief Executive (deputy - Director of Provider Development)
Items discussed	<u>Update from meeting on 23rd May 2023</u> Key items discussed included: • Darren (Daz) Dooler has replaced Maddy Sutcliffe on the Committee as representative for the voluntary, community, faith and social enterprise (VCSFE) sector. • The role of Independent Chair is out to advert. • Relocation of the Wakefield Walk-in Service- the Committee approved the proposal to find new city centre premises for the walk-in service, currently based on King Street, Wakefield. The lease on the current premises ends in June 2024. In securing a new premises, the location of other urgent and primary care services (including potential for co-location) will be taken into account. • Report of the Place Lead o NHS England has asked all Integrated Care Boards (ICBs) to reduce their overall operational running costs by a total of 30% by 2025. This equates to £10m across West Yorkshire. A new operating model is being developed to achieve the reduction. o An initial proposal to establish a Health Determinants Research Collaboration in Wakefield district has been submitted. o Transformation and integration work continues at pace across the system. o The waiting list for domiciliary care has been successfully reduced from over 300 people in December 2021 to just 6 people at the end of March 2023. • Report from the Chairs of the Provider Collaborative and Wakefield Professional Leadership Group- the name of the Provider Collaborative has been changed to the Transformation and Delivery Collaborative to reflect the group's key role in underpinning our key transformation and performance objectives. Terms of Reference will be updated. The Collaborative escalated an item from its May meeting- Adult ADHD waiting times for diagnostic assessment. There will be a paper on this issue at the next Committee meeting. The Wakefield Professional Leadership Group is made up of the most senior professional leaders within the Partnership and is accountable to the WDHCP Committee.

	• Maternity and neonatal discussion- the local ambition to transform maternity services is in line with a number of local, regional and national strategies. The most significant risk is maternity staffing. A detailed recruitment and retention plan is in place, with a strong focus on staff wellbeing. • Final Operational and Financial Plan. • Summary of 2022/23 Quarter 4 Quality, Safety and Experience report- The Committee noted the report. The Committee also noted the local preparations for the new Ofsted and CQC inspection framework for the experiences and outcomes of children and young people who have special educational needs and/or disabilities (SEND). • Performance Exception Report. • Finance update- the Committee received an update which set out the financial position for organisations within the Wakefield Place as at the end of March 2023. Wakefield delegated Integrated Care Board (ICB) reported in line with its control total. Both Wakefield Place NHS organisations reported in line with their control totals. • End of year governance- a series of papers were presented as part of the year-end governance including Wakefield District Health and Care Partnership Committee End of Year Annual Report 2022/23, and Committee Workplan 23/24. Each committee member was asked to complete a survey as part of the Committee Effectiveness Review. • Wakefield Place Risk Register- this was received.
Date of next meeting	Next meeting scheduled for 6th July 2023.
Further information	Meeting papers are available here: Committee meetings - Wakefield District Health & Care Partnership (wakefielddistricthcp.co.uk)

Transformation and Delivery Collaborative (formerly Wakefield Provider Collaborative)

Member	General Manager, Wakefield Community Services
Items discussed	Update from meeting on 16th May 2023 Key items discussed included: • Development Session: reflections, outcomes and next steps. • Escalations from alliances/programmes. • Autism Strategy. • Professional Collaborative Forum update. • Healthy Weight Programme: Weight Management Service Findings.

	• Adult ADHD Paper. • Items for escalation to Wakefield District Health & Care Partnership.
Date of next meeting	Next meeting scheduled for 20th June 2023.

Wakefield Mental Health Alliance

Member	Director of Provider Development (Chair), with Trust representative as a member.

Items discussed	Update from meeting on 14th June 2023
	
	Key agenda items included:
	
	• Mental Health Alliance Dashboard.
	• Standing item updates.
	  o Mental Health Emergency Dept Strategy Group.
	  o Older People and Dementia Group.
	  o Community Mental Health Transformation.
	  o NHS 111 roll out.
	  o VCSE funders alliance.
	• Mental Health Alliance stakeholder meeting update.
	• SWYPFT - Older peoples inpatient mental health service update.
	• Partner updates.
	• Wakefield Mental Health Alliance next phase.
	• Wakefield Provider Collaborative.
	• Wakefield District Health and Care Partnership feedback.
	• West Yorkshire MHLDA Board.

Date of next meeting	Next meeting scheduled for 19th July 2023.

Wakefield Health and Wellbeing Board

Member	Chief Executive (deputy - Director of Provider Development)
Items discussed	Update from meeting on 9th March 2023 The agenda was focused on Health and Wellbeing Priorities. Key items discussed included: • Children and young people- a presentation was given by Vicky Schofield, Corporate Director, Children and Young People, plus colleagues from the Wakefield Families Together Partnership including Trust staff. • Overview and Scrutiny Committee papers.

Date of next meeting	Next meeting to be confirmed (this has provisionally been arranged for 20th July 2023).
Further information	Papers and draft minutes are available at: Health and Wellbeing Board - Wakefield Council

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.

Calderdale Cares Partnership Board

Member	Chief Executive

Items discussed	Update from meeting on 25th May 2023
	
	Agenda items included:
	
	• Citizen feedback- this focused on elective recovery.
	• Deep dive: elective recovery.
	• Calderdale Cares Provider Collaborative progress update- there are three priority areas for the Provider Collaborative: increasing social value, tackling climate change and supporting new ways of integrated working in the Upper Calder Valley. All organisations are represented, and workstream leads are in place.
	• Place Lead report
	  o Interviews have recently taken place for the Independent Chair for the Partnership, and Jo Bibby will be taking up this role.
	  o There was recognition of how well providers responded to industrial action.
	  o Work is ongoing to update the ICB operating model.
	• Risk register.
	• Place Quality and Safety Report- an overview of recent priority quality and patient safety activities was given.
	• Place Finance Report- The year-end position for 2022/23 for a planned deficit of -£0.2m was delivered. There is high risk associated with 23/24 and concern whether the pay increase will be fully funded.
	• Place Performance Report.
	• Place Committee Work Plan and future agenda Items.
	• Matters for escalation for inclusion in the Triple `A` Report.

Date of next meeting	Next meeting scheduled for 20th July 2023.
Further information	Further information and meeting minutes can be found here: https://www.calderdalecares.co.uk/about-us/meeting-papers/

Calderdale Cares Community Programme Board

Member	Deputy Director Strategy and Change
Items discussed	Update from meeting on 11th May 2023 Items discussed included: • Calderdale Cares Community Programme Board Workshops update • Community- led approach to increasing physical activity. • Calderdale Healthwatch. The meeting of 8th June 2023 was cancelled.
Date of next meeting	Next meeting is scheduled for 13th July 2023.
Further information	Papers are available on the Future NHS platform for those with an account. https://future.nhs.uk/CalderdaleCCPBoard/view?objectId=36472912 Accounts can be set up at: https://future.nhs.uk/system/register

Calderdale Health and Wellbeing Board

Invited Observer	Director of Nursing & Quality
Items discussed	The April meeting of the Health and Wellbeing Board was cancelled. Update from meeting of 9th March 2023 • Update on membership of the Board. • Health and Wellbeing Strategy - update on Developing Well Report. The Calderdale Wellbeing Strategy 2022-27 sets out ambition that children aged between the ages of 6 and 25 should have hope and aspiration. In January 2022 the Developing Well strategic board was established to drive and coordinate work to achieve this ambition. Progress of this work was outlined. • 2023 Calderdale Community Information Directory briefing- a paper was shared and supported to develop a Calderdale Community Information Directory (CID), as part of an integrated digital platform, to support Calderdale's communities. • Health and Care priorities update.
Date of next meeting	Next meeting is scheduled for 28th June 2023.
Further information	Papers and minutes are available at: https://calderdale.moderngov.co.uk/ieListMeetings.aspx?CId=148&Year=0

Kirklees

The Kirklees Delivery Collaborative meets on a regular basis, and is developing a Partnership Agreement for the Collaborative.

The Kirklees Mental Health Alliance continues to meet and progress workstreams. Governance arrangements for the Alliance are aligned to the Kirklees place governance arrangements.

Kirklees ICB Committee

Member	Chief Executive (deputy – Director of Provider Development)
Items discussed	Update from meeting on 10th May 2023. Items discussed included: • People story- this focused on the trauma-informed approach being taken at Calderdale and Huddersfield NHS Foundation Trust for young people in the Emergency Departments. Funding has been secured for two years from the Violence Reduction Unit and the West Yorkshire Health and Care Partnership and is helping with signposting young people attending with different needs e.g. anxiety, substance misuse etc. • Kirklees Health and Care Plan- this was received by the Committee. The Delivery Collaborative will oversee the delivery of the plan. • Kirklees Financial Plan- there was significant focus on both the ICB and Place financial plan for 2023/24. • Operational Planning 2023/24 high level overview- a summary of the planning submission for Kirklees Health and Care Partnership submitted to NHSE in March 2023 for 2023/24 was provided. • Committee Annual Report, Terms of Reference and Work Plan. • Questions from members of the public. • Accountable Officer's Report. • Kirklees Place Quality Report- an overview against quality and patient safety activities was provided. • Finance and Contracting Report. • Performance Report against Key Performance Indicators for 2022/23. • High Level Risk Report. • Items for the attention of the ICB Board.
Date of next meeting	Next meeting scheduled for 12th July 2023.
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 6th June 2023 Items discussed included: • People stories. • Loneliness Partnership- an update was provided on the Loneliness Partnership's strategic direction and making loneliness everyone's business. • Kirklees Inclusive Economy Strategy- an update was provided on the development of the strategy and role of Health and Care Partnership in supporting and delivering it. The Strategy focuses on the intersection of inclusion, sustainability and productivity. • Cost of Living Challenges- a further update on implications of cost-of-living challenges and update on work on poverty was given. • Work plan.
Date of next meeting	Next meeting scheduled for 6th July 2023.

Kirklees Health and Wellbeing Board

Invited Observer	Director of Provider Development
Items discussed	Update from meeting of 30th March 2023 Key agenda items included: • Kirklees Safeguarding Adults Board Annual Report 2021-2022. • Implementing the Kirklees Health and Wellbeing Strategy Progress Report- an update on the implementation of the Kirklees Health and Wellbeing Strategy. • Kirklees Health and Wellbeing Strategy Priorities- Connected Care and Support. • Kirklees Health and Wellbeing Strategy Priorities - Healthy Places. • Kirklees Health and Wellbeing Strategy Priorities - Mental Wellbeing Update. • Agenda planning for 2023/24.
Date of next meeting	Next meeting scheduled for 29th June 2023.
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 5th June 2023 Key agenda items included: • Services delivered in the community – a presentation was given on the Community Services contract timeline, update on the proposed service bundles and governance process. • Discharge Programme update. • Delivery of Kirklees Health and Care Plan, role of Kirklees Delivery Collaborative and Partnership Agreement- it was agreed to support direction of travel for the Well Programmes, to approve Kirklees Delivery Collaborative role in overseeing delivery, and for members to commit time and resource to implementation of this work. The Partnership Agreement was discussed with expectation that Partners will 'sign off' the Agreement at the July 2023 Delivery Collaborative meeting.
Date of next meeting	Next meeting scheduled for 3rd July 2023.

Kirklees Mental Health Alliance

Member	Director of Provider Development (Co-Chair), with Trust representative as a member.
Items discussed	Update from meeting on 15th May 2023 • Investments- health psychology at Calderdale and Huddersfield NHS Foundation Trust. • Patient story. • Suicide prevention deep dive. • Public health substance misuse programme update. • NHS 111. • Programme highlight reports (by exception only). • Strategic developments- WY MHLDA Partnership Board. • Forward Plan.
Date of next meeting	Next meeting scheduled for 26th June 2023.

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 27 June 2023
Agenda item 11.3

Private/Public paper:	**Public**		
Title:	**Specialised NHS-Led Provider Collaboratives and Alliances - Update**		
Paper presented by:	Adrian Snarr - Director of Finance, Estates and Resources Sean Rayner - Director of Provider Development Salma Yasmeen - Director of Strategy and Change/ Deputy Chief Executive		
Paper prepared by:	Izzy Worswick – Associate Director, Provider Collaboratives & Planning		
Mission/values:	The development of joined- up care through partnership working is central to the Trust's strategy, and is supportive of our mission- to help people reach their potential and live well in their community. The Trust values are central to our approach to partnership working.		
Purpose:	The purpose of this paper is to provide the Trust Board with: 1. An update on key developments within the West Yorkshire and South Yorkshire and Bassetlaw Specialised NHS-Led Provider Collaboratives and key priorities that are of relevance to the Trust. 2. An update on the Phase 2 Provider Collaboratives.		
Strategic objectives:	Improve Care	✓	
	Improve Health	✓	
	Improve Resources	✓	
	Make this a great place to work		
BAF Risk(s):	Risk 1.1 - Changes to integrated care system operating models and required cost reductions could result in less focus on mental health, learning disability and autism, community services and/or place Risk 1.2 - Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. Risk 3.1 - Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively. Risk 3.2 - Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.		
Contribution to the objectives of the Integrated Care System/Integrated	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through provider collaboratives, and also developments and discussions in progress where relevant.		

Care Board/Place based partnerships	
Any background papers / previously considered by:	Strategic discussions and updates on Provider Collaboratives and developments have taken place regularly at Trust Board.
Executive summary:	**West Yorkshire Specialised NHS-Led Provider Collaboratives** In West Yorkshire, the Trust is Co-ordinating 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 (AED) Provider Collaboratives, for which Leeds and York Partnership NHS Foundation Trust (LYPFT) is the co-ordinating provider. All Provider Collaboratives continue to experience staffing challenges (medical and nursing), and this issue continues to be a focus, with support from West Yorkshire integrated care system (ICS) recruitment and retention workstreams. 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- work on the Community Pathway has been a key focus and a Project Lead is now in place to support the Women's Pathway work. • Repatriation plans for patients placed out of area (West Yorkshire) and outside of natural clinical flow. • Involvement in national work to revise the secure service specifications. • Support for improvement plans across the collaborative. For the 2 months to May 2023 the collaborative operated with a financial surplus. The Adult Eating Disorders Provider Collaborative reported a deficit at month 2. This and can be attributed to deficits against the out of area budget and the cross flows income target. Due to current staffing challenges, the Children and Young People's collaborative continues to operate at reduced occupancy. A restoration and re-occupancy plan has been developed, the trajectories of which are being met. Nevertheless, this has resulted in increased use of out of area beds. A deficit position was reported at month 2, largely due to 2 extraordinary, high cost and complex packages of care. **South Yorkshire and Bassetlaw Provider Collaboratives** In South Yorkshire and Bassetlaw, the Trust is Co-ordinating Provider of the Adult Secure Provider Collaborative. The Provider Collaborative Oversight Group for the collaborative is in place, ensuring oversight of the Trust's commissioning responsibilities which reports into the Trust's Collaborative Committee.

	The draft 'Lead Provider' contract has been shared with the Trust by NHS England (NHSE) and discussions are ongoing. A year-to-date surplus is reported, but a forecast deficit. Risk share discussions continue with partners in South Yorkshire. **Phase 2 Provider Collaboratives** The Trust underwent a process of 'due diligence' and developed a Memorandum of Understanding (MOU) to support a transition period of handover from NHSE to the West Yorkshire Provider Collaborative Commissioning Hub. A recommendation of go live of 1st April 2023 was supported by the Collaborative Committee on 7th February 2023 and Trust Board on 28th February 2023, subject to the MOU with NHSE being in place. The West Yorkshire Specialised Mental Health, Learning Disabilities and Autism Programme Board also supported this recommendation at its meeting on 24th March 2023. A project group has been established with representation from SWYPFT FCAMHS colleagues and the Commissioning Hub to manage the transition to a Provider Collaborative, in line with the MOU. Work is underway by the West Yorkshire Specialised Provider Collaborative Commissioning Hub to shadow the existing governance arrangements for FCAMHS within SWYPFT as Co-ordinating Provider (FCAMHS Board, established contract monitoring and quality arrangements etc) in order to define their role within these in the future and ensure clear delineation between provider and commissioner functions. In November 2022, NHSE/I published the Perinatal Provider Collaborative selection process. Lead Provider (coordinating provider) applications were invited. An expression of interest was developed by LYPFT, with input from partners via the Perinatal Partnership Board. This was shared with all partner Boards and submitted in March 2023. Following a panel process in April 2023, NHS England has now confirmed that LYPFT will be the lead provider for the Yorkshire and Humber Perinatal Mental Health 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 June 2023

Agenda item 11.3

Specialised NHS-Led Provider Collaboratives and Alliances - Update

1. Introduction

The purpose of this paper is to provide an update to the Trust Board on the Specialised NHS-Led Provider Collaboratives, focusing on developments that are of importance or relevance to the Trust. The paper includes updates on the West Yorkshire and South Yorkshire & Bassetlaw Provider Collaboratives where the Trust is a Co-ordinating Provider or partner, and an update on the national Phase 2 Provider Collaboratives.

2. Phase 1 Provider Collaboratives

In **West Yorkshire**, Provider Collaboratives have been established for national Phase 1 services:

- Adult Low and Medium Secure Services - co-ordinated by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT).
- Children and Young People Mental Health (CYPMH) inpatient services (Tier 4) - co-ordinated by Leeds and York Partnership NHS Foundation Trust (LYPFT).
- Adult Eating Disorder Services - co-ordinated by LYPFT.

In addition to being Co-ordinating Provider for Adult Secure, the Trust is a partner in both the Adult Eating Disorder and CYPMH Provider Collaboratives.

The Adult Eating Disorder Collaborative went live on 1st October 2020, and the CAMHS and Adult Secure Collaboratives 1st October 2021 (with transitional support from NHSE/I until 31st March 2022).

In **South Yorkshire and Bassetlaw**, Provider Collaboratives have also been established for all national Phase 1 Services:

- Children and Young People Mental Health (CYPMH) inpatient services (Tier 4) - co-ordinated by Sheffield Children's Hospital.
- Adult Eating Disorder Services - co-ordinated by Rotherham Doncaster and South Humber NHS Foundation Trust.
- Adult Secure Services - co-ordinated by SWYPFT.

The Adult Eating Disorder and CYPMH Provider Collaboratives went live on 1st October 2022, and the Adult Secure Provider Collaborative on 1st May 2022.

Although the South Yorkshire Integrated Care System does not now include the Bassetlaw population, for the purpose of the Phase 1 services the Provider Collaboratives continue to include the Bassetlaw population. Hence Bassetlaw is still included in the title.

3. Phase 1 Provider Collaboratives - West Yorkshire

Recent developments for all West Yorkshire Provider Collaboratives include:

- Annual review and update of the West Yorkshire Provider Collaboratives Quality Surveillance Process. Updates reflect the learning from the last 12 months and are in line with the National Quality Board's 'Quality Risk Response and Escalation Guidance'.

- Further development of Standard Operating Procedures (SOPs) for all West Yorkshire Provider Collaboratives, for example a SOP for temporary reduced activity/closure to admissions.

- Further implementation of the new approach to contract meetings. Quarter 4 "Service Review Meetings" have been held with the Adult Secure Provider Collaborative partners which included a deep dive narrative/presentation by providers to complement data collection for quality oversight.

- Understanding the new Patient Safety Incident Response Framework (PSIRF). The Commissioning Hub continue to work with providers to map out existing commissioner oversight arrangements and to clarify plans for future commissioner oversight.

All Provider Collaboratives continue to experience staffing challenges (medical and nursing), and this issue continues to be a focus, with support from West Yorkshire integrated care system (ICS) recruitment and retention workstreams.

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- work on the Community Pathway has been a key focus and a Project Lead is now in place to support the Women's Pathway work.
- Repatriation plans for patients placed out of area (West Yorkshire) and outside of natural clinical flow.
- Involvement in national work to revise the secure service specifications.
- Support for improvement plans across the collaborative.

For the 2 months to May 2023 the collaborative operated with a financial surplus.

There has been a focus on reviewing the 2023/24 Lead Provider Contract Variation. 2022/23 contract variations with in-area partners are being progressed to signature as a priority.

SWYPFT, in its role as Lead Provider, has completed visits to each of the in-area partners in order to review how the collaborative is operating, and any learning from the first 18 months as a collaborative. An Adult Secure Provider Collaborative Board development session is planned for July 2023 in order to share learning from these visits, and to discuss future plans for the collaborative.

The most recent meeting of the Collaborative Committee of the Trust Board took place on 5th June 2023, with a further meeting planned for 8th August 2023.

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 Community). Short and medium-term options to address this are being developed.

The original Adult Eating Disorder Provider Collaborative business case assumed a level of income generation from other provider collaboratives placing patients in West Yorkshire. The national ambition for provider collaboratives to place patients close to home has resulted in a reduction of referrals and admissions from out of area, which negatively impacts on income.

At month 2, a deficit position of £83k is reported. This is a deterioration against a break even plan and can be attributed to deficits against the out of area budget and the cross flows income target. A strategic approach has been initiated, and the inpatient unit is operating at over 85% capacity. An Inpatient and Referral Oversight Group has been established to manage patient and referral flow.

The forecast position for 2023/24 financial year is a £253k deficit. The collaborative will investigate ways to increase crossflows income and reduce out of area placements.

3.3 West Yorkshire Children and Young People's Mental Health (Inpatient) Provider Collaborative

Due to current staffing challenges, the Children and Young People's collaborative continues to operate at reduced occupancy. A restoration and re-occupancy plan has been developed, the trajectories of which are being met. Nevertheless, this has resulted in increased use of out of area beds.

A year-to-date deficit of £470k is reported for the 2023/24 financial year to May 2023 against a balanced plan. Two high-cost exceptional packages of care (EPCs) are currently driving the position.

4. Phase 1 Provider Collaboratives - South Yorkshire

4.1 South Yorkshire Adult Secure Provider Collaborative

The Collaborative went 'live' on 1st May 2022, with the Trust as 'Co-ordinating Provider'.

Key areas of focus have included the following:

- Governance structures are in place, with attendance from SWYPFT as Co-ordinating Provider. The Commissioning Hub is fully established.
- The Provider Collaborative Oversight Group for the collaborative provides oversight of the Trust's commissioning responsibilities. This reports into the Trust's Collaborative Committee.
- The draft Co-ordinating Provider contract has been shared with the Trust by NHS England. This has been reviewed by the Commissioning Hub and discussions with NHSE/I remain ongoing.
- The Partnership Agreement is being updated, and Hosting Agreement for the SYB Commissioning Hub.
- Risk share discussions continue between providers.

Due to ongoing negotiations between NHSE, the Commissioning Hub and one of the independent sector partners in South Yorkshire, the Trust has been unable to sign the Lead

Provider Contract. However, a way forward has been agreed and a final version of the Lead Provider contract from NHSE is awaited.

NHSE have shared the Stage 6 offer for 2023/24 which is being received and is yet to be confirmed.

A year to date surplus of £385k is reported, but a forecast deficit of £626k.

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.
- Children and Young People's Mental Health 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/I undertook consultation for phase 2 Adult Secure and CYPMH services. Following consultation, Adult Low and Medium Secure Acquired Brain Injury and Deaf Service and 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 (WY), the Trusts who comprise the WY MHLDA collaborative have agreed a set of principles to determine which Trust is the 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

NHSE has developed a standard operating procedure (SOP) to support with operationalising the FCAMHS recommendations, coproduced with experts by profession and experience.

The Trust underwent a process of 'due diligence' and developed a Memorandum of Understanding (MOU) to support a transition period of handover from NHSE to the West Yorkshire Provider Collaborative Commissioning Hub.

A recommendation of go live of 1st April 2023 was supported by the Collaborative Committee on 7th February 2023 and Trust Board on 28th February 2023, subject to the MOU with NHSE

being in place. The West Yorkshire Specialised Mental Health, Learning Disabilities and Autism Programme Board also supported this recommendation at its meeting on 24th March 2023.

A project group has been established with representation from SWYPFT FCAMHS colleagues and the Commissioning Hub to manage the transition to a Provider Collaborative, in line with the MOU.

Work is underway by the West Yorkshire Specialised Provider Collaborative Commissioning Hub to shadow the existing governance arrangements for FCAMHS within SWYPFT as Co-ordinating Provider (FCAMHS Board, established contract monitoring and quality arrangements etc) in order to define their role within these in the future and ensure clear delineation between provider and commissioner functions.

Progress against the MOU is as follows:

- SWYPFT FCAMHS colleagues and the Commissioning Hub met to discuss current processes for quality monitoring in May 2023, and any current issues. An options paper as to how quality oversight will be managed going forward will be developed and discussed at the FCAMHS Partnership Board, Provider Collaborative Patient Safety and Quality Group, and August Collaborative Committee.
- The Commissioning Hub continue to shadow existing quality review processes.
- The Commissioning Hub have met with NHSE to understand data available via the national FCAMHS dashboard.
- Quarterly highlight reports have been shared by SWYPFT FCAMHS colleagues with the Commissioning Hub.
- SWYPFT FCAMHS colleagues share any new quality concerns with the Commissioning Hub.
- Serious incidents (SIs) continue to be reported by providers in line with the National SI framework, with SWYPFT as Lead Provider notified. SWYPFT FCAMHS colleagues will notify the Commissioning Hub of any SIs during the transition period.
- The Commissioning Hub have shadowed Q4 contract meetings between SWYPFT and the subcontracted providers.
- All providers have been notified of invoice arrangements for 2023/24.

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.

Within West Yorkshire, Leeds and York Partnership 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, and discussions with NHSE are ongoing.

In November 2022, NHSE/I published the Perinatal Provider Collaborative selection process. Lead Provider (coordinating provider) applications were invited. An expression of interest was developed by LYPFT, with input from partners via the Perinatal Partnership Board. This was shared with all partner Boards, and submitted in March 2023. Following a panel process in April 2023, NHS England has now confirmed that LYPFT will be the lead provider for the Yorkshire and Humber Perinatal Mental Health Collaborative.

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 27June 2023
Agenda item 12.1

Private/Public paper:	**Public**		
Title:	**Trust Board self-certification (FT4) – corporate governance statement 2022/23**		
Paper presented by:	**Adrian Snarr - Director of Finance, Estates and Resources**		
Paper prepared by:	Julie Williams - Deputy Director of Corporate Governance		
Mission/values:	Respectful, honest, open and transparent. Relevant today and ready for tomorrow.		
Purpose:	To provide assurance to Trust Board that it is able to make the required self-certifications that the Trust complies with the conditions of the NHS provider licence.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	All risks		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The self-certification process provides evidence to assure the Board that the Trust is operating in line with its licence. It also provides assurance to partners and the system through publication on the Trust website.		
Any background papers / previously considered by:	Part 1 of the Trust Board self-certification (G6/CoS7) – compliance with NHS provider licence conditions - was presented to Trust Board in April 2023.		
Executive summary:	**Background** NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (including requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.		

	As part of the annual planning arrangements, NHS Improvement requires the Trust to make a number of governance declarations. The Trust Board approved the first self-certifications (G6/CoS7) on 25 April 2023 and the following further self-certifications (FT4) are required by 30 June 2023: • The provider has complied with required governance arrangements (as required by condition FT4(8) of the NHS Provider Licence) (appendix 1 – Corporate Governance Statement) • The training of Governors (as required by s151(5) of the Health and Social Care Act 2012) (see below). **Self-certification - part two (FT4)** <u>Corporate Governance Statement 2022/23</u> The attached paper (appendix 1) sets out the detailed statements (numbered 1-6) Trust Board is required to make and the assurance to support self-certification against the statements. 1. The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. 2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time-to-time. 3. The Board is satisfied that the Trust implements effective board and committee structures, clear responsibilities for its board, for committees reporting to the board and for staff reporting to the board and those committees and clear reporting lines and accountabilities throughout its organisation. 4. The Board is satisfied that the Trust effectively implements systems and / or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively, for timely and effective scrutiny and oversight by the Board of the Licence holder's operations, to ensure compliance with healthcare standards binding on the Licence holder. 5. The Board is satisfied that there is sufficient capability at Trust Board level to provide effective organisational leadership on the quality of care provided. 6. Trust Board effectively implements systems to ensure that it has in place personnel on Trust Board, reporting to Trust Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the Trust's NHS provider licence. The deputy director of corporate governance is satisfied that the paper attached provides sufficient evidence that the Trust has satisfied and met the six statements above. From the assurance provided, Trust Board is asked to certify that it is satisfied with the risks and mitigating actions against each area of the Trust's Draft Corporate Governance Statement.

	<u>Training of Governors</u> The Trust has developed, through the Members' Council Co-ordination Group, a programme of training and development to ensure governors have the skills and experience required to fulfil their duties. The Trust has supported the training and development of governors in a number of ways: • New governors have an induction meeting with the Chair • The Trust offers 1:1 support and 'buddying' as part of the induction programme for new Governors. • The Members' Council workplan now includes discussion items and development sessions, allowing governors, with the support of Trust Board, to look at a particular area of Trust services or activity in more detail. From the assurance provided, Trust Board is asked to certify this it "***is satisfied that, during the financial year most recently ended, the Trust has provided necessary training to its governors, as required by S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role***." The Board should note that following the implementation of the Code of Governance for NHS Provider Trusts on 1 April 2023 the Trust will no longer be required to conduct these retrospective self certifications.
Recommendation:	**Trust Board is asked to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance and CONFIRM that it is able to make the required self-certifications in relation to:** • **the Corporate Governance Statement 2022/23** • **the training for Governors 2022/23**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2023

Corporate Governance Statement 2022/23

1. The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.
The Trust continues to implement, develop and improve its arrangements to ensure it meets the principles and standards of good corporate governance and to ensure it has the systems and processes in place to meet these as well as its statutory, legal and regulatory duties and requirements. As part of this continuous improvement process, Trust Board undertook a well-led governance review during 2015, which has been followed up by CQC well led reviews in each of 2017, 2018 and 2019. In 2022/23 the Trust commissioned an independent desktop well led review from Aqua to support a review of where it is currently performing in terms of "good" corporate governance, against the CQC well led assessment process. Overall, the report was positive, there was a small number of minor actions that have been completed, other recommendations were developmental in nature against the well led framework. The most recent CQC well led review (2019) provided a rating of **good**. Review and scrutiny of the Trust's governance arrangements took place as part of the well-led review, which included interviews with the Trust Board and staff. The review concluded that the Trust Board and leadership team had the appropriate range of skills, knowledge, and experience, and showed integrity on an ongoing basis. The report also highlighted that there was a robust and realistic strategy for achieving Trust priorities and effective internal governance structures, systems and processes in place to support delivery of the strategy. The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust continues to assess its compliance with CQC registration requirements on a regular basis through our quality improvement and assurance team. To support our assessment, we have developed a quality assurance and improvement 'self-governing' assessment model. This philosophy builds on our emphasis on self-governance and evaluation. As a series of methods and tools, this approach helps map the relationships between quality improvement and quality assurance and will provide a continual source of evidence for teams to inform how well they are performing against appropriate and helpful metrics for quality. Overall, we are now rated Good for being responsive, caring, well led and effective, and requires improvement for being safe. This means that overall, we have been rated Good as a Trust.

However, the CQC did identify areas for improvement. Therefore, in line with the vision we set out in our Quality Strategy we will use the Model for Improvement to address themes identified in the CQC inspection report (2019) which not only impacts on our requires improvement rating for safety but in serious incident reports, fitness to practice cases and CQC Mental Health Inspections.

CQC inspection 2019: update 2022-23

Following the May-June 2019 core service visits and well-led review, the CQC issued the Trust with **12 MUST do and 37 SHOULD** do actions. These included 1 MUST do and 8 SHOULD do Trust wide actions.

12 of our 14 core services were rated as 'good.' Our overall rating changed to 'Good.' Our wards for adults of working age and PICU, and our specialist community services for children and young people (CAMHS) received a rating of 'requires improvement.'

To address these concerns The Trust developed an improvement plan. The plan was initially due to be complete in June 2020, however, due to the Covid-19 pandemic some elements of the plan, i.e. actions related to risk assessment and care planning, and suitable psychology provision on our older peoples' wards, were delayed. All other elements of the plan were completed.

In May 2023/24 the Trusts inpatient services were inspected by the CQC. The initial outcome letters were in public to Trust Board on 27 June 2023. On receipt of the full CQC report the Trust will continue to work with the CQC to respond to their report and formulate action plans to deal with any outcomes.

In 2022-23Clinical Governance Clinical Safety committee (CGCSC)

The Clinical Governance and Clinical Safety Committee provides assurance to Trust Board on service quality and the application of controls and assurances in relation to clinical services. It scrutinises the systems in place for effective care co-ordination and evidence-based practice and focuses on quality improvement to ensure a co-ordinated holistic approach to clinical risk management and clinical governance is in place, protecting standards of clinical and professional practice. The Committee met ten times in 2022/23. The Committee has terms of reference and is required to produce an annual report outlining achievements against objectives and compliance with the terms of reference. The annual report, work programme and updated terms of reference for the CGCSC were provided to the Audit Committee to provide assurance to Trust Board.

Quality initiatives in 2022/23

The quality initiatives prioritised for action in 2022/23 as part of the quality account process were as follows:

Patient Safety

Throughout 2022/23, we have continued to make good progress with our patient safety strategy work in line with national priorities and developments. We have:

- Reviewed our internal patient safety strategy and agreed that our ambitions remained current as it is structured around the NHS Patient Safety Strategy and reflects the ongoing national workstreams (described below). We will review our strategy at the end of 2023/24 to consider future arrangements in line with NHS Patient Safety Strategy developments
- Our patient safety specialists have joined a number of developing patient safety networks at all our places and with Integrated Care Boards (ICBs) and provider collaboratives colleagues along with regional and national level networks to support the patient safety priorities. Some key areas of work are outlined below:

Suicide prevention

- In 2022/23 we launched our suicide prevention strategy
- Relaunched the delivery of suicide alertness and suicide interventions training
- Commissioned additional professional training in the form of collaborative assessment and management of suicidality training for senior practitioners actively working with individuals where suicide is identified as a risk
- Continued promotion and awareness raising of basic suicide prevention training for all staff employed irrespective of professional qualification

Electronic prescribing medication administration (EPMA) roll-out

- The rollout included all 29 Mental Health Inpatient wards (444 beds) covering all localities. The initial go-lives took place in the first quarter of 2021 and, following a pause, concluded between February 2022 and March 2023.
- It has been a true multidisciplinary and multi-professional project from the start involving clinical and IM&T colleagues, from design to implementation to evaluation.
- A broad range of benefits were identified which are linked with the Trust's values, strategic objectives and priorities. A full project evaluation and benefits realisation is underway. However, some immediate benefits have been realised including:
    - Legible and complete prescriptions
    - Improved medicine administration (timely and appropriate)

- Reduced medication incidents reported
- Providing a single and comprehensive view of a service user's current and historical medication
- Ability to view a service user's medication wherever a clinician or service user may be located

Clinical record keeping

- Following the CQC inspection 2019 where care plans and risk assessments were highlighted as requiring improvement to meet the expected standards of care, there has been an ongoing effort to improve. There have been internal and external factors which have impacted on the delivery of this work and therefore the work undertaken has not had the desired impact on improvement. Since the last quality account there has been a concerted focus on this priority piece of work adopting partnership approach to quality improvement methodology.
- There is a care plan and risk assessment improvement group which has been facilitated in partnership between the nursing, quality and professions directorate and the integrated change team. This approach has created an improvement group with high levels of engagement, motivation for change and commitment to delivery.

- The group meet every three weeks and work to date has included:
  - A deep dive into the problems/challenges and the development of a problem statement
  - The development of a driver diagram and change ideas identified to date
  - Initial 'quick win' changes to be implemented to improve data recording and reporting
  - A plan for task and finish groups to lead the work going forward
  - A look and see approach in clinical settings
  - Specific focus groups/targeted conversations
  - Keeping it on the agenda in meetings and forums to continue engagement and involvement at every level
  - A solution focused approach to the leadership style

Regular clinical record keeping audits, with improvement plans in response owned by CGs.

In addition, these actions are being monitored and mitigated by:

- Strategic, Trustwide improvement projects
- Local quality improvement projects and initiatives
- Local governance arrangements (ward manager and matron checks)

- Support from corporate services
- Clinical record keeping audits
- Quality monitoring visits
- Clinical audit
- Patient experience triangulation (surveys, complaints, staff surveys etc.)
- Ongoing dialogue with the CQC – being open, honest and transparent.

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

Risks
The Trust does not apply or applies inconsistently good corporate governance. Mitigated by robust scrutiny through the Trust's governance and assurance processes.

There are a number of areas to provide assurance that the Trust applies the principles, systems and standards of good corporate governance.

- The Trust's Constitution, based on Monitor's model constitution, underpins its governance arrangements and the Trust operates within its Constitution at all times. Where necessary, the Trust seeks external advice on any changes, and ensures amendments are approved in line with the process set out in the Constitution.
- A review of the Trust's Constitution was undertaken in year to ensure compliance with the new code of governance which came into effect on the 1 April 2023. It was approved by Trust Board 31 January 2023 and ratified by Members Council on 24 February 2023
- The Trust complies with all relevant rights and pledges set out in the NHS Constitution with the exception of the pledge "The NHS commits to make the transition as smooth as possible where you are referred between services, and to include you in the relevant discussions". The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there are occasions where the nature of an individual's illness makes this inappropriate. The annual self-assessment will be presented to Trust Board in July 2023.
- Each committee of the Trust Board is required to prepare an annual report, which is presented to the Audit Committee. The Audit Committee reviews overall effectiveness of committee structure. This provides assurance to Trust Board that each committee is meeting its terms of reference and is seeking assurance on areas of risk in line with its terms of reference. The outcome is reported to Trust Board annually in April.

- Each group and committee of the Members' Council is required to prepare an annual report and review of the terms of reference, which is reported to the Member's Council annually in April / May and provides assurance that each group / committee is meeting its terms of reference and work programme.
- The Trust undertakes an annual assessment of compliance against NHS Improvement / Monitor's Code of Governance (still in effect during 2022/23) which is reported to Trust Board.
- The Trust has a register of interests in place for both Trust Board and the Members' Council, which is reviewed annually and both Directors and Governors are proactively asked to update their declarations. Directors and Governors are expected to declare any additions or changes to their declarations. The Chair of the Trust reviews the declarations and considers whether there are any conflicts of interest presenting a risk to the Trust. Non-Executive Directors also make a declaration of independence on an annual basis. All Non-Executive Directors have made a positive declaration.
- From April 2015, members of Trust Board have also been asked to make a declaration that they meet the fit and proper person requirement introduced in response to a recommendation made in the Francis Report. All members of Trust Board have made such a declaration and the Trust undertakes appropriate enquiries to ensure that newly appointed Directors meet the requirements as well as seeking an individual declaration. All members of Trust Board and the Executive Management Team have disclosure and barring (DBS) checks in place.
- All elections made to the Members' Council are held in accordance with the Model Election Rules in the Trust's Constitution.
- Elections are overseen by an external organisation (currently Civica Election Services) to ensure independence and transparency, and to ensure the Trust meets its statutory duties.
- The Trust was awarded a Licence on 1 April 2011. The Trust ensures it meets the conditions of its Licence through a process of self-assessment. There are no major issues or risks identified in relation to the Trust's continued compliance with its Licence.
- The most recent Care Quality Commission (CQC) rating overall is good (which includes a rating of good for the well-led domain). During 2022/23, the Board continued its development programme which included amongst other items equality, diversity and inclusivity training, understanding and measuring the value of a board, and system governance structures.
- A new Board development programme is now in development for 23/24.

An assessment by internal audit found the Trust's arrangements around the overarching governance and risk management arrangements provided significant assurance and the Head of Internal Audit Opinion is one of significant assurance on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The Board Assurance Framework and Organisational Risk Register with mitigating actions are reported to Trust Board on a quarterly basis set in the context of the Board's risk appetite statement.

Risk

The outcome of the inspection required some areas that require improvement. Mitigated by an action plan to address areas for improvement.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust continues to assess its compliance with CQC registration requirements on a regular basis through our quality improvement and assurance team. To support our assessment, we have developed a quality assurance and improvement 'self-governing' assessment model. This philosophy builds on our emphasis on self-governance and evaluation. As a series of methods and tools, this approach helps map the relationships between quality improvement and quality assurance and will provide a continual source of evidence for teams to inform how well they are performing against appropriate and helpful metrics for quality.

The Care Quality Commission has not taken enforcement action against South West Yorkshire Partnership NHS Foundation Trust during 2022/23.

There has not been a CQC inspection completed during 2022/23

Risk
The Trust does not comply with the requirements of its Licence. Mitigated by ongoing review of Trust compliance and reporting to Trust Board as part of the NHS Improvement / Monitor requirements.

-

The following also provide assurance to Trust Board that the Trust has good corporate governance arrangements in place and complies with its Licence:

Examples of corporate governance audits undertaken 2022/23and their ratings are:

Data protection & Security Toolkit – substantial assurance
System/partnership working: place governance - assurance
Care group risk management Care group risk management - significant assurance

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

- The Head of Internal Audit Opinion for 2022/23provides significant assurance on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

- As Accounting Officer, the Chief Executive prepares an Annual Governance Statement. This document describes the risk and assurance processes for the Trust and meets the requirements set out in NHS Improvement's Foundation Trust Annual Reporting Manual 2023. The Statement for 2022/23 was assessed as fit for purpose and meeting guidance as part of the audit of the Trust's annual report and accounts.
- The Trust's Board assurance framework and risk register have been assessed as appropriate as part of an internal audit of the risk and governance in 2022/23 which received significant assurance.
- The Trust Board reviews compliance with the NHS Constitution annually, and was last reviewed in February 2023
- The Constitution was updated in January 2023 to align to the NHS England Code of Governance for NHS Provider Trusts and was approved by Trust Board on 31 January 2023 and ratified by the Members Council on 24 February 2023
- The Trust Board receives annual self-certifications of compliance with the NHS Provider Licence (April) and corporate governance statement (June).

Risk
The Trust does not continue to have good corporate governance arrangements in place. Mitigated by submission of financial and performance metric data on a monthly basis, through ongoing review of internal governance processes and through internal audit processes.

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

In addition to measuring performance against our quality priorities we monitor our performance against a range of other key performance indicators (KPIs). A number of these are reported to our Trust Board and others are reported and acted upon internally. A range of performance data is also shared with our commissioners.

During 2022/23 the impact of the Covid-19 pandemic meant that contractual arrangements and national priorities around reporting shifted. Despite this, the Trust continued to report and monitor its performance against our strategic objectives using metrics that were already in existence. Additional operational data was identified in 2020/21 to assist with monitoring the impact and effect of Covid-19. This continued to be reported on during 2022/23.

For 2022/23, the Trust identified those metrics that would best demonstrate performance against achievement of its agreed objectives. These are reported to the Trust Board as part of the Integrated Performance Report (IPR) every month. The KPIs represent a mix of nationally and locally set targets. A review of the integrated performance report content and format commended in year.

Trust Board receives an Integrated Performance Report (IPR) on a monthly basis. This enables Trust Board to satisfy itself that the Trust is meeting its financial and quality performance targets. Other reports to Trust Board and its committees provide further assurance that the Trust is fulfilling its purpose in an effective and efficient manner.

In addition, actions identified from each of the internal audits are allocated a lead within the organisation and tracked through an online web portal 'Pentana'. Progress updates and supporting information is be uploaded to the tracker which are reviewed by auditors and action leads, and once complete they are closed by the auditor. The audit actions are tracked through updates to the Audit Committee.

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

Risk
Trust does not have regard to guidance. Mitigated by the Company Secretary having oversight of the systems and processes in place to ensure guidance is identified, captured, assessed and implemented.

The Accounting Officer, Deputy Director and Company Secretary ensure that Trust Board is made aware of guidance on good corporate governance from NHS Improvement, an assessment of the Trust's immediate position is undertaken and any action or development required to ensure compliance is initiated.

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

Risk
The Trust does not have effective structures at Trust Board level. Mitigated by annual committee review process, independent review by internal audit of effectiveness, clear view of roles and responsibilities, and clear approach to leadership and management throughout the Trust.

Trust Board is clear that its role is to set the strategic direction and associated priorities for the organisation, ensure effective governance for all services and provide a focal point for public accountability. The general duty of Trust Board, and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for members of the Trust as a whole and the public. Trust Board is clear of its accountability and responsibility.

Trust Board and committee structures in place are effective and meet the requirements of the Trust's Constitution. Committees are supported by terms of reference and annual work plans and have clear reporting mechanisms to Trust Board. The Trust Board has a work programme and agenda is drawn up with reference to the board assurance framework, and cycle of meetings. The Trust has eight committees:

- Audit Committee
- Clinical Governance and Clinical Safety Committee
- Equality, Inclusion and Involvement Committee
- Finance, Investment and Performance Committee
- Mental Health Act Committee
- People and Remuneration Committee
- West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative Committees-in-Common
- Charitable Funds Committee (Committee of the Corporate Trustee)
- Collaborative Committee

The Committees are chaired by a Non-Executive Director and, with the exception of the Audit Committee, have Non-Executive and Executive Director membership. The Audit Committee membership comprises exclusively of Non-Executive Directors. Agendas, which are risk-based, are compiled and agreed by the chair of the committee in conjunction with the lead Director. Each committee has an annual work programme, which is incorporated into agendas as appropriate. Lead Directors are responsible for ensuring, with the Company Secretary and lead PA for each meeting, that papers are commissioned to meet the Terms of Reference of the Committee, to provide assurance that risk is mitigated within the Trust and to provide assurance that the Trust is working to deliver and continuously improve the services it provides whilst achieving value for money and best use of resources.

The membership of committees is reviewed regularly by the Chair of the Trust in terms of Non-Executive Directors. The committee structure is reviewed for appropriateness from time-to-time by the Chair, with support from the Chief Executive and Company Secretary. An update to the internal meeting governance framework was agreed by Trust Board in December 2022.

Each committee is required to prepare an annual report, which is presented to the Audit Committee. The Audit Committee reviews overall effectiveness of committee structure. This provides assurance to Trust Board that each committee is meeting its terms of reference and is seeking assurance on areas of risk in line with its terms of reference. The outcome is reported to Trust Board annually in April.

The Executive Management Team's (EMT) role is to ensure that resources are deployed to support the delivery of the Trust's plan, to ensure that the Chief Executive can discharge their accountability to best effect through effective delegation and prioritisation of work, to support each other to find appropriate linkages and synergies, to ensure performance is scrutinised and challenged, both Trust-wide and by Care Groups (CGs), and to ensure the work of the EMT is aligned with that of Trust Board.

Trust Board is supported by an involved and proactive Members' Council, which forms a key part of the Trust's governance arrangements. The Members' Council is clear that its role is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of the members of the Trust as a whole and the interests of the public. The Members' Council continues to develop its skills and experience in its ability to challenge and hold Directors to account for the Trust's performance. The Members' Council holds an annual session specific to holding the Non-Executive Directors to account. This is supported by a training session to enable the governors to develop their skills to run the session successfully.

The Trust works within a framework that devolves responsibility and accountability throughout the organisation through robust service delivery arrangements. There are clear structures with clear responsibility and accountability below Director level. Within CGs, deputy directors provide operational leadership and management allowing CG Directors to focus on building and managing strategic and partner relationships and to lead the transformation agenda. CGs are supported by arrangements at service line level where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to ensure excellence in service delivery and quality and to enact the service change required to achieve transformation.

CGs are supported by corporate directorates, which provide co-ordinated support services linked to the accountabilities of executive directors. There are six domains comprising financial management, information and performance management, people management, estates management, compliance, governance and public involvement and engagement, and service improvement and development.

4. The Board is satisfied that the Trust effectively implements systems and / or processes:

- **a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively**
- **b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations**
- **c) to ensure compliance with healthcare standards binding on the Licence holder, including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions**
- **d) for effective financial decision-making, management and control (including, but not restricted to, appropriate systems and / or processes to ensure the Licence holder's ability to continue as a going concern)**
- **e) to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Trust Board and Committee decision-making**
- **f) to identify and manage (including, but not restricted to, manage through forward plans) material risks to compliance with the conditions of its Licence**

g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and, where appropriate, external assurance on such plans and their delivery
h) to ensure compliance with all applicable legal requirements.

Risk
The Trust does not have the systems and processes to ensure compliance with its Licence. Mitigated by performance reporting arrangements to Trust Board, including exception reports on areas of risk or concern, quarterly exception reports, robust committee arrangements in place providing assurance that the systems and processes in place are effective.

As part of its annual audit, the Trust's external auditor, Deloitte, will determine they are satisfied that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources in 2022/23. This work will be completed by the end of August 2023.

The Trust's internal audit plan is risk-based to enable the Trust to identify areas where improvement is sought and to learn from best practice. The Audit Committee approved the internal audit plan for 2022/23. The plan included core reviews to inform the Head of Internal Audit Opinion relating to core financial controls, governance, and risk management, which included a focus on Board committee arrangements, policy monitoring and data security and protection toolkit. This was supported by a number of cyclical and risk reviews covering cost improvement process and reporting. The work undertaken by internal audit is contained in an annual audit plan approved by the Audit Committee. Development of the work programme involves pre-discussion with the EMT. It is based on an audit of core activity around areas such as financial management, corporate governance and Board assurance processes, and audit of other areas following assessment and evaluation of risks facing the Trust. This includes priority areas identified by the EMT focusing on risk and improvement areas. Internal audit provides the findings of its work to management, and action plans are agreed to address any identified weaknesses. Internal audit findings are also reported to the Audit Committee for consideration and further action if required. A follow up process is in place to ensure that agreed actions are implemented. Internal audit is required to identify any areas at the Audit Committee where it is felt that insufficient action is being taken to address risks and weaknesses.

In respect of the internal audit plan for 2022/23, 7 internal audit reviews have been conducted and presented to the Audit Committee Have been completed and presented to the Committee. Of these, there were:

- 4 'significant assurance' reports
- 1 'substantial' assurance report
- 2 'limited assurance' report

In addition, two further reports were received in year, carried over from 21/22, which received significant assurance.

Action plans are developed for all internal audit reports in response to the recommendations and the Audit Committee invites the lead Director for each 'limited' or 'no assurance' report to attend to provide assurance on actions taken to implement recommendations. For all 'limited' and 'no assurance' reports, a follow up audit is undertaken within twelve months. Completion of recommended actions is tracked by

the Audit Committee and over the course of the year there is a first follow up implementation rate of 86% and an overall implementation rate of 94%.

The Head of Internal Audit's overall opinion for 202223 provided **significant assurance**' that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The conclusions and recommendations from all internal audit reports are reported into EMT and the Audit Committee and if deemed appropriate the Audit Committee will seek further assurance and updates on actions being taken.

The Trust continues to develop and implement service line reporting, which is monitored and scrutinised by the Audit Committee on behalf of Trust Board. Further work will be undertaken in the coming year to use the information to benchmark internally and learn from best practice.

Trust Board receives an Integrated Performance Report (IPR) on a monthly basis. This enables Trust Board to satisfy itself that the Trust is meeting its financial and quality performance targets. Other reports to Trust Board and its committees provide further assurance that the Trust is fulfilling its purpose in an effective and efficient manner.

The Trust was (and continues to be) registered with the Care Quality Commission (CQC) with no conditions. The Trust has a robust process in place to ensure that it meets the requirements of its registration. Action plans were developed in response to recommendations included in the most recent inspection reports published in 2019.

The Trust continues to assess its compliance with CQC registration requirements on a regular basis through our quality improvement and assurance team. To support our assessment, we have developed a quality assurance and improvement 'self-governing' assessment model. This philosophy builds on our emphasis on self-governance and evaluation. As a series of methods and tools, this approach helps map the relationships between quality improvement and quality assurance and will provide a continual source of evidence for teams to inform how well they are performing against appropriate and helpful metrics for quality.

The following steps have been put in place to assure the Trust Board that appropriate controls are in place to ensure the accuracy of data, these are described below and demonstrate that there are appropriate arrangements in place to ensure the quality and accuracy of performance information.

We have a strong system of quality reporting:

- Quality metrics are reviewed monthly by Trust Board and the EMT, alongside the performance reviews undertaken by CGs as part of their governance structures.

- The Integrated Performance Report covers substantial quality and performance information and is reported to the Board and EMT. This is supplemented by detailed reports on specific elements of quality, such as incidents, complaints and patient experience.
- The Clinical Governance and Clinical Safety Committee oversee the development of the Quality Account and associated detailed reports.
- Corporate leadership of data quality through the Director of Finance and Resources, supported by the Chief Nurse/Director of Quality, and Professions.
- Data quality objectives that are linked to business objectives, supported by the Trust's Data Quality Policy and evidenced through the Trust's Information Assurance Framework.
- The commitment to, and responsibility for, data quality by all staff is clearly communicated through Trust induction, mandatory training for information governance and training for the Trust's clinical information systems.
- The Director of Nursing, Quality, and Professions (Caldicott Guardian) and Director of Finance and Resources (SIRO) co-chair the Trustwide Improving Clinical Information and Information Governance (ICIG) meeting. The group ensures there is a corporate framework for management and accountability of data quality, with a commitment to secure a culture of data quality throughout the organisation.
- The effectiveness of the Trust's arrangements is scrutinised by the Audit and Clinical Governance and Clinical Safety Committees.

The CQC 'Monitoring the Mental Health Act in 2019/20' looked at how services nationally responded to the pandemic.

The Trust implemented a range of actions to ensure that service users' rights continued to be upheld during the pandemic period. The Mental Health Act teams, clinical staff and associate hospital managers successfully developed virtual and 'paper' hearings, supported virtual tribunals and established access to advocacy through virtual means. Face-to-face visits with Independent mental health advocates and independent mental capacity advocates resumed in September 2020. The pandemic led to restricted visiting in all Trust inpatient areas and a Virtual Visitor scheme was developed.

A quarterly briefing is also provided to the Trust Mental Health Act Committee.

The Trust accounts are prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual which defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. This was confirmed by the Trust Board in April 2023.

The Trust has policies and procedures in place to ensure it complies with legislation both as an employer and as a provider of NHS services

Risk
The Trust is unable to meet the requirements of its operational and financial plans. Mitigated by regular review at finance, investment and performance committee to ensure its plans provide sufficient investment in services and to consider the planned end-of-year outturn position.

The Board Assurance Framework and Organisational Risk Register with mitigating actions are reported to Trust Board on a quarterly basis set in the context of the Board's risk appetite statement. Other key issues are identified through the biennial Board investment appraisal reports along with PESTLE (Political, Economic, Sociological, Technological, Legal, Environmental) and SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis and are set out below. In addition to the key risks identified above we identified and acted upon a number of other issues as set out below.

The Trust continues to lay the foundations for its ambitious vision to provide outstanding physical, mental, and social care in a modern health and care system. This is backed by priority programmes and associated structures. The priority programmes help to address the strategic risk of having insufficient capacity and help to prioritise our efforts.

During 2022/23 we have undertaken a significant amount of work in integrated care partnerships in each of our four local areas. We have also worked with partners in each of our places to develop the governance structures and approach in response to the new Health and Social Care Bill which has been given royal assent and becomes law as of 1 July 2022.

In Barnsley the Trust continues to be a key partner within the Barnsley Integrated Care Partnership which brings partners together from across the system to develop new models of care and integrated clinical pathways and to monitor system performance.

We have provided data and insight into the intelligence cell and have provided significant support into the public vaccination programme. Our community services have worked consistently with those of the acute hospital to ensure that people have been discharged quickly with the right level of support. We have received external recognition for our integrated discharge to assess processes.

We have contributed to a place-based plan which focuses on addressing health inequalities in the Barnsley population. Collectively we have further developed a three-tier model for addressing inequalities which is supported by a collective plan to address inequalities in Barnsley.

We have further developed an alliance agreement with the Barnsley Healthcare Federation with joint leadership arrangements to enable closer alignment between primary and community care for the people of Barnsley. We have also developed a joint operational plan that prioritises learning disabilities (LD) and severe mental illness (SMI) annual health checks to address inequalities. Frailty and dementia are also a shared priority.

We have worked with the whole system to deliver the Mental Health strategy under the leadership of the Mental Health Partnership Board. We are working with system partners to deliver the community mental health transformation in Barnsley.

In **Calderdale** we have contributed to a place-based plan which focuses on addressing health inequalities in the Calderdale population. We have continued to work with the system leadership to implement the single plan for Calderdale, Calderdale Cares, that sets out the vision to

improve, health, social and economic outcomes for local residents. This has included working with partners to accelerate the arts, health, and wellbeing agenda. We have helped lead the collaborative work within community and primary care services for the people of Calderdale. This has included work with care homes and the community mental health transformation. We are part of a collaborative in Calderdale with a focus on tackling climate change, increasing social value and supporting new ways of integrated working in the Upper Calder Valley

This year we have continued to support creativity and health within Calderdale with positive feedback. This has been recognised as exemplary practice by the National Centre for Creative Health. We have also continued to integrate physical activity into systems and processes as part of the Active Calderdale Programme, which through its strategy aims to ensure Calderdale is the most active borough in the north by 2024.

In Kirklees we have contributed to a place-based plan which focusses on addressing health inequalities in the Kirklees population. We have continued work on the development of an alliance of partners to deliver mental health and wellbeing service improvements for the people of Kirklees, through the Kirklees Mental Health Alliance. We have been a pro-active partner in the development of Kirklees Place-based partnership arrangements as part of the establishment of the statutory West Yorkshire Integrated Care System during 2022. We are working with partners to develop the Kirklees Health and Care Plan.

Across Kirklees, Calderdale, and Wakefield:
- We continue to work closely with colleagues in the Mid Yorkshire Hospitals and Calderdale and Huddersfield Trusts at a strategic and operational level to improve care and pathways for people with a mental health problems who access their emergency and inpatient services.

In **Wakefield** we have contributed to a place-based plan which focuses on addressing health inequalities in the Wakefield population. We have played a strong role in the Wakefield District Health and Care Partnership, which has continued to progress the integration agenda underpinned by a *System partnership principles of ways of working together.* We are the 'host' of the Wakefield Mental Health Alliance, which is accountable to the Wakefield Provider Collaborative. The Alliance provides a framework for all partners to be involved in service transformation, improvement, and investment prioritisation. This work is led by the Trust through our Director of Provider Development.

Work with partners in Wakefield to increase uptake of annual health checks (AHC) for people with learning disabilities has continued. At end March 2023, our AHC figure for people aged 14+ with a learning disability in Wakefield was 77.4%, exceeding the target for the year (75%). This work has included providing training to GP practices, working with the ICB and Healthwatch Wakefield to audit GP practices for accessibility of AHCs, and proactive engagement with those experiencing barriers to attending for an AHC.
The community learning disabilities team have developed much more joined up partnership relationships with other providers, such as care homes, to support reduction of health inequalities for people with learning disabilities in care homes and other provider settings.

The Trust is an active participant in two Integrated Care Systems (ICS) and we have continued to work with partners. In both ICSs we have participated in the development of the transformation of community mental health services.

In **South Yorkshire Integrated Care System,** we have worked to connect and align our work on addressing health inequalities. we have worked with provider partners within the mental health learning disabilities and autism provider collaborative across the ICS and have connected the work of the partnership group for Barnsley. We have participated in the development of a population health management approach. Our work on social responsibility and sustainability is aligned to the work across the ICS.

The Trust achieved 'go live' for the South Yorkshire and Bassetlaw (SYB) Adult Secure Provider Collaborative on 1 May 2022, for which the Trust leads the Provider Collaborative. Provider collaboratives are a partnership of mental health, learning disability and autism service providers led by an NHS lead provider working to provide co-ordinated and improved specialised services across a specified geography. They work in partnership to improve services and ensure that services are provided as close as possible to patients' homes, using commissioning budgets innovatively to improve patients' experience and outcomes across whole care pathways. Commissioning arrangements for the collaborative are established through the SYB Mental Health Provider Collaborative Commissioning Hub. Oversight of the Trust's commissioning responsibilities for the collaborative is via the Collaborative Committee (see below). The Trust are members of the South Yorkshire and Bassetlaw Partnership Board which oversees the SYB specialised provider collaboratives (Adult Secure, CAMHS and Adult Eating Disorders).

In the **West Yorkshire Health and Care Partnership** we have been involved in a range of work under the auspices of the WY Mental Health, Learning Disabilities & Autism Programme Board, including work streams on neurodiversity, complex mental health rehabilitation, psychiatric intensive care unit beds and children and young people's mental health. The Trust is the coordinating provider for the West Yorkshire Adult Secure Lead Provider Collaborative, working with NHS and independent sector providers in West Yorkshire. In May 2022 the Trust constituted a new committee (Collaborative Committee) the purpose of which is to ensure delineation between provision and commissioning responsibilities (finance, contracting, planning and quality assurance) of the West Yorkshire Adult Secure Provider Collaborative and other specialised mental health provider collaboratives as appropriate and to provide oversight and assurance of the Trust's commissioning responsibilities as Lead Provider.

The Trust are a partner in the West Yorkshire Adult Eating Disorder Provider Collaborative, and Children and Young People's Mental Health Provider Collaborative – both coordinated by Leeds and York Partnership NHS Foundation Trust. Over the past year, the Trust has continued to work with partners to plan for Phase 2 of the Specialised Provider Collaborative Programme.

The Trust continues to develop and create capacity in the communities we serve through innovative models of delivery and support for service users and carers. We have developed a recovery approach with recovery colleges across our districts. Alongside this we host Altogether Better, a national initiative which supports development of community champions. This is all complemented by our charity EyUp! and linked charities Creative Minds, Spirit in Mind and the Mental Health Museum. Creative Minds is a partnership with over 100 third sector organisations, delivering sport, leisure and creative activities that build resilience and wellbeing. Spirit in Mind delivers faith-based support.

5. The Board is satisfied that:

a) there is sufficient capability at Trust Board level to provide effective organisational leadership on the quality of care provided **b) Trust Board's planning and decision-making processes take timely and appropriate account of quality of care considerations** **c) the collection of accurate, comprehensive, timely and up-to-date information on quality of care** **d) Trust Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care** **e) the Trust, including Trust Board, actively engages on quality of care, with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources** **f) there is clear accountability for quality of care throughout the Trust, including, but not restricted to, systems and/or processes for escalating and resolving quality issues, including escalating them to Trust Board where appropriate.**
<u>Risk</u> *The Trust does not have the capacity and capability at Trust Board level. Mitigated by quality performance reporting to Trust Board, annual quality report, customer services processes and ongoing engagement with stakeholders, service users / carers and staff, clear process in place for whistleblowing and raising concerns, and processes in place for recruitment and selection of Trust Board members.* The Trust continues to regularly review processes against governance best practice, including: • policies developed, reviewed and in place • governance systems • the assurance framework and risk register presented to Trust Board quarterly • Integrated performance report submitted monthly to Trust Board • audits undertaken both internally and externally • a programme of unannounced visits • reports submitted to Trust Board and its Committees, as well as the Members' Council, detailing our performance against mandatory, contractual, quality & safety metrics and action plans as required. The Trust's Quality Account publication for 2022/23 will provide a summary of the Trust's quality achievements and challenges, demonstrating how it meets its statutory and regulatory requirements as well as how it meets the expectations of its service users, carers, stakeholders, its members and the public. The report will not be externally audited as this is not currently a requirement and will be submitted to NHS England in June 2023. The process introduced by the Chief Nurse/Director Quality, and Professions to assess risk to and impact on quality and safety of the cost improvement and efficiency savings proposed by CGs continued to be applied in 2022/23. The Quality Impact Assessment process, led by the Director of Nursing, Quality, and Professions undertaken in conjunction with clinical and general management within CGs, provides assurance throughout the process to the Executive Management Team (EMT) and, through regular reports, to the Clinical Governance and Clinical Safety Committee and Trust Board that cost improvements do not have an adverse effect on Trust services.

Quality impact assessments are carried out on all Trust cost improvement plans with Medical Director and Director of Nursing, Quality, and Professions approval required before a scheme can proceed. Quality Impact Assessments (QIAs) can also be invoked in year where concerns trigger the requirement to do so.

Given the temporary financial arrangements in place, with the suspension of cost improvement programmes during 2022/23 this process was not required during the year. It is being reintroduced for 23/24.

The Trust's approach to quality improvement is clear that quality is the responsibility of all staff from 'ward to board'. Reporting processes and mechanisms through Trust Board, its committees, EMT and through to CGs and their governance processes reflects this approach. Accountability for quality is also clear through the leadership and management arrangements within the Trust. CGs continue to enable better and more rapid decision-making, as close as possible to the point of care delivery, which, in turn, enables more effective clinical engagement and leadership in service development and delivery as well as providing service users with greater access to decision-making.

The Trust's approach to clinical quality improvement is based on continuous service improvement, working in innovative ways to meet local priorities, to ensure compliance with national standards and external regulation, adoption of lean systems thinking, and making the most of shared learning opportunities across the healthcare system, using quality to deliver best value. The Trust's strategic priorities and combined support service offer aligns clinical services and support functions to deliver the best care possible to those who use Trust services.

Trust Board receives regular reports, directly and through the Clinical Governance and Clinical Safety Committee, on all aspects of clinical quality and safety including management of incidents and complaints, equality and diversity, service user experience, control of infection and research and development. The Clinical Governance and Clinical Safety Committee provides assurance to Trust Board that issues and risks identified in a number of portfolio areas, such as managing aggression and violence, safeguarding adults and children, infection prevention and control, reducing restrictive practice, and information governance, are being addressed. Where the Clinical Governance and Clinical Safety Committee identify an area of concern which has been raised at a particular time, it is scrutinised on behalf of the board by receiving regular reports for a period.

Performance reports to Trust Board provide assurance against a range of Key Performance Indicators (KPIs) relating to service quality and, where reports indicate underperformance, action plans are provided to and monitored by Trust Board. This was continued for priority indicators during 2022/23.

The Trust has a range of arrangements in place for monitoring service user experience as an indicator of service quality.

The Trust has in place an Equality, Involvement, Communication and Membership Strategy which has supporting annual action plans to ensure an integrated approach. This is insight driven and will ensure:

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

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

The Trust is compliant with the Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infection (Hygiene Code). The Trust has an Infection Control Strategy in place and the infection control annual plan and annual report are considered by the Clinical Governance and Clinical Safety Committee on behalf of Trust Board. Trust Board monitors infection control through the monthly performance reports and the quarterly compliance report. Hygiene and quality of environment are maintained through cleaning schedules and through service level agreements and regular visits to clinical areas by the Director of Nursing and Quality, include checks for cleanliness.

The Trust publishes information in relation to the Friends and Family test for service users and staff.

The Trust actively engages with its service users, their carers, staff and stakeholders on the quality of its services through the development of its Quality Account and in the development of its services.

The Trust has a whistleblowing policy in place, which sets out clearly staff responsibility to raise concerns and how they can do this. The policy is clear on the escalation process and who concerns should be reported to. The policy is supported by information on the Trust's intranet and in associated documentation, such as the fraud and bribery act policy, safeguarding policies, and serious incident reporting and management policy. Arrangements are scrutinised by the Audit Committee. The Trust has also appointed Freedom to Speak Up Guardians (FTSUG), rather than one individual due of the diverse nature of services and large geographical spread of the Trust, the FTSUG provide staff with another way to raise concerns at work. Trust Board has also identified the Deputy Chair as the Senior Independent Director. All Executive Directors have regular one to one meetings with the Chief Executive to ensure that any incidents/concerns are discussed at a senior level in the Trust.

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

Trust Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.

The Chair and Non-Executive Directors have a broad base of skills and experience, including financial, commercial, legal, community engagement, and health and social care. It is the role of the Nominations Committee to assess the mix of skills and experience across Trust Board annually and when appointing Non-Executive Directors to the Board and to ensure a balance is maintained with skills complementing those of Executive Directors. To inform this process and to ensure Trust Board retains a balance of skills and experience to operate effectively as a unitary board, a review of Trust Board skills and experience will be undertaken as part of the Trust Board development plan. The recruitment process for new members of the Trust Board incorporates testing against the values of the organisation and discussion panel including staff (with representation from staff equality networks), governors and service users / carers.

All new Non-Executive Directors have a detailed induction programme tailored to individual requirements and Board responsibilities. The Chair is subject to an annual assessment of performance by the Members' Council, led by the Senior Independent Director, and involving Non-Executive Directors, Executive Directors, Governors and stakeholders. Trust Board undertakes ongoing Board development, using external expertise where required. During 2022/23 a structured development programme was followed using the NHS Improvement framework.

The Chief Executive is subject to formal annual appraisal by the Chair. Executive Directors are subject to annual appraisals by the Chief Executive, and Non-Executive Directors are subject to annual appraisal by the Chair, both of which inform individual development plans for all Board members. The outcome of the Non-Executive Director appraisals is reported to the Members' Council.

Continuous professional development of clinical staff, including medical staff, supports the delivery of high quality clinical services. The Trust has policies, processes and procedures in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and re-validation requirements. This process of assessing the organisation's readiness for medical and nursing re-validation has been scrutinised both by Trust Board and by the Clinical Governance and Clinical Safety Committee.

Trust Board satisfies itself that the management team has the necessary skills and competencies to deliver the Trust's strategic objectives. Where gaps are perceived, the Chief Executive will seek to address Trust Board concerns, supported by the Workforce and Remuneration Committee.

All appointments to senior management positions are subject to rigorous and transparent recruitment processes. Senior managers have objectives linked to the delivery of the strategic objectives and operational plan. The Chair and Chief Executive continue to review the capacity of senior managers within the Trust to ensure there is the required and necessary balance to deliver and maintain high quality and safe services during a time of unprecedented transformational change within the organisation and wider NHS and succession planning. Professional and clinical leadership is devolved into the organisation under the leadership of the Chief Nurse/ Director of Quality and Professions, and the Chief Medical Officer.

Through our leadership and management development framework, we have continued to support our leaders and managers in their needs-led development on a limited basis during the year. We have provided continuing access to:

- Institute of Leadership and Management (ILM) qualification & non-qualification programmes and CPD activities
- Executive coaching, 1:1 & peer coaching, mentoring, and reciprocal mentoring.
- Building Leadership for Inclusion (BLFI) programmes to support the development of colleagues from under-represented communities or with protected characteristics
- Talent pool and talent programmes in partnership with the Wakefield District Health and Care Partnership and the West Yorkshire Mental Health Collaborative.
- Hosting of both a Fellow and an NHS Graduate Trainee.

We are closing 202/23with a review and reset of our leadership and management framework to reflect our post pandemic needs and role as a leader in place and system from 2023-24onwards.

The planned roll out of the Great Place to Work Leadership Forum was paused due to a pausing of non-essential learning &and development activity and service pressures. The programme has been co-designed with colleagues working in ward manager &and team leader roles, with input from senior managers. The programme re-started in April 2022.

Risk
The Trust does not have suitably qualified individuals at all levels of the organisation. Mitigated by recruitment and selection processes for Trust Board, Director-level appointments and staff at all levels.

For non-medical professional qualifications, all nursing, allied health professionals and psychology registered professional staff are subject to revalidation arrangements through their professional bodies. The Trust provide a monitoring and reminder system to all registered professional staff to ensure that registration is maintained. The revalidation process is also monitored by nominated professional leads with routine reporting into Clinical Governance and Clinical Safety Committee around compliance.

The Nursing and Midwifery Council (NMC) have remained clear that if a nurse is able to revalidate within the allocated timeframe, then they should so, however, during the Covid-19 pandemic, the NMC helped to support the process of revalidation by providing extensions where required. For those due to revalidate between July and December 2020 who required more time to send their application, a request for a 12-week extension was available through the NMC Online account.

For nurses due to revalidate from January 2021, if more time is required to complete an application, an 8-week extension can be sought through the NMC Online account. The NMC require a reason for the extension and each request is considered on a case by case basis.

For the recruitment of medical staff, doctors are assessed during the application and interview process to ensure they have the relevant qualifications and experience to fulfil the post. Medical HR will meet with the doctors to verify their ID and complete the Disclosure and Barring Service (DBS) check. The Medical Directorate request information relating to 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 Responsible Officer (RO), prior to 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.

Once a doctor joins the organisation, they are connected to the Trust on the General Medical Council (GMC) connect and added to the appraisal system, L2P. They have an induction meeting with the Associate Medical Director (AMD) of Appraisal and Revalidation and after this are appraised in line with their dates. All appraisals are reviewed by the AMD and Responsible Officer (RO), before being passed or returned to the individual. There are regular meetings between AMD,RO and business manager and any issues are raised in these meetings. In addition, there is a Responding to Concerns Action group (RtCAG), whose membership comprises of RO, AMD, Medical Director, Director of Nursing & Quality and Chief people Officer, where any issues about a doctors fitness to practice are raised, including reviewing any complaints with a named medic.

From the 2021/22 appraisal report to the trust Board, 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. Post-Covid-19, medical appraisal and revalidation has reverted back to pre-pandemic processes and timescales following a period of paused appraisals.

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Trust Board 27 June 2023
Agenda item 12.1

Private/Public paper:	**Public**		
Title:	**Use of Trust Seal**		
Paper presented by:	Adrian Snarr - Director of Finance, Estates and Resources		
Paper prepared by:	Andy Lister - Head of Corporate Governance		
Mission/values:	Respectful, honest, open and transparent. Relevant today and ready for tomorrow.		
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	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	N/A		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Compliance with the Trust's Standing Orders provides assurance to systems and partners of the Trust's adherence to the framework within which the Trust operates and how its officers conduct Trust business.		
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 since the last report to Board in March 2023.
Recommendation:	**Trust Board is asked to NOTE the update to the Trust Seal since the last report in March 2023.**

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Trust Board annual work programme 2023-24

	Business and risk
	Performance and monitoring
	Strategic Board Meeting
✘	Item deferred

Note that some items may be verbal

Agenda item / issue	25 Apr	30 May	27 June	25 July	22 Aug	26 Sept	31 Oct	28 Nov	19 Dec	30 Jan	27 Feb	26 Mar
Standing Items												
Welcome, Introduction and Apologies	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
Declarations of Interest	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
Minutes from the previous meeting	✘		✘	✘		✘	✘	✘		✘		✘
Action log and matters arising from previous meeting	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
Service User/Staff Member/Carer Story	✘		✘	✘		✘	✘	✘		✘		✘
Chair's remarks	✘		✘	✘		✘	✘	✘		✘		✘

Agenda item / issue	25 Apr	30 May	27 June	25 July	22 Aug	26 Sept	31 Oct	28 Nov	19 Dec	30 Jan	27 Feb	26 Mar
Chief Executive's Report	✘		✘	✘		✘	✘	✘		✘		✘
Questions from the public (item 3)	✘		✘	✘		✘	✘	✘		✘		✘
Any other business (public and private)	✘		✘	✘		✘	✘	✘		✘		✘
Risk and Assurance												
Board Assurance Framework	✘			✘			✘			✘		
Corporate / organisational risk register	✘			✘			✘			✘		
Strategic overview of business and associated risk											✘	✘
Review of Risk Appetite statement							✘					
Complex Incidents update (private session)	✘		✘	✘		✘	✘	✘		✘		✘
Serious Incidents quarterly report (public)			✘			✘		✘				✘
Risk assessment of performance targets, CQUINS and System Oversight Framework and agreement of KPIs (when published)			✘	✘								
Assurance from Trust Board committees and Members' Council	✘		✘	✘		✘	✘	✘		✘		✘
Guardian of safe working hours annual report			✘									
Workforce Equality Standards						✘						
Medical appraisal / revalidation annual report						✘						
Ligature Annual Report								✘				
Freedom to Speak Up Annual report (July Annual report and January 6 monthly update)				✘						✘		
Medical Education Annual Board report								✘				

Agenda item / issue	25 Apr	30 May	27 June	25 July	22 Aug	26 Sept	31 Oct	28 Nov	19 Dec	30 Jan	27 Feb	26 Mar
Data Security and Protection toolkit	✘ (update)		✘									
Annual report and accounts (including Quality Account for 2022)		✘										
Annual Governance Statement	✘											
Equality and diversity annual report							✘					
Incident management annual report			✘									
Health and safety annual report			✘									
Patient Experience annual report			✘	✘								
Sustainability annual report						✘						
Premises Assurance Model (new annual report 2021)			✘									
EPRR Compliance report						✘						
IPC BAF												✘
Integrated Care Systems and Partnerships												
South Yorkshire update including the South Yorkshire Integrated Care System (SY ICS)	✘		✘	✘		✘	✘	✘		✘		✘
West Yorkshire update including the West Yorkshire & Health & Care Partnership (WYHCP)	✘		✘	✘		✘	✘	✘		✘		✘
Provider Collaboratives and Alliances	✘		✘	✘		✘	✘	✘		✘		✘
Performance reports												
Integrated Performance Report (IPR)	✘		✘	✘		✘	✘	✘		✘		✘
Safer Staffing report	✘							✘				
System Oversight Framework (when released)			✘									

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Service Line Performance report (private – under review)	✘		✘	✘		✘	✘	✘		✘		✘
Strategic Direction												
Board Development		✘			✘				✘		✘	
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 (if required)							✘					
Compliance with NHS provider licence conditions and code of governance (now changed due to new corporate governance code – to be confirmed)												
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**							✘					

Agenda item / issue	25 Apr	30 May	27 June	25 July	22 Aug	26 Sept	31 Oct	28 Nov	19 Dec	30 Jan	27 Feb	26 Mar
Estates strategy **update**										✘		
Policy on Policies *(April 2023)*	✘											
Standards of Conduct in Public Service Policy (conflicts of interest)	✘											
Customer Services policy *(June 2023)*			✘			✘						
Equality, Involvement, Communication and Membership Strategy *(October 2023)*							✘					
Estates strategy (full)				✘								
Learning from Healthcare Deaths Policy *(January 2024)*										✘		
Workforce strategy *(March 2024)*												✘
Digital Strategy (full) *(March 2024)*												✘
Trust Board declaration and register of fit and proper persons, interests and independence policy *(March 2024)*												✘

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 (October 2023) (if required)
- Equality, Involvement, Communication and Membership Strategy (October 2023)
- Emergency Preparedness Resilience and Response Policy (November 2025)
- Customer Services Policy *(June 2023)*
- Digital Strategy *(next due for review in March 2024)*
- Estates Strategy *(July 2023)*
- Learning from Healthcare Deaths Policy *(next due for review in January 2024)*
- Organisational Development Strategy *(integrated into GPTW strategy)*
- Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) *(April 2023)*
- Procurement Strategy
- Quality Strategy *(March 2026)*

- Risk management governance framework *(next due for review in April 2025)*
- Standards of Conduct in Public Service Policy (conflicts of interest) *(next due for review in September 2025)*
- Sustainability and Social Responsibility Strategy *(July 2025)*
- 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 2024)*
- Research and Development Strategy *(October 2025)*